STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012705	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKS AT NORTHERN LIGHTS (THE)	**702 BRATLEY DRIVE , WASHBURN, Wisconsin, 54891**

(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) COMPLETION DATE
N0000	Initial Comments On 10/12/2026, Surveyor conducted a verification visit and complaint investigation at Oaks at Northern Lights (The). Three of 3 complaints were substantiated. Three violations were identified. All violations were repeat violations. See Statement of Deficiencies (SOD) 8G0P12, dated 10/12/2024; SOD 8G0P13, dated 06/03/2025; and SOD 8G0P14, dated 03/23/2026. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 17	N0000		
N0230	Orientation 83.19 Before an employee performs any job duties, the CBRF shall provide each employee with orientation training which shall include all of the following: (1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); (5) CBRF policies and procedures; (6) Recognizing and responding to resident changes of condition. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the provider did not ensure 1 of 2 employees sampled had completed required orientation prior to performing job duties.	N0230		

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

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N0230	Continued from page 1 This is a repeat violation. See Statement of Deficiencies 8G0P12, dated 10/12/2024. Findings include: On 10/12/2026, Surveyor reviewed records for Caregiver A, hired on 09/09/2026; and Caregiver B, hired on 09/14/2026. Caregiver B's record included a document titled, "Care Assistant Training Checklist." The checklist included Caregiver B's hire date. The checklist included the following training tasks, listed in a column: - Emergency plans - Facility policies and procedures - Resident care plans - Reporting changes in resident condition Next to the training tasks column was a column of boxes for Caregiver B's initials as well as his/her trainer's initials, which indicated Caregiver B had completed the task. Next to the initials was a column that was labeled as "Date." The emergency plan training, resident care plan training, and reporting changes in resident condition training were not initialed as completed, nor were they dated. No training on the checklist was dated. There were signature lines at the bottom of the checklist for both Caregiver B and his/her trainer, as well as a line labeled "Date of Completion." None of the lines were filled out. Surveyor reviewed the facility's employee schedule for 09/13/2026 to 09/26/2026. The schedule showed that Caregiver B had worked on 09/22/2026, 09/23/2026, 09/25/2026, and 09/26/2026. At approximately 1:37 PM, Surveyor interviewed Director of Wellness (DOW) C. DOW C stated the dates on the schedule with Caregiver B's name on them were the days s/he was training on the floor at	N0230		

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N0230	Continued from page 2 the facility performing caregiver duties. DOW C stated the orientation checklist was completed over a series of days. DOW C stated Caregiver B was not yet done with his/her training checklist. At approximately 2:10 PM, Surveyor interviewed DOW C again. DOW C stated the resident care plans were reviewed with new staff when they were trained on working with medications and the medication cart. DOW C stated the medication cart training, along with care plan review, was done later in the orientation training checklist. The provider did not ensure all employees completed orientation training prior to performing job duties when Caregiver B was working on the floor without having completed all the required orientation training topics.	N0230		
N0352	Rights of Residents: Receive medication 83.32(3)(h) 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 LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the provider did not ensure each resident had the right to receive medications as prescribed by a practitioner. Two of 5 residents sampled were not administered medications as prescribed. This is a repeat violation. See Statement of Deficiencies 8G0P14, dated 03/23/2026. Findings include: On 07/23/2026, 08/19/2026, and 09/16/2026, the Department received complaints about medication administration. On 10/12/2026, at approximately 10:58 AM, Surveyor	N0352		

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N0352	Continued from page 3 interviewed Director of Wellness (DOW) C. DOW C stated there had recently been an issue with staff administering medication to Resident 1. DOW C stated one of Resident 1's medications had run out, and staff had not notified DOW C that it was out. DOW C stated the medication prescription was not filled correctly by the pharmacy. DOW C stated there was a discrepancy with Resident 1's medication orders that DOW C was not aware of. DOW C stated Resident 1 had gone 14 days without receiving the medication. At approximately 1:37 PM, Surveyor interviewed DOW C again. DOW C stated there was an issue with staff miscommunication. DOW C stated Caregiver E would mark the medications as administered in residents' medication administration records (MARs) when s/he had not been the one to administer the medications. DOW C stated staff who had actually been passing medications would not sign off on the MARs but tell Caregiver E they planned to administer medications. DOW C stated Caregiver E would then mark the medication as administered on the MARs, without verifying actual administration. DOW C stated medications were missed as a result. DOW C stated Resident 2's lidocaine patch had been left on him/her for a couple of days due to staff miscommunication. DOW C stated there had been another incident with Resident 2's lidocaine patch which resulted in Resident 2 going a day without his/her patch. DOW C stated Agency Staff (AS) D had marked Resident 2's MAR as having administered his/her lidocaine patch. DOW C stated another staff went to remove the patch at the end of the day but discovered that the patch was not on Resident 2. DOW C stated AS D had thought Resident 2 was a different resident. Surveyor reviewed records for Resident 1, admitted on 07/02/2026; and Resident 2, admitted on 01/14/2026. The records included the following: RESIDENT 1 Resident 1's face sheet, which listed Resident 1's diagnoses. The diagnoses included Parkinson's disease, multi-system degeneration of the automatic nervous system, gastro-esophageal reflux disease, major depressive disorder, and hypothyroidism. Medication orders from 07/01/2026 to 10/31/2026.	N0352		

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N0352	Continued from page 4 The orders indicated Resident 1 was prescribed the following medications: - 50 milligrams (mg) of lamotrigine to be given by mouth twice daily for Parkinson's disease and multi-system degeneration of the autonomic nervous system. - 100 mg of gabapentin daily at bedtime for multi-system degeneration of the autonomic nervous system. - 25 micrograms (mcg) of levothyroxine daily in the morning for hypothyroidism. - 15 mg of mirtazapine daily at bedtime for major depressive disorder. - 150 mg of venlafaxine twice daily for major depressive disorder. - A daily multivitamin and a daily calcium plus vitamins D and K supplement. - 40 mg of omeprazole daily in the morning for gastro-esophageal reflux disease. A MAR for July 2026. The MAR indicated the following medications were not administered due to the medications being out of the facility: - One dose of gabapentin on 07/14/2026. The missed dose was labeled as not needing follow-up. - Two doses of Resident 1's mirtazapine had not been administered due to the medication being out of the facility from 07/13/2026 to 07/14/2026. The missed doses were labeled as not needing follow-up. - Eleven doses of Resident 1's multivitamin had not been administered due to the medication being out of the facility on 07/03/2026 to 07/14/2026. The missed doses were labeled as not needing follow-up.	N0352		

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N0352	Continued from page 5 - Eleven doses of Resident I's omeprazole had not been administered due to the medication being out of the facility from 07/03/2026 to 07/14/2026. The missed doses were labeled as not needing follow-up. - One dose of Resident I's venlafaxine had not been administered due to the medication being out of the facility on 07/14/2026. The missed dose was labeled as not needing follow-up. - Eleven doses of Resident I's calcium plus vitamins D and K supplement had not been administered due to the medication being out of the facility from 07/03/2026 to 07/13/2026. The missed doses were labeled as not needing follow-up. A MAR for August 2026. The MAR indicated the following medications were not administered due to the medications being out of the facility: - Twenty-eight doses of lamotrigine over 14 days from 08/02/2026 to 08/15/2026. The MAR indicated 27 of the missed doses were due to the medication not being available, but that it did not require follow-up. Only 1 missed dose was labeled as needing follow-up. - One dose of Resident I's levothyroxine had not been administered on 08/15/2026 due to the medication not being available. The MAR indicated the missed dose did not require follow-up. - Two doses of Resident I's mirtazapine were not administered from 08/14/2026 to 08/15/2026. The MAR indicated both doses were not administered due to the medication not being available, but only 1 dose was labeled as needing follow-up. - Two doses of multivitamin from 08/14/2026 to 08/15/2026. The MAR indicated the doses were missed due to the medication not being available and not needing follow-up. - Two doses of omeprazole from 08/14/2026 to 08/15/2026. The MAR indicated the doses were	N0352		

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N0352	Continued from page 6 missed due to the medication not being available and not needing follow-up. - Five doses of venlafaxine from 08/13/2026 to 08/15/2026. The MAR indicated the dose was missed due to the medication not being available and not needing follow-up. Progress/e-MAR notes from 07/02/2026 to 10/11/2026. The notes included the following: - On 07/03/2026, an e-MAR note read, in part, "Did not give to resident due to only having one blister pack and not knowing what to give them. I tried calling on call nurse and no one answered ..." The note referenced Resident 1's carbidopa-levodopa administration on 07/03/2026. - On 08/14/2026, a series of e-MAR notes read, in part, "... med [medication] not available." The notes each referenced Resident 1's mirtazapine, lamotrigine, and gabapentin administration. - On 08/16/2026, a series of notes read, in part, "Yesterday evening writer was alerted to resident had [sic] running out of medication. [Family member] was concerned about resident. [Family member] requested resident be sent to ER for evaluation ... LATE ENTRY ... Missing dose of Levothyroxine on 8/15/2026. Medication was not in house ... LATE ENTRY ... Resident missed 2 doses of Gabapentin 100mg on 8/14/26 and 8/15/26 ... LATE ENTRY ... Missing medication Mirtazapine on 7/13/26-7/14/26 and 8/14/26-8/15/26. Medication not available ... LATE ENTRY ... Missing medication of Venlafaxine 8/14/26-8/15/2026. Resident missed 5 doses of medication ... LATE ENTRY ... Resident missed doses of omeprazole 20mg on 8/14/26-/15/26 [sic] resident missed 2 doses of medication ... LATE ENTRY ... Missing doses on [sic] multi-vitamin on 8/14/26-8/15/26. Resident missed 2 doses ..." - On 08/17/2026, a note read, in part, "On 08/15/2026 ... DOW received a call from resident [sic] [family member]. [Family member] was upset resident missed mediations [sic]. [Family member] stated resident had been out of 2 medications since August 2nd. [Family member] had resident to be sent out to er [emergency room] for evaluation. Medication missed 8/2/2026 - 8/15/26 Lamotrigine 25 mg 2	N0352		

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N0352	Continued from page 7 [tablets twice daily]. Total of 26 missed doses ..." - On 09/27/2026, an e-MAR note read, in part, "... [overnight staff] wasn't informed the med [medication] was not given like usual. [Overnight staff member] did not see it wasn't given in time for [him/her] to receive ..." The note referenced Resident 1's carbidopa-levodopa administration on 09/26/2026. - On 10/07/2026, an e-MAR note read, in part, "... Resident stated they received [sic] medication [sic] however it was not charted, whether resident actually got it is unknown ..." The note referenced Resident 1's carbidopa-levodopa administration on 10/06/2026. - On 10/11/2026, an e-MAR note read, in part, "... wasn't informed med [medication] was not given ..." The note referenced Resident 1's carbidopa-levodopa administration on 10/10/2026. MARs for September 2026 and October 2026. Surveyor cross-referenced the MARs with the e-MAR notes (see above). An incident report, dated 08/15/2026. The incident report read, in part, "... Medication Error. - Vitamin D3 ... resident missed doses from 7/3/26-7/13/26 ..." An incident report, dated 08/15/2026. The incident report read, in part, "... Medication Error. - Medication missed 8/2/2026 - 8/15/26 Lamotrigine 25mg 2 [tablets twice daily]. Total of 26 missed doses ... Client taken to hospital by family request to be evaluated ..." RESIDENT2 Medication orders from 01/01/2026 to 10/31/2026. The orders indicated Resident 2 was prescribed the following medications: - Lidocaine topical patch 5% to be applied to Resident 2's right upper arm once daily and to remove the patch per the schedule.	N0352		

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N0352	Continued from page 8 Progress notes from 01/01/2026 to 10/12/2026. The notes included the following: - On 09/29/2026, an e-MAR note read, in part, "...patch not on..." The note referenced Resident 2's lidocaine topical patch administration on 09/29/2026. A MAR for September 2026. Surveyor cross-referenced the MAR with the e-MAR note (see above). In summary, approximately 80 doses of medication were not administered as prescribed for Resident 1 from July 2026 to October 2026. Resident 1's lidocaine patch was not applied on 09/29/2026 as prescribed. The provider did not ensure each resident had the right to receive medications as prescribed.	N0352		
N0431	Health monitoring. 83.38(1)(g) As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This LICENSURE REQUIREMENT is NOT MET as evidenced by:	N0431		

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N0431	Continued from page 9 Based on record review and interview, the provider did not ensure the health of every resident was monitored. One of 5 residents sampled did not receive health monitoring for wound care. This is a repeat violation. See Statement of Deficiencies (SOD) 8G0P12, dated 10/12/2024; and SOD 8G0P13, dated 06/03/2025. Findings include: On 07/23/2026, the Department received a complaint regarding wound care monitoring. On 10/12/2026, Surveyor reviewed records for Resident 2, admitted on 01/14/2026. The records included the following: - Resident 2's face sheet, which indicated s/he was diagnosed with a pilonidal cyst. - A move-in assessment, dated 01/15/2026. The assessment indicated Resident 2 required wound care assistance. The assessment indicated Resident 2 required wound care 3 times weekly. The assessment read, in part, "...Wound Care by (RN/LPN [registered nurse/licensed practical nurse] - Daily); Wound Location: Sacral cyst..." - Physician orders for Resident 2's wound care, dated 01/22/2026. The orders indicated RM F was to complete Resident 2's wound care and dressing changes. The orders ended on 01/26/2026. - Physician orders for Resident 2's wound care, dated 01/26/2026. The orders read, in part, "...Ensure bandage is on sacral wound every shift...for Wound Care..." - An initial individualized service plan (ISP). The ISP read, in part, "...Wound Care by (RN/LPN Daily)...Date initiated: 01/15/2026..." - An updated ISP. The ISP read, in part, "...Wound care order...cover with [dressing]. Date Initiated:	N0431		

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N0431	Continued from page 10 01/26/2026 ... Interventions: Daily dressing change ... Date Initiated: 01/15/2026 Revision on: 02/16/2026 ... " - Progress notes dating from 01/01/2026 to 10/12/2026. The notes indicated multiple times that FM F provided Resident 2's wound care after 01/26/2026 instead of staff. - A progress note, dated 01/21/2026. The note read, in part, "Spoke with resident and [Family Member (FM)] F regarding wound care. [FM F] was taught at Monday's appointment how to provide wound care and will provide wound care nightly at bedtime. Supplies provided by writer. Apologies given to both resident and [FM F] for thelack [sic] of wound care plan by Friday ... " - A progress note, dated 01/26/2026. The note read, in part, "... Spoke with resident and [FM F] about new wound care order and staff taking over wound care on a daily basis ... " - A progress note, dated 03/03/2026. The note read, in part, "... [FM F] stated that [Resident 2] has puss coming [sic] the pressure sore on [his/her] lower back. [FM F] said that [s/he] would let the Director know ... " - A progress note, dated 03/26/2026. The note read, in part, "... Wound Care ... every evening shift for Wound Care ... wound care did yesterday/resident asleep ... " - A progress note, dated 07/22/2026. The note read, in part, "... [FM F] brought it [sic] writers [sic] attention that [Resident 2's] bandage had not been changed since writer did it on 7/19. [FM F] is going to notify Director. Writer notified staff ... " - Hospital documentation from a wound care visit on 03/25/2026. The documentation read, in part, "... [FM F] reports the staff did not manage the wound and did not move [Resident 2] very often, so the wound opened back up and became infected. [Resident 2] was prescribed antibiotics which cleared the infection, but the wound still remained, although improved ... Prior treatment: Cleaning wound with soap and water and covering with silicone foam	N0431		

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OAKS AT NORTHERN LIGHTS (THE)	**702 BRATLEY DRIVE, WASHBURN, Wisconsin, 54891**

(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)	(XS) COMPLETION DATE
N0431	Continued from page 11 border dressing ..." - A medication administration record (MAR) for January 2026. The MAR read, in part, "... [FM F] to do Wound Care for coccyx ... Start Date-01/22/2026 ... D/C [discontinued] Date-01/26/2026 ... Wound Care: 1. Wash sacral decubitus ulcer ... cover with [dressing] every evening shift for Wound Care-Start Date-01/26/2026 ..." - A MAR for July 2026. The MAR read, in part, "... Wound Care: 1. Wash sacral decubitus ulcer. . cover with [dressing] every evening shift for Wound Care-Start Date-01/26/2026 ... Ensure bandage is on sacral wound every shift..." The MAR indicated Resident 2's dressing had been applied daily (3 times out of 4 by Caregiver E) from 07/19/2026 to 07/22/2026. At approximately 1:37 PM, Surveyor interviewed Director of Wellness (DOW) C. DOW C stated Resident 2 had his/her wound when s/he had been admitted. DOW C stated care staff had told FM F they were caring for Resident 2's wound. DOW C stated that the staff were not caring for Resident 2's wound, so FM F had to come in and do it. DOW C stated staff were supposed to be caring for Resident 2's wound. DOW C stated Resident 2's care team was supposed to change Resident 2's wound dressing daily. DOW C stated Caregiver E had come to him/her regarding Resident 2's dressing not getting changed. DOW C stated Caregiver E had documented that Resident 2's bandage had been changed because other care staff had told him/her it had been changed. DOW C stated Caregiver E documented that Resident 2's bandage had been changed when it actually had not been changed. In summary, Resident 2 admitted to the facility with his/her wound. Resident 2's assessment and initial ISP indicated facility staff were to care for his/her wound. FM F cared for Resident 2's wound when staff were supposed to, per Resident 2's physician orders and ISP. Staff erroneously documented that Resident 2's dressing was changed on his/her MAR when Resident 2's dressing had not been changed per his/her orders and ISP. The provider did not ensure Resident 2's health was monitored as needed.	N0431		