STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	410133	A. BUILDING: _____ B. WING _____	R-C 05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN PARK HOUSE	109 W LAKE ST WAUPACA, WI 54981

(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 000}	Initial Comments On 05/19/2026, Surveyor conducted an onsite visit at Garden Park House to investigate 6 complaints and to conduct a verification visit. Additional information was collected through 05/20/2026. Six (6) of 6 complaints were substantiated and 2 of 6 previous deficiencies were uncorrected. A total of 6 new deficiencies were identified and 3 of 6 were repeat deficiencies. Census: 7 Under statutory provisions of WI Stat. Ch. 50 a $200 revisit fee is being assessed.	{N 000}		
{N 158}	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall	{N 158}		

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

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{N 158}	Continued From page 1 maintain documentation of any investigation. This Rule is not met as evidenced by: Based on record review and interview, after receiving allegations of neglect on or about 01/18/2026 and 02/25/2026, the provider did not take immediate steps to protect residents or conduct and document thorough investigations to determine if neglect occurred. In addition, Licensee A did not submit a misconduct incident report to the Department regarding the 02/24/2026 allegation. This is a repeat deficiency. See Statement of Deficiency CBLW14, dated 10/09/2025. Findings include: The Department received a complaint alleging Caregiver H sleeps during 3rd shift placing residents at risk and Licensee A is aware. Prior to conducting the onsite visit, Surveyor reviewed Department records. On 01/23/2026, Licensee A submitted a Misconduct Incident Report to the regional Bureau of Assisted living office. The report detailed an incident on 01/17/2026 when Resident 7 went to the staff office to request pain medication and found Caregiver H "on sofa with eyes closed and took a picture...[Resident 7] had trouble rousing [Caregiver H]" In response, on 01/19/2026, Caregiver H was given "1 week off with no pay...final warning." The report did not include evidence of an interview with Resident 7, or any other staff or residents. The report included a warning notice issued to Caregiver H. The notice included a	{N 158}		

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{N 158}	Continued From page 2 written statement from Caregiver H dated 01/19/2026 where s/he denied the allegations and blamed Resident 7 for taking a photo out of context. The report included a summary of the investigation which read, "[Caregiver H] has been a good employee not calling in, coming in as scheduled, coming to staff meetings, doing required job duties. On similar complaint from [Resident 7], I came in for 2 weeks working nights with [Caregiver H]. I would come in at different hours and once [s/he] was listening to music on [his/her] iPod. [Resident 7] has been a troublemaker and has had complaints about food, staff and misinformation given...We have tried to work with [Resident 7] but [s/he] likes to feel in control and stir up negative conversations." Surveyor reviewed facility records provided by Licensee A on 05/19/2026: "Night Shift No-Sleeping Policy...Night shift employees must remain awake, alert, and available to residents at all times. Sleeping, dozing, resting with eyes closed, or lying down on any furniture while on duty is strictly prohibited....Any violations of this policy will result in disciplinary action, up to and including termination." "Facility Policy on Caregiver Misconduct...Definition (of misconduct)...Neglect or failure to provide necessary care...Allegations of misconduct will be taken seriously and investigated promptly..." On 05/19/2026 at 2:50 PM and 05/20/2026 at 10:30 AM, Surveyor interviewed Licensee A. --Licensee A confirmed 3rd shift staff work alone and must stay awake. S/he confirmed residents	{N 158}		

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{N 158}	Continued From page 3 need 24 hour awake staff, including Resident 12 who has dementia, wanders during 3rd shift and lingers at the exit door. --Licensee A confirmed s/he suspended Caregiver H for 5 days due to sleeping during 3rd shift, however also blamed Resident 7. S/he referred to Resident 7 as being "a pill" who stirred up trouble and Licensee A explained s/he was frustrated Resident 7 took a photo of Caregiver H. Licensee A confirmed the photo showed Caregiver H with his/her eyes closed in a manner consistent with sleeping, but s/he did not retain evidence of the photo as part of the investigation. --Licensee A said Resident 7 made the initial report to Manager B and s/he (Licensee A) did not interview Resident 7, or other staff or residents as part of the investigation to determine the potential scope of the problem. --Licensee A said s/he "talked" to Caregiver H, but did not have documentation of the date, time or content of the discussion. --Licensee A said the references in the report to checking on Caregiver H during 3rd shift, occurred in 2025 when similar allegations were made and s/he did not implement those measures after receiving the 1/17/2026 allegations. --Licensee A said to the best of his/her recall, s/he "probably" received the allegations on 01/18/2026. S/he reviewed the schedule with Surveyor and said Caregiver H worked alone during 3rd shift on 01/18/2026 and the 5 day suspension began 01/19/2026. -Licensee A said s/he was not present when Caregiver H wrote the statement on the warning form and it was not part of an interview process. -Licensee A did not describe any other steps taken to protect residents after 01/19/2026, other than requiring 3rd shift staff to sign off after completing assigned tasks.	{N 158}		

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{N 158}	Continued From page 4 Licensee A then explained s/he was aware of another incident occurring in late February 2026 involving Caregiver H sleeping during 3rd shift. Licensee A said in response, s/he told Caregiver H if it happened again, s/he would need to terminate his/her employment. S/he said this caused Caregiver H quit a few days later on 02/27/2026. Surveyor asked how s/he became aware of the concerns Caregiver H was sleeping during February and Licensee A replied "I don't know if it was me that walked in on [him/her]. I could have found [him/her] sleeping." However, Licensee A said s/he could not recall for sure, s/he did not document the incident or allegations, and s/he did not conduct, document or submit an investigation into the concerns. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws	{N 158}		
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 record review and interview, the provider did not comply with special orders issued from the Department to retroactively conduct a complete investigation into allegations of misconduct described in Statement of Deficiency (SOD) CBLW14, dated 10/09/2025. This is a repeat deficiency. See Statement of	N 196		

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N 196	Continued From page 5 Deficiency SWRZ11, dated 01/04/2022. Findings include: The Department received a complaint alleging Caregiver H sleeps during 3rd shift placing residents at risk and Licensee A is aware. Prior to conducting the onsite visit on 05/19/2026, Surveyor reviewed Department records. During the previous survey ending on 10/09/2025 (SOD CBLW14), a deficiency was identified after Licensee A did not take immediate action to protect residents or conduct thorough investigations after receiving the following allegations: ---On 08/25/2025 and 09/17/2025 it was alleged by Residents 4 and 7 that Caregiver H was sleeping during 3rd shift. ---On 09/24/2025 and 09/25/2025 it was alleged Resident 9 was found soaked with urine during the overnight hours when Caregiver H was working. ---On 10/08/2025 it was alleged Resident 9 was locked out of the facility the previous night while Caregiver H was working and Caregiver H was unaware Resident 9 was missing. SOD CBLW14 was issued on 12/10/2025 and included Special Orders that read in part, "WITHIN 45 DAYS OF receipt of this notice, the licensee shall, retroactively, with available information, document a complete investigation report of the alleged incidents of caregiver misconduct described in SOD CBLW14. The investigation will conform to requirements and guidelines specified by Wis. Admin. Codes ch. DHS 13, ch. DHS 83 and the Wisconsin Caregiver Program Manual..."	N 196		

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N 196	Continued From page 6 The Wisconsin Caregiver Program Manual reads in part, "ENTITY INTERNAL INVESTIGATION RESPONSIBILITIES - All entities regulated by DQA must conduct a thorough internal investigation and document the findings for all allegations or incidents at the entity. A thorough internal investigation may include: Collecting and preserving any physical and documentary evidence including videos; Interviewing alleged victims and witnesses; Collecting other corroborating/disproving evidence ...Documenting each step taken during the internal investigation. These steps should be taken as part of the entity's initial attempt to determine what, if anything, happened and to determine the complete factual circumstances surrounding the alleged incident ...The entity must document the results of their internal investigation. The answers to questions asked during the entity's internal investigation are the foundation when determining whether or not to report an incident to DQA ...The entity must report the incident to DQA using the Misconduct Reporting System (see 6.6.1). Protection of Clients Immediately upon learning of the incident, the entity must take necessary steps to protect clients from possible subsequent incidents of misconduct or injury." On 12/23/2025, Licensee A submitted an investigative report to the Bureau of Assisted Living regional office and did not use the Misconduct Reporting System (MRS). On that same date, the regional office sent an email to Licensee A explaining the process for using the MRS. The email included links to resources and an email address for the Office of Caregiver (OCQ) to contact for assistance. Furthermore, the OCQ records indicated on 12/29/2025, OCQ staff contacted Licensee A via phone and left a	N 196		

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N 196	Continued From page 7 voicemail offering assistance with the MRS, but Licensee A did return the call. In addition, on 01/26/2026, OCQ staff sent Licensee A a detailed email explaining how to troubleshoot technical issues with the MRS system and a direct contact person if s/he was unable to do so, and Licensee A did not respond to the email. Surveyor reviewed the aforementioned report submitted on 12/23/2025 to the regional office. It did not conform to requirements in DHS 83 or to the guidelines in the Wisconsin Caregiver Program Manual. --The report did not include evidence of a thorough investigation into allegations Caregiver H was sleeping during 3rd shift on 08/24/2025 and 09/17/2025. The report did not include documentation of any new or revised investigation after 10/09/2025. The report did not include evidence of follow up interviews with Resident 4 or Resident 7 or that Resident 7's photographic evidence was reviewed and considered. --The report did not include evidence of any investigation into allegations Caregiver H did not provide overnight incontinence care to Resident 9 on 09/24/2025 and 09/25/2025. --The report did not include evidence of a thorough investigation into allegations Caregiver H was unaware Resident 9 was missing from the facility all night 10/07 into 10/08/2026. The report concluded "Staff believed the resident had returned home." However, Caregiver H's statement read, "Resident has been locking [his/her] door and sleeping. So, when there was no answer I obviously didn't intrude into [his/her] room." Caregiver H's statement was documented on a warning notice, which was the same document provided during the previous survey.	N 196		

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N 196	Continued From page 8 --The report concluded, "[Caregiver H] has been a reliable, committed, and a kind staff person. We are fortunate to have [him/her]." On 05/20/2026 at 10:30 AM, Surveyor conducted an interview with Licensee A: --Licensee A verified s/he did not conduct interviews with Resident 4 or Resident 7 as part of the investigation submitted 12/23/2025 and s/he did retain or further consider photographic evidence collected by Resident 7. --Licensee A verified s/he did not interview Resident 9 or re-interview Caregiver H regarding the 10/07-10/08/2025 allegations, and relied on the same written warning documentation completed during the previous survey. --Licensee A explained the statement about Caregiver H thinking Resident 9 returned to his/her previous residence during the overnight hours 10/07-10/08/2025, was based on Licensee A's interpretation of what may have happened and was not based on any investigative steps. In addition: --Licensee A said Caregiver H remained employed as the 3rd shift staff until s/he quit on 02/27/2026. Licensee A said prior to Caregiver H's resignation, s/he received at least two more allegations Caregiver H was sleeping during 3rd shift. Licensee A verified the facility schedules one caregiver on 3rd shift and residents require awake staff, including Resident 12 who has dementia and is known to linger at the exit doors during the overnight hours. --Licensee A acknowledged s/he has not contacted OCQ to resolve his/her technical difficulties using the MRS system. Cross Reference N0158 DHS 83.12(3)(a) Caregiver: Investigating	N 196		

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N 196	Continued From page 9 Abuse & Neglect	N 196		
N 346	83.32(3)(b) Rights of Residents: Confidentiality In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Confidentiality. Confidentiality of health and personal information and records, and the right to approve or refuse release of that information to any individual outside the CBRF, except when the resident is transferred to another facility or as required by law or third-party payment contracts and except as provided in s.146.82(2) and (3), Stats. The CBRF shall make the record available to the resident or the resident ' s legal representative for review. Copies of the record shall be made available within 30 days, if requested in writing, at a cost no greater than the cost of reproduction. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure resident records were secured to ensure confidentiality. Medication and health records for all residents were stored in the unlocked kitchen and office. Findings include: The Department received a complaint alleging concerns with confidentiality. On 05/19/2026 at 9:09 AM, Surveyor observed medication administration records (MARs) for all residents were kept on the counter in the kitchen, near the medication storage cabinet. The kitchen	N 346		

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N 346	Continued From page 10 did not have lockable doors to secure the records. Surveyor also observed the kitchen lead into the staff office where resident records were kept in binders on a shelf. Surveyor observed the binders contained confidential records to include physician orders, assessments and individual service plans. The office did not have lockable doors to secure the records. Surveyor observed the records remained in their same locations throughout the morning and early afternoon. During an interview with Licensee A and Manager B at 1:24 PM, Surveyor reviewed the concerns. Licensee A acknowledged the MARs and resident binders are normally kept in the locations observed by Surveyor with the potential residents or visitors could access them.	N 346		
{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, record review and	{N 389}		

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{N 389}	Continued From page 11	{N 389}		

interview, the provider did not ensure Resident 14 and Resident 12's individual service plans (ISPs) were updated when the residents experienced changes in their needs or physical/mental condition.

Resident 14's ISP was not updated to identify dietary needs when his/her dentation changed and was not updated with fall prevention interventions after s/he experienced a fall in December 2025. On 05/19/2026, Resident 14 was served food s/he could not eat and experienced a fall resulting in injury.

Resident 12's ISP was not updated to identify chronic foot pain or interventions to relieve pain and was not updated to identify supervision needs in connection with wandering. Resident 12 had diagnoses to include dementia and at least twice between January and May 2026, was found at or outside the exit during the overnight hours. In addition, Resident 12's ISP was not signed by his/her legal decision maker.

This is a repeat deficiency. See Statement of Deficiency CBLW14, dated 10/09/2025.

Findings include:

Resident 14:

On 05/19/2026 at 8:35 AM, Surveyor entered the facility and observed Resident 14 in the dining room. S/he had a large swollen and scraped area on his/her forehead and Resident 14 was talking with Manager B about the injury. Surveyor interviewed Resident 14 and s/he explained s/he fell out of bed while rolling over early this morning and hit/his hear head during the fall. Resident 14 said s/he went back to sleep for a few hours and

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{N 389}	Continued From page 12	{N 389}		

just recently came downstairs to tell Manager B. Resident 14 said s/he had a fall about 6 months ago where s/he was trapped between the recliner and dresser and had to yell for help.

During the interview, Resident 14 was served breakfast by Manager B. The meal was eggs, a piece of bacon and a piece of ham. While Resident 4 was eating, s/he showed Surveyor a temporary false front tooth s/he had to remove to eat the meal. Resident 14 said s/he has had a bone graft and is waiting for a dental implant. Resident 14 said s/he does not like the food and some of it s/he can't eat. Resident 14 ate the eggs and stood up to throw away the bacon and ham. S/he said, "It's hard to chew."

Surveyor reviewed Resident 14's record on 05/19/2026 at 11:45 AM. Resident 1 was admitted on 08/14/2021 with diagnoses to include frontotemporal dementia. Resident 14's file contained a fall report dated 12/22/2025. The report documented an unwitnessed fall discovered when Resident 14 called for help. S/he was found face down between his/her recliner and dresser.

Resident 14's ISP was most recently signed and dated 12/26/2025.
--The ISP was silent to the history of falls, risk of future falls, or interventions to prevent falls.
--The ISP was silent to dietary needs due to his/her missing front tooth. The ISP noted s/he was "independent with eating...no choking issues." The ISP documented, "1/8/26 [dentist office] for broken tooth" but did not indicate the tooth was removed or describe changes in oral care needs while Resident 14 was awaiting the dental implant.

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{N 389}	Continued From page 13 On 05/19/2026 at 1:24 PM Surveyor interviewed Licensee A and Manager B. They explained Manager B is responsible for ISP updates. Both Licensee A and Manager B said it is not their process to complete fall assessments after each fall. Manager B said s/he had ideas for fall prevention for Resident 14 to include rearranging his/her room and potentially moving some furniture out so there was less clutter, however those interventions had not been implemented and were not in the ISP. Manager B took Surveyor to Resident 14's room and pointed out how the bed frame is tall, the mattress is deep, and there is a large wooden wardrobe approximately 8 inches from the bed. S/he also pointed out an area next to Resident 14's recliner that was close to the dresser, present ongoing risk s/he could get trapped between if s/he experienced a fall similar to the one in December. Resident 14 was in his/her room at the time. S/he accessed the bed by using a step stool and demonstrated how s/he rolled out of bed and hit his/her head on the wardrobe. On 05/20/2026 at 10:30 AM, Surveyor interviewed Licensee A and reviewed the concerns related to Resident 14's ISP not being updated to identify his/her dietary needs or interventions to prevent falls. Licensee A agreed Resident 14 had a missing tooth, was awaiting an implant and needed a modified diet. S/he also explained s/he has realized there is "a real problem with my paperwork here" and "ISPs have been a real issue." Licensee A said s/he was planning on hiring someone to assume responsibility for ISPs. Resident 12: The Department received a complaint about the	{N 389}		

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provider's response to Resident 12's elopement risk.

Surveyor reviewed Resident 12's record on 05/19/2026 at 12:45 PM. Resident 12 was admitted on 11/08/2023, had an activated power of attorney (POA) for health care effective 11/17/2025 and diagnoses to include "moderate dementia."

Surveyor reviewed observation notes for January 2026 and May 2026. The documentation indicated Resident 12 had a pattern of night waking, frequent complaints of foot pain, and 2 incidents when s/he was found at or outside of the exit door during overnight hours. Examples include:

01/12: Caregiver noted Resident 12 may need a "low dose pain pill" because the "pain in [his/her] feet is so much." S/he also wrote, "4:45 AM I heard front door open & close. It was [Resident 12]"
01/19: "Make sure [Resident 12] does not go outside in this weather!"
05/01: "Back to sleep 12:00 midnight...1:50 (AM) back to sleep...down (in common area) at 3:20 AM"
05/03: awake at 2:10 AM, 5:00 AM
05/07: lotion on feet 3 times during 1st shift
05/10: "11:40 PM heard front door slam - it was [Resident 12] standing on porch - no coat. Advised not to be out...it is very late!...Back to bed at 1:00 AM." Awake at 5:00 AM
05/13: "Put lotion on feet once (1st shift)...foot soak at 5:45 PM"
05/14: "Grumpy - feet hurt - put Volterin [sic] on x2 and gave 2 Tylenol."
05/15: "Lotta [sic] pain today (mumbling, swearing)...11:30 PM complaining about

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{N 389}	Continued From page 15 feet...went back to bed at 1:20 AM...(awake) at 5:10 AM." 05/16: Spoke to Licensee A suggesting additional medication for pain. 05/18: Complained about his/her feet during 2nd shift and "up and down multiple times" between 1:15 AM and 1:40 AM. Surveyor also noted observation notes prompted for 3rd shift checks at 11:30 PM, 2:00 AM and 5:00 AM for all residents, including Resident 12. There was no charting of 2 hour checks for Resident 12. Resident 12's ISP was last updated 05/01/2026 and was not signed by his/her POA. The ISP section titled "Supervision" noted s/he needed "reminders to try & sleep at NOC (3rd shift) & not walk around building" and "2 hour checks at night." The section titled "Wandering" read, "aware of surroundings." The ISP was silent to Resident 12's history of lingering at or outside the door during the overnight hours or interventions to mitigate elopement risk. The ISP was silent to Resident 12's foot pain or interventions to help manage it. During the aforementioned interview with Licensee A and Manager B, they confirmed Resident 12 suffers from chronic foot pain. Manager B said staff provide foot rubs with lotion, foot soaks and prescribed Voltaren. Licensee A also said they have been in communication with Resident 12's medical provider about the pain. Manager B confirmed the ISP did not identify the presence of or pain or the plan to manage it While discussing Resident 12's supervision needs, Manager B said the ISP prompts for 2 hour checks but acknowledged the ISP was not	{N 389}		

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{N 389}	Continued From page 16 updated based on assessment after the 2 incidents when Resident 12 was found at our outside the exit door. Manager B also acknowledged Resident 12's ISP was not signed by his/her legal decision maker, activated in November of 2025. S/he said Resident 12's POA does not visit often but did not describe efforts to involve him/her in the service plan or obtain his/her signature to acknowledge agreement with the plan. Cross Reference N0415 DHS 83.37(2)(d) Documentation Of Medication Administration N0427 DHS 83.38(1)(c) Leisure Time Activities	{N 389}		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: The provider did not maintain complete documentation of medication administration. Documentation was incomplete for Residents 12,	N 415		

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N 415	Continued From page 17 13, and 14. Their MARs contained blank entries that did not confirm if the medications were administered or provide a reason for non-administration. In addition, Resident 12's medication record did not document effectiveness of PRN (as needed) medication administered for pain. Findings include: Prior to conducting the onsite visit, Surveyor reviewed Department records. On 01/13/2026, Licensee A submitted a self-report documenting medication errors for Residents 13 and Resident 14. According to the report: --Resident 13 did not receive HS (bedtime) doses of medications including ibuprofen and mirtazapine on 01/11/2026. --Resident 14 did not receive HS doses of divalproex ER, lorazepam, trazadone, ziprasidone on 01/11/2026. Surveyor reviewed Resident 13 and Resident 14's January 2026 medication administration records on 05/19/2026 at 11:45 AM: --Resident 13's MAR was inconsistent with the self-report and indicated s/he received all HS medications on 01/11. However, the entries on 01/12 were left blank for HS doses of ibuprofen and mirtazapine. --Resident 14's MAR was inconsistent with the self-report and indicated the HS dose of lorazepam was administered on 01/11. However, the MAR included blank entries for the following medication administrations; 01/07 12:00 PM dose of oxybutynin, 01/20 and 01/29 HS doses of lorazepam Surveyor also reviewed Resident 14 and Resident 12's May 2026 MARs:	N 415		

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N 415	Continued From page 18 --Resident 14's MAR included blank entries for the following: -----05/07: 9:00 AM dose of vitamin B -----05/08 9:00 AM doses of aspirin, vitamin B, amlodipine, lorazepam ziprasidone and oxybutynin -----05/08: HS doses of lorazepam, ziprasidone and divalproex -----05/09 9:00 AM dose of vitamin B -----05/17 9:00 AM dose of oxybutynin --Resident 12's MAR included blank entries for HS doses of melatonin on 05/05, 05/07, 05/11 and 05/12. On 05/19/2026 at 2:00 PM, Surveyor reviewed the aforementioned records with Licensee A and Manager B. They confirmed Surveyors review of the record and said based on the documentation, they were unsure if the residents received the medications on the dates when the administration records were left blank. Licensee A said s/he did not have an explanation about why the medication omissions documented on the self-report were different than the documentation on the MARs and s/he did not recall how the medication errors were brought to his/her attention. During the aforementioned review of the records, Surveyor also noted Resident 12's MAR listed Voltaren Cream as needed and acetaminophen every 4 hours as needed. May 2026 observation notes documented s/he suffered from recurrent foot pain. The May 2026 MAR (05/01- 05/19), documented administration of the medicated cream 7 times and administration of the acetaminophen 6 times for "foot pain." The MAR did not document effectiveness for either medication.	N 415		

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N 415	Continued From page 19 During the 2:00 PM interview with Licensee A and Manager B, they confirmed Resident 12 is administered Voltaren for chronic foot pain and they have been working with his/her medical provider on the issue. The managers verified the record did not contain documentation of Resident 12's response to the medication to determine if it was effective to manage his/her pain. Cross Reference N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes	N 415		
N 427	83.38(1)(c) Leisure time activities. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Leisure time activities. The CBRF shall provide a daily activity program to meet the interests and capabilities of the residents. Employees shall encourage and promote resident participation in the activity program. The CBRF shall develop and post the activity schedule in an area available to residents. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not develop a daily activity program to meet the interests and capabilities of the residents. Weekend activities were not routinely scheduled and weekday activities were repetitive and did not meet the	N 427		

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N 427	Continued From page 20 interests and capabilities of all residents. Findings include: The Department received a complaint alleging a lack of meaningful activities for residents. OBSERVATIONS on 05/19/2026: Surveyor observed the posted activity calendar for May 2026 at 8:40 AM. --Monday - Friday: "AM Cards" --Monday - Friday: 6:00 or 7:00 PM either bingo or movie --Wednesdays: 1:00 PM Bible study --Weekends: 3 of 10 weekend days listed either cards or movie. The rest were blank. Surveyor was onsite beginning at 8:35 AM. Surveyor did not observe any morning activity. The only observed activity was a game of cards at approximately 3:00 PM involving approximately 3 residents. Surveyor observed Resident 12 throughout the day --8:45 AM & 9:00 AM sitting in dining room, staring off into space. --12:45 PM sitting in dining room, staring off into space --1:40 PM & 1:46 PM sitting on the couch staring at the wall INTERVIEWS on 05/19/2026: Surveyor interviewed Resident 12 at approximately 8:55 AM. Resident 12 said s/he is "sometimes bored, sometimes happy." Surveyor asked Resident 12 how s/he liked living at the facility and s/he replied, "It's OK." Surveyor asked	N 427		

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what s/he likes about the facility and s/he replied, "Not much." Surveyor asked for examples of what s/he doesn't likes about the facility and Resident 12 was unable to communicate any specifics.

Surveyor interviewed Resident 14 at approximately 8:50 AM. Surveyor asked about activities and s/he said, "we watch movies all the time." Resident 14 said s/he likes movies but does not like bingo. Resident 14 said s/he loves watching sports.

Surveyor interviewed Resident 10 at 9:17 AM. S/he also said the main activity is bingo, which s/he doesn't like. Resident 10 said s/he stays in his/her room most of the time.

Surveyor interviewed Resident 15 at 9:52 AM. S/he said the after supper they play bingo or watch a movie. Resident 15 said s/he would like to see more outdoor activities, like having a picnic a few blocks down at the lake.

Surveyor interviewed Housekeeper J at 9:31 AM. S/he volunteered, "I feel so bad for [Resident 12]...[s/he] will sit in the hall or sit in the kitchen...there is nothing for him to do...A walk would be great for [him/her]...[S/he] will play cards with [Resident 13], but that's [staff]'s job, not [Resident 13]'s"

RECORD REVIEWS on 05/19/2026:

Surveyor reviewed Resident 12's record at 12:45 PM. Resident 12 was admitted on 11/08/2023 and a handwritten note in the file dated 11/09/2023 indicated s/he was a farmer and loves watching sports. The individual service plan (ISP) last updated 05/10/2026 described Resident 12 as having "moderate dementia" but pleasant and

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cooperative. It noted staff should "encourage group functions...uplift spirits & social skills by interacting frequently...easy to please...encourage participation in leisure time activities." A section titled "Leisure Time Activities" read, "Cards with staff 3x/week - exercise group 1x/week - 1:1 walk with staff 2x week." Surveyor reviewed May 2026 observation notes and participation in movies and cards was charted. One walk was charted on 5/16/2026 and there was no charting of participation in exercise group. The record did not include an assessment to determine the types of activities that would meet Resident 12's interests and capabilities.

Surveyor reviewed Resident 14's record at 11:45 AM. Resident 14 was admitted on 08/14/2021 and had diagnoses to include frontotemporal dementia. Resident 14's ISP read, "Spends a lot of time watching TV - Becoming more isolated...encourage to join in activities - too much alone time...Goal 07/08/25, 3 activities a week...does not meet goal - stays in room most of time." The ISP did not include individualized interventions to encourage Resident 14's participation in activities or an assessment to determine the types of activities that would meet his/her interests and capabilities. The record included a member centered plan from the managed care organization dated 02/01/2026 which read, "[Resident 14] and CBRF staff report that [Resident 14] is not participating in activities 2-3x a week...discussed activities that [Resident 14] would enjoy in the building and will continue to work on offering activities that [s/he] might enjoy participating in."

MANAGEMENT INTERVIEW on 05/19/2026:

Surveyor interviewed Licensee A and Manager B

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N 427	Continued From page 23 at approximately 2:00 PM. Regarding Resident 14: Manager B said Resident 14 loves sports and movies and does not like bingo or Bible study. Manager B described occasional community outings that Resident 14 enjoys but said most of his/her days are spent in his/her room watching TV. Regarding Resident 12: Manager B agreed Resident 12 spends his/her day moving to different locations in the building and staring off into space and said Resident 12 does not really like activities. Licensee A said s/he tried giving him/her a container of nuts and bolts, but s/he got bored quickly. Both managers agreed the daily activity program needs improvement and they would make changes based on the interest and capabilities of the residents.	N 427		