Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017991	A. BUILDING: _____ B. WING _____	C 10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANN ST HOUSE	321 ANN STREET TOMAH, WI 54660

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N 000	Initial Comments On 10/13/2025, Surveyor conducted a licensure survey at Ann St House. Data collection continued through 10/22/2025. Five deficiencies were identified. One of the 5 deficiencies were repeat violations. See Statement of Deficiency (SOD) EK2G11, dated 11/18/2020. Census: 8	N 000		
N 164	83.12(4)(b) Reporting when law enforcement is called. A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a written report was sent to the department when law enforcement was called to the CBRF (community based residential facility) in response to an incident that jeopardized the health, safety, or welfare of residents on 09/08/2025. This is a repeat deficiency. See Statement of Deficiency (SOD) EK2G11, dated 11/18/2020.	N 164		

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

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N 164	Continued From page 1 Findings include: This facility serves up to 8 residents in the client groups of alcohol/drug dependent, developmentally disabled, emotionally disturbed/mental illness, traumatic brain injury, terminally ill, and physically disabled. On 10/13/2025 at approximately 11:45 AM, Surveyor asked Manager B if there had been any police intervention in the past 3 months. Manager B stated the police were called last month due to an incident involving Resident 1 being physically aggressive towards other residents. On 10/13/2025 at approximately 12:30 PM, Surveyor interviewed Manager B further about the incident involving police and Resident 1 one month ago. Manager B stated Resident 1 had a history of aggressive behavior. Manager B stated police had been called a couple times on 09/08/2025 for Resident 1 being physically and verbally aggressive towards other residents. Manager B stated Resident 1 had been given a 30-day notice after the incident. Manager B stated s/he would fill out an incident report and send it on to Administrator A for review and to submit to the department. On 10/13/2025 at approximately 1:00 PM, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 11/27/2023 and had a guardian. Resident 1 had diagnoses that included disorganized schizophrenia, impulse disorder, and fragile X chromosome. The individual service plan (ISP) with unknown date, indicated Resident 1 required staff assistance to help manage and redirect aggressive/combative behaviors. The ISP	N 164		

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N 164	Continued From page 2	N 164		

indicated Resident 1 displayed destructive behaviors. The ISP read in part, "Resident requires staff assistance/intervention to maintain positive interactions with others as when [s/he] becomes upset, sometimes [s/he] will throw objects, hit others, swear, slam doors, scream, or call others names."

An incident report dated 09/08/2025 at 4:24 PM, indicated Resident 1 got upset for an unknown reason and started screaming and yelling at other residents. Resident 1 threw a plate of hot food at another resident, burning their arm. Resident 1 threw a bottle of hot sauce at the same resident when they were walking away that hit their leg. Then, Resident 1 picked up a metal napkin holder and threw it at another resident's head. Staff got the residents to safety. Resident 1 refused staff interventions and started to threaten killing a resident within the home. The report indicated a resident called the police who deescalated the situation. The two residents involved wanted to press charges and get a restraining order against Resident 1.

An incident report dated 09/08/2025 at 5:39 PM, indicated Resident 1 became upset after staff asked him/her to clean up his/her mess. Resident 1 slammed a door in staff's face and kept screaming at staff. Again Resident 1 started to threaten killing another resident in the home and the police were called. The police were able to deescalate the situation.

A 30-day notice was given on 09/17/2025 and read in part for the reason of discharge, " ...there is imminent risk of serious harm to the health and safety of the resident, other residents or employees, as documented in the resident's record. Facility administration states that multiple

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N 164	Continued From page 3 and continuing incidents of various risk behaviors present an imminent risk of serious harm to the health or safety of yourself, other residents, or staff." On 10/13/2025, Surveyor reviewed the department's file for the provider and did not find a self-report for these incidents on 09/08/2025. On 10/15/2025 at 12:56 PM, Surveyor received an email from Administrator A. When asked if the incident on 09/08/2025 with police intervention was reported to the department, Administrator A replied, "I did not. I know I need to do this, and forgot to include the department when I sent out the reports." On 10/22/2025 at 2:00 PM, Surveyor interviewed Administrator A. Administrator A confirmed s/he did not self-report the incident involving police invention on 09/08/2025 to the department.	N 164		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes.	N 220		

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N 220	Continued From page 4 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 4 of 4 employees sampled (Caregiver D, Caregiver E, Caregiver F, and Manager B) were screened for communicable illness, including tuberculosis (TB), prior to working with residents. Findings include: This facility serves up to 8 residents in the client groups of alcohol/drug dependent, developmentally disabled, emotionally disturbed/mental illness, traumatic brain injury, terminally ill, and physically disabled. On 10/13/2025, Surveyor reviewed employee records. Caregiver D was hired on 02/02/2022. Caregiver D's record did not include evidence of communicable disease screening and had a TB test with a read by date of 04/14/2022. Caregiver E was hired on 05/04/2023. Caregiver E's record did not include evidence of communicable disease screening and had a TB test with a read by date of 11/10/2023. Caregiver F was hired on 02/18/2025. Caregiver F's record did not include evidence of communicable disease screening and had a TB test with a read by date of 04/10/2025. Manager B was hired on 03/12/2024. Manager B's record did not include evidence of communicable disease screening and had a TB test with a read by date of 04/26/2024.	N 220		

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N 220	Continued From page 5 All TB tests were completed after the employee's date of hire. On 10/15/2025 at 12:56 PM, Surveyor received an email from Administrator A, which read in part, "We were recently cited for this at another facility and will use the health screen form going forward. We send all of our employees to the clinic for the screening and TB test, but have never been asked for the Health Screening from a surveyor previously, so we only retained the TB tests for documentation." On 10/22/2025 at 2:00 PM, Surveyor interviewed Administrator A. Administrator A stated they were already working to correct this issue and staff were taken off the schedule until it had been completed.	N 220		
N 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and staff interview, the provider did not ensure cleaning compounds, polishes and toxic substances were securely stored. Toxic substances were stored in an unlocked cabinet under the kitchen sink and on a side table. This practice had the potential to affect 8 residents.	N 499		

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N 499	Continued From page 6 Findings include: This facility serves up to 8 residents in the client groups of alcohol/drug dependent, developmentally disabled, emotionally disturbed/mental illness, traumatic brain injury, terminally ill, and physically disabled. On 10/13/2025 at 11:00 AM, Surveyor observed a can of disinfectant sitting on a side table by the office. On 10/13/2025 at 1:50 PM, Surveyor observed the following cleaning compounds with warning labels located under an unsecured cabinet below the kitchen sink: -deodorizer -toilet bowl cleaner -carpet cleaner. On 10/13/2025 at 1:50 PM, Surveyor discussed the concern with Manager B. Manager B stated the cleaning compounds could be kept in a secured storage room with the other cleaning supplies, in a secured kitchen cabinet, or they could get a lock for the current cabinet. On 10/22/2025 at 2:00 PM, Surveyor interviewed Administrator A about the unsecured cleaning compounds. Administrator A stated s/he understood the concern and would remove the items promptly.	N 499		
N 507	83.46(1)(f) Combustibles. Combustible materials shall not be placed within 3 feet of any furnace, boiler, water heater, fireplace or other similar equipment.	N 507		

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N 507	Continued From page 7 This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure combustible materials were not placed within 3 feet of the furnace and water heater. Findings include: On 10/13/2025 at approximately 11:30 AM, Surveyor observed both furnaces in the basement. The furnace near the stairs had a cardboard box, insulation, and wooden accordion doors, within 3 feet of the furnace and water heater. On 10/22/2025 at 2:00 PM, Surveyor interviewed Administrator A about the items stored by the furnace. Administrator A stated s/he understood the concern and would remove the items promptly.	N 507		
N 535	83.48(1)(b) Smoke and heat detectors per NFPA 72. Smoke and heat detectors shall be installed and maintained in accordance with NFPA 72 National Fire Alarm Code and the manufacturer ' s recommendation. Smoke detectors powered by the CBRF ' s electrical system shall be tested by CBRF personnel according to manufacturer ' s recommendation, but not less than once every other month. CBRFs shall maintain documentation of tests and maintenance of the detection system. This Rule is not met as evidenced by: Based on record review and interview, the provider did not conduct smoke detector tests	N 535		

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N 535	Continued From page 8 every other month in 2024 and 2025. Findings: This facility serves up to 8 residents in the client groups of alcohol/drug dependent, developmentally disabled, emotionally disturbed/mental illness, traumatic brain injury, terminally ill, and physically disabled. On 10/13/2025 at approximately 11:45 AM, Surveyor conducted a review of provider records for smoke detector tests. The provider did not have documentation of conducting smoke detector tests every other month in 2024 and 2025. On 10/15/2025 at 12:25 PM, Surveyor received an email from Administrator C. The email read in part, "In addition, fire detection systems are monitored on a daily basis [sic] staff while doing their rounding, this is just a visual inspection and looking for the green light. All components of the facility's fire detection system are also continuously monitored by a central panel. There is an audible tone as well as a digital display indicating if anything is out of order." On 10/22/2025 at 2:00 PM, Surveyor interviewed Administrator A. Administrator A verified that smoke detector tests were not documented as completed at least every other month in 2024 and 2025.	N 535		