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N 000	Initial Comments From 08/21/2026 to 09/02/2026, the bureau of assisted living southern regional office conducted 4 complaint investigations at VitaCare Living Cross Plains a CBRF located in Cross Plains, WI. As a result of this survey, 9 violations of DHS Chapter 83 and 1 violation of DHS Chapter 50 was issued. Three of 4 complaints were substantiated. Census: 16	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 maintain documentation of any investigation. This Rule is not met as evidenced by:	N 158		

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

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Based on record review and interview, the provider did not ensure immediate steps were taken to ensure the safety of all residents, nor was a documented investigation conducted in response to allegation(s) of abuse, neglect, or misappropriation of property.

FINDINGS:

On 08/07/2026, the Department received a complaint with concerns about resident treatment.

On 08/21/2026, Surveyor arrived at the facility for 4 complaint investigations.

EXAMPLE 1: Resident 3

On 08/21/2026 at 9:00 AM, Surveyor interviewed Resident 3 reported that his/her only complaint was that some staff speak in a rude manner to him/her. Resident 3 stated staff can seem annoyed by his/her requests and have an accusatory tone in response. Resident 3 couldn't specify any examples.

On 08/21/2026, Surveyor reviewed Resident 3's facility record. Resident 3 was admitted to the facility on 10/21/2021. Resident 3 was his/her own person. Resident 3 was diagnosed with but not limited to: anxiety disorder, bipolar, depression, and schizophrenia.

On 08/21/2026, Surveyor reviewed Resident 3's progress notes:
1.) On 08/08/2026 at 9:59 AM, Med Passer F documented, "states [S/He's] not happy because some of the workers are being rude to [him/her], and [s/he's] been trying to avoid a resident so [s/he's] just staying in [his/her] room alone."

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2.) On 08/08/2026 at 3:30 PM, Med Passer F documented, "Stayed in [his/her] room most of the day. Stated that [s/he] is a bit depressed and feels sick so [s/he] doesnt (sic.) want to be bothered."

On 08/21/2026 at 1:00 PM, Surveyor discussed the above concerns with Administrator A and Assistant B. Administrator A stated s/he had not been made aware of any caregiver misconduct towards Resident 3 in August 2026. Surveyor read Resident 3's progress notes from August 8, 2026. Administrator A reported s/he had not been made aware that Resident 3 reported staff being rude on August 8th and so an investigation hadn't been conducted.

EXAMPLE 2: Resident 5

On 08/28/2026, the Department received a complaint with concerns about medication administration practices.

On 08/28/2026 at 12:30 PM, Surveyor called Family Member I. Family Member I reported s/he is close with Resident 5 and speaks with him/her on the phone often. Family Member I reported Resident 5 reported that a caregiver took his/her Fentanyl patch off without replacing it.

On 08/28/2026, Surveyor reviewed Resident 5's facility record. Resident 5 was admitted to the facility on 07/09/2026. Resident 5 was on hospice service. Resident 5 was diagnosed with but not limited to: diaphragmatic hernia without obstruction or gangrene, fibromyalgia, and spinal stenosis.

On 09/01/2026, Surveyor reviewed Resident 5 MCO critical incidents log. There were 2 incidents

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N 158	Continued From page 3 titled, "Medication Errors," the first incident was dated 07/24/2026 and the second was 08/03/2026. 1.) On 07/24/2026, the following narrative was documented, "member report to [Family Member I] about the incident: "the girl walked in, grabbed the patch saying this needs to come off. I said you can't take it off unless you put another one on. [S/He] said no this has been on since Sun (Sunday). And (sic.) you can't put another one on until Wednesday and then [s/he] walked out of the room with the old patch in [his/her] hand and no new one ...spoke with [Assistant B], the assistant director on 7/30; [s/he] report they now have some safety standards in place. [S/He] reports hospice put a sticker on, and the used patch needs to be placed into a plastic bag, and given to the RN, or placed on [his/her] desk ..." On 09/02/2026 at 1:00 PM, Surveyor discussed the above concerns with Administrator A and Assistant B. Administrator A and Assistant B acknowledged an investigation into the allegation of misappropriation of Resident 5's Fentanyl patch wasn't documented by Previous Nurse N. Assistant B reported s/he had not been made aware of the incident by Previous Nurse N. CROSS REFERENCE N0348 DHS Chapter 83.32(3)(d) Rights Of Residents: Freedom From Mistreatment	N 158		
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	N 214		

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N 214	Continued From page 4 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: Based on observation, record review, and interview, the administrator did not 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. From 08/21/2026 to 09/02/2026, Surveyor identified 9 violations of DHS Chapter 83, 1 violation of DHS Chapter 50, 5 repeat violations, and substantiated 3 complaints. FINDINGS INCLUDE: Facility if a class CNA non-ambulatory license with a capacity of 19 resident and serves irreversible dementia, Alzheimer's, physically disabled, and advanced aged. On 07/24/2026, the Department received a complaint with concerns related to adequate staffing and adequate food supply. On 08/07/2026, the Department received a complaint with concerns related to resident living environment, medication administration practices and resident treatment.	N 214		

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N 214	Continued From page 5 On 08/12/2026, the Department received a complaint with concerns related to resident living environment. On 08/21/2026, Surveyor arrived at the facility for 3 complaint investigations. On 08/28/2026, the Department received a complaint with concerns related to medication administration practices. From 08/21/2026 to 09/02/2026, Surveyor identified 9 violations of DHS Chapter 83, 1 violation of DHS Chapter 50, and 3 complaints were substantiated. The following violations were identified: 1.) 83.12(2)(a) Caregiver: Investigating Abuse & Neglect 2.) 83.15(3)(a) Administrator Shall Supervise Daily Operation 3.) 83.32(3)(d) Rights Of Residents: Freedom From Mistreatment 4.) 83.37(2)(d) Documentation Of Medication Administration 5.) 83.37(2)(e) Other Administration Given Or Delegated By Rn 6.) 83.38(1)(g) Health Monitoring 7.) 83.38(1)(h) Medication Administration 8.) 84.43(1) Environment Safe, Clean, And Comfortable 9.) 83.45(3) Toxic Substances 10.) 50.09(1)(L) Care The following violations were repeat violations: 1.) 83.37(2)(d) Documentation Of Medication Administration 2.) 83.38(1)(g) Health Monitoring 3.) 83.38(1)(h) Medication Administration 4.) 83.43(1) Environment Safe, Clean, And Comfortable	N 214		

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N 214	Continued From page 6 5.) 83.45(3) Toxic Substances On 08/21/2026 at 9:40 AM, Surveyor interviewed Resident 1. Resident 1 reported that some staff "give attitude" when s/he asks for things. Resident 1 reported that supervisors are rarely in the building and so s/he doesn't know how to report his/her concerns or issues. On 08/21/2026 at 3:00 PM, Surveyor discussed the above concerns with Administrator A and Assistant B. Administrator A and Assistant B acknowledged Resident 3 and Resident 5's July 2026 MARs were missing documentation for their scheduled narcotic medications. Administrator A stated s/he had not been made aware of any caregiver misconduct towards Resident 3 in August 2026. Surveyor read Resident 3's progress notes from August 8, 2026. Administrator A reported s/he had not been made aware that Resident 3 reported staff being rude on August 8th and so an investigation hadn't been conducted. Administrator A and Assistant B acknowledged environmental concerns in facility kitchen, resident living room, resident dining room, Resident 1's room, and Resident 2's room.	N 214		
N 348	83.32(3)(d) Rights of Residents: Free from mistreatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from mistreatment. Be free from physical, sexual and mental abuse and neglect, and from financial exploitation and misappropriation of property.	N 348		

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This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure Resident 5 was free from misappropriation of property.

FINDINGS INCLUDE:

Facility if a class CNA non-ambulatory license with a capacity of 19 resident and serves irreversible dementia, Alzheimer's, physically disabled, and advanced aged.

On 08/07/2026, the Department received a complaint with concerns related to resident living environment.

On 08/21/2026, the Department received a complaint with concerns related to resident living environment.

On 08/21/2026, Surveyor arrived at facility for complaint investigation.

On 08/21/2026, Surveyor reviewed Resident 5's facility record. Resident 5 was admitted to the facility on 07/09/2026. Resident 5 was on hospice service. Resident 5's diagnosis list did not include dementia.

On 08/21/2026, Surveyor reviewed Resident 5's observation notes. On 08/02/2026 at 1:35 PM, Assistant B documented, " [Resident 5] reported to [Family Member I] that 63 dollars came up missing from wallet ...Noted writer was just informed today August 2, 2026."

On 08/21/2026 at 12:08 PM, Surveyor requested Assistant B's investigation into the allegation of

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misappropriation of money on 08/02/2026.

On 08/21/2026 at 1:00 PM, Assistant B handed Surveyor the grievance from stating the results of the investigation. Assistant B stated s/he didn't have any further documentation related to investigation into the missing money. Assistant B stated incident happened days prior to him/her getting the report and Resident 5 wasn't a reliable reporter.

On 08/21/2026, Surveyor reviewed Resident 5's facility record. Resident 5 was admitted to the facility on 07/09/2026. Resident 5 was on hospice service. Resident 5's diagnosis list did not include dementia.
On 08/21/2026, Surveyor reviewed Resident 5's grievance/complaint dated 08/10/2026. Assistant B documented the following," ...6) What actions were taken to resolve grievance/complaint: investigation with staff and resident completed ...7.) Results of actions taken: resident unclear of date of incident stated different days of the week, unclear of amount missing advised to hospice $40, spoke to [Assistant B] and was $63. Advised family with resident hx of dementia, family should maintain funds in their possession. If would like to have resident have funds lock box will be provided to protect funds for resident ..."

On 08/28/2026 at 12:30 PM, Surveyor called Family Member I. Family Member I reported s/he is close with Resident 5 and speaks with him/her on the phone often...Family Member I reported during their last visit s/he supplied Resident 5 with spending cash approximately $70.00. Family Member I stated Resident 5 has a great memory and keeps close track of his/her money. Family Member I reported that Resident 5 called him/her very upset because while Resident 5 was at a

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meal in the diningroom his/her cash went missing from their purse in the bedroom. Family Member I reported staff escorted Resident 5 to his/her meals and the purse had been left in his/her room during the meal. Family Member I stated the investigation into the missing cash wasn't satisfactory. Family Member I had asked Resident 5 if s/he wanted to involve the police but Resident 5 declined.

On 09/01/2026, Surveyor reviewed Resident 5's managed care organization (MCO) record.

On 09/01/2026, Surveyor reviewed Resident 5's MCO comprehensive assessment dated 07/10/2026. Documented Resident 5 as his/her own legal decision maker. The diagnosis list did not document dementia.

On 09/01/2026, Surveyor reviewed Resident 5's MCO incident report dated 07/19/2026. The following was documented, " Concern Summary: Member had $63.00 in [his/her] wallet, and when [s/he] came back from lunch, [his/her] money was gone ...Member reports and aid (sic.) came down to get [him/her] for lunch. When [s/he] returned, [s/he] had the same worker return [him/her] to [his/her] room. When [s/he] came back to [his/her] room, [s/he] saw that [his/her] purse was moved. When [s/he] looked into [his/her] purse, [s/he] found that $63.00 that [Family Member I] had given and watched [him/her] place in [his/her] wallet, was missing. The member called [Family Member I] to let [him/her] know. The member was fearful to bring this up ...[Family Member I] was not sure if [s/he] was going to make a police report for the missing money. [Family Member I] reiterated the only people who have a key to the member's room are the staff, and the member ...Actions taken by CMU/IDT: Attempted to

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contact the facility. Am unable to reach the facility contact ...Summary of Findings: Substantiated concern related to misappropriation due to inadequate investigation by provider. Provider responded by providing member with a lock box to store money and valuables and assist member with tracking [his/her] money. Provider is on heightened oversight due to ongoing provider concerns with staff oversight and operations ..."

On 09/02/2026, Surveyor reviewed Resident 5's hospice record. The following entries were documented:
1.) On 08/03/2026, Hospice Nurse P documented, " ...We discussed missing money. Pt asked staff for change of 68$ from staff member then placed money in [his/her] wallet. [Family Member I] watched on video [Resident 5] placing money in [his/her] wallet. [S/he] then placed purse on the floor and found it the next day in a different location with only 1 dollar inside. Writer assisted pt with looking for money in different locations, no money found..."

2.) On 08/25/2026, Hospice Social Worker Q documented, " ...Patient reported that [s/he] had money stollen (sic.) out of [his/her] room at new facility, but that [s/he] declined to file a police report. The incident was reported to facility director as well as [his/her] [Name Of MCO Provider] team. Staff states that they are working to get patient a lock box for [his/her] valuables ..."

EXIT INTERVIEW:

On 09/02/2026 at 1:00 PM, Surveyor discussed the above concerns with Administrator A and Assistant B. Administrator A and Assistant B stated on 07/19/2026 Previous Nurse M oversaw investigations and reporting misappropriation to

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the Department. Assistant B acknowledged s/he had been notified of Resident 5's missing cash on 08/02/2026 and completed the grievance form on 08/10/2026. Assistant B could not identify why s/he documented Resident 5 as having a history of dementia on the grievance form. Administrator A and Assistant B acknowledged Resident 5 didn't have any medical diagnosis related to cognitive impairment. Assistant B could not describe why s/he had told MCO and Surveyor Resident 5 was an unreliable reporter. Administrator A and Assistant B acknowledged facility didn't have documentation of an investigation into the misappropriation of cash beyond the grievance form. Administrator A and Assistant B acknowledged Resident 5 and Family Member I reported the cash was present in Resident 5's purse. Administrator A and Assistant B acknowledged Resident 5 reported to Family Member I and MCO provider the cash was in his/her purse prior to going to the dining room for lunch on 07/19/2026 and when s/he returned to his/her room the money was missing from his/her purse.

On 09/03/2026 at 2:00 PM, Surveyor spoke with Resident 5 over the phone. Resident 5 reported s/he remembered approximately $63.00 dollars going missing from his/her wallet. Resident 5 stated Family Member I had put cash in his/her wallet during most recent visit. Resident 5 reported that s/he left his/her purse in their room during lunch in the dining room. Resident 5 reported s/he thought s/he had locked his/her room before leaving for lunch. Resident 5 reported when s/he returned to his/her room after lunch. Resident 5 found that his/her purse had been moved and s/he immediately checked their wallet to find all but $1.00 was missing from his/her wallet. Resident 5 stated s/he called

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N 348	Continued From page 12 Family Member I and reported the missing money to a facility member the same day as the incident. CROSS REFERENCE N0158 DHS Chapter 83.12(2)(a) Caregiver: Investigating Abuse & Neglect	N 348		
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: Based on record review and interview, the provider did not ensure 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 and that any side effects observed by the employee or symptoms reported by the resident were documented, the need for any PRN (as needed) medication and the resident ' s response were documented.	N 415		

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N 415	Continued From page 13 From 07/07/2026 to 07/31/2026, Provider did not document the administration 10 doses of schedule II narcotic tablets on resident's medication administration records (MARs). This is a repeat violation from previous statement of deficiency (SOD) W10511 dated 07/15/2025 and SOD W10512 dated 11/18/2025. FINDINGS INCLUDE: On 08/07/2026, the Department received a complaint with concerns about medication administration practices. On 08/21/2026, Surveyor arrived at the facility for 4 complaint investigations. EXAMPLE 1: Resident 3 On 08/21/2026, Surveyor reviewed Resident 3's facility record. Resident 3 was admitted to the facility on 10/21/2021. Resident 3 was his/her own person. Resident 3 was diagnosed with but not limited to: acute left-sided low back pain with left-sided sciatica and lumbar back pain with radiculopathy affecting right lower extremity. On 08/21/2026, Surveyor reviewed Resident 3's July 2026 medication administration record (MAR). Resident 3 was prescribed the narcotic (controlled substance schedule II) hydrocodone-acetaminophen (APAP) 5-325mg tablets every 6 hours for radiculopathy. The following intervals of his/her scheduled narcotic tablets were left blank on the MAR: 1.) 07/07/2026 at 10:00 PM 2.) 07/17/2026 at 10:00 PM 3.) 07/18/2026 at 5:00 AM 4.) 07/27/2026 at 10:00 PM	N 415		

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N 415	Continued From page 14 EXAMPLE 2: Resident 5 On 08/21/2026, Surveyor reviewed Resident 5's facility record. Resident 5 was admitted to the facility on 07/09/2026. Resident 5 was on hospice service. Resident 5 was diagnosed with but not limited to: diaphragmatic hernia without obstruction or gangrene, fibromyalgia, and spinal stenosis. On 08/21/2026, Surveyor reviewed a comprehensive assessments dated 07/09/2026 and 08/21/2026. The comprehensive assessments documented that facility staff were to administer all of Resident 5's prescription medications. On 08/21/2026, Surveyor reviewed Resident 5's July 2026 MAR. Resident 5 was prescribed 2 scheduled narcotics (controlled substance schedule II). Resident 5 was to be administered 2 tablets of Oxycodone-APAP 5-325mg every 6 hours and a Oxycodone 10mg tablet every 4 hours for pain. The following intervals of his/her narcotic tablets were left blank on the MAR: 1.) 07/15/2026 at 12:00 AM, Oxycodone-APAP 5-325mg tablets 2.) 07/17/2026 at 12:00 AM, Oxycodone-APAP 5-325mg tablets 3.) 07/18/2026 at 6:00 AM, Oxycodone-APAP 5-325mg tablets 4.) 07/21/2026 at 4:00 AM, Oxycodone 10mg tablet 5.) 07/22/2026 at 12:00 AM, Oxycodone 10mg tablet 6.) 07/22/2026 at 4:00 AM, Oxycodone 10mg tablet INTERVIEW:	N 415		

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N 415	Continued From page 15 On 08/21/2026 at 3:00 PM, Surveyor discussed the above concerns with Administrator A and Assistant B. Administrator A and Assistant B acknowledged Resident 3 and Resident 5's July 2026 MAR were missing documentation for their scheduled narcotic medications. CROSS REFERENCE N0431 DHS Chapter 83.38(1)(g) Health Monitoring CROSS REFERENCE N0432 DHS Chapter 83.38(1)(h) Medication Administration	N 415		
N 416	83.37(2)(e) Other administration given or delegated by RN Other administration. Injectables, nebulizers, stomal and enteral medications, and medications, treatments or preparations delivered vaginally or rectally shall be administered by a registered nurse or by a licensed practical nurse within the scope of their license. Medication administration described under sub. (2)(e) may be delegated to non-licensed employees pursuant to s. N 6.03(3). This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure injectable medications were delegated by a Registered Nurse (RN) pursuant to the Nurse Practice Act [s. N 6.03(3)] and in accordance with accepted standards of practice for unlicensed caregiver (Med Passer C). Resident 2 was prescribed an as needed (PRN) Epinephrine (Epi-Pen) intramuscular (IM) injection for severe allergic reaction. Med Passer C had not been delegated to administer the IM injection by an RN.	N 416		

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N 416	Continued From page 16 FINDINGS INCLUDE: On 08/07/2026, the Department received a complaint with concerns about medication administration practices. On 08/21/2026, Surveyor arrived at facility for 4 complaint investigations. On 08/21/2026 at 9:45AM, Surveyor did a medication cart audit with Med Passer C. Med Passer C stated s/he oversaw the administration of medications to all residents for that shift. Med Passer C reported s/he and Caregiver D were the only staff in the building at that time. Med Passer C reported s/he had the only set of medication cart keys for that shift. On 08/21/2026, Surveyor reviewed Resident 2's record. Resident 2 was his/her own person. Resident 2 was admitted to the facility on 01/02/2026. Resident 2's individualized service plan, titled "Planned Services," documented staff were to administer Resident 2's medications was prescribed. On 08/21/2026, Surveyor reviewed Resident 2's August 2026 medication administration record (MAR). The following order was documented, "Epinephrine Give 0.3 mg intramuscularly as needed (for severe allergic reaction). (Ends: 12/31/27 11:59 PM)" On 08/21/2026 at 1:00 PM, Surveyor requested documentation of Med Passer C's RN delegation from Administrator A. Administrator A reported staff training were maintained at their sister facility. Administrator A stated s/he would email Surveyor documentation by end of the next business day.	N 416		

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N 416	Continued From page 17 On 08/25/2026, Surveyor reviewed Med Passer C's RN delegation. The RN delegation did not contain intramuscular (IM) injection delegation. On 08/25/2026 at 9:39 AM, Surveyor emailed Administrator A and Assistant B notification that Resident 2 had been prescribed an as needed (PRN) Epinephrine IM injection for severe allergic reaction and that Med Passer C did not have documentation of being delegated the IM injection skill. On 08/25/2026 at 10:29 AM, Administrator A emailed Surveyor stating s/he would provide the RN delegation for IM injection the following week.	N 416		
N 431	83.38(1)(g) Health monitoring. 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	N 431		

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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 Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure residents were provided health monitoring adequate to his/her needs.

This is a repeat violation from previous statement of deficiency (SOD) 8OI011, dated 01/07/2026.

FINDINGS INCLUDE:

On 08/07/2026, the Department received a complaint with concerns about medication administration practices.

On 08/21/2026, Surveyor arrived at the facility for 4 complaint investigations.

EXAMPLE 1: Resident 3

On 08/21/2026 at 8:50 AM, Surveyor over heard Resident 3 tell staff s/he was surprised they were measuring his/her blood pressure.

On 08/21/2026, Surveyor reviewed Resident 3's facility resident record. Resident 3 was admitted to the facility on 10/21/2021. Resident 3 was his/her own person. Resident 3 was diagnosed with but not limited to: acute systolic heart failure, and hypertension.

On 08/21/2026, Surveyor reviewed Resident 3's

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individualized service plan (ISP). The ISP wasn't signed by Resident 3. It was documented that staff were to administer his/her prescribed medications. Under the subsection titled, "Record-Blood Pressure," the following was documented, "Check and record blood pressure. Notify RN if: Systolic (top number) B/P is less than 100 or hold if symptomatic with dizziness-Low BP concerns and call DR (doctor) ..."

On 08/21/2026, Surveyor reviewed Resident 3's July 2026 medication administration record (MAR). The following order was documented, "Carvedilol Tab 6.25mg (Daily) take 1 tablet by mouth twice daily for congestive heart failure (okay to hold one dose if systolic blood pressure less than 100 or [s/he] is symptomatic with dizziness-low blood pressure concerns and call md. med tech should not hold without checking blood pressure first.)..." All 60 doses were documented as administered.

On 08/21/2026, Surveyor reviewed Resident 3's August 2026 MAR. The following order was documented, "Carvedilol Tab 6.25mg (Daily) take 1 tablet by mouth twice daily for congestive heart failure (okay to hold one dose if systolic blood pressure less then 100 or [s/he] is symptomatic with dizziness-low blood pressure concerns and call md. med tech should not hold without checking blood pressure first.)..." All 41 doses were documented as administered.

On 08/21/2026, Surveyor reviewed Resident 3's profile. Under the subsection titled, "TREATMENT & THERAPY," it was documented that staff were to measure Resident 3's blood pressure once daily.

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N 431	Continued From page 20 On 08/21/2026, Surveyor requested all blood pressure measurements on Resident 3 from 07/01/2026 to 08/21/2026. Resident 3's blood pressure was measured: 07/03/2026, 07/23/2026, 08/19/2026, 08/20/2026 and 08/21/2026. EXAMPLE 2: Resident 4 On 08/21/2026, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the facility on 06/08/2026. Resident 4 was diagnosed with but not limited to: insulin dependent diabetes mellitus. On 08/21/2026 at 1:00PM, Surveyor requested Resident 4's August MAR and August blood glucose levels. Assistant B printed off Resident 4's August MAR and showed Surveyor that staff documented blood glucose level in the, "Scheduled Med Notes," section of the MAR. On 08/21/2026, Surveyor reviewed Resident 4's August 2026 MAR. The following insulin and blood glucose levels were documented: 1.) "Novolog Flexpen 100unit/ML (Daily) Inject 1-5 units subcutaneously 3 times daily before meals: <150= 0 units, 151-200= 1 unit, 201-250= 2 units, 251-300= 3 units, 301-350= 4 units, 351-400= 5 units for type 2 diabetes mellitus. give even if npo (nothing by mouth)/meals skipped. (do not give more than every 4 hours when npo) *prime pen with 2 units prior to each dose." 2.) "Lantus Solostar 100 Unit/MI (Daily) 100 inject 9 units subcutaneously at unit/ml bedtime ..." 3.) "True Matrix Test Glucose (Daily) Use as directed 4 times daily." The intervals ordered were for 8:00AM, 12:00PM, 4:00PM, and 8:00PM. The subsection of the MAR titled, "Scheduled Med Notes," did not contain documentation of blood glucose levels for the following intervals:	N 431		

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N 431	Continued From page 21 1.) 08/01/2026 at 8:00AM 2.) 08/01/2026 at 12:00PM 3.) 08/02/2026 at 12:00PM 4.) 08/07/2026 at 8:00AM 5.) 08/07/2026 at 12:00PM 6.) 08/11/2026 at 12:00PM 7.) 08/13/2026 at 12:00PM 8.) 08/18/2026 at 8:00PM 9.) 08/19/2026 at 8:00AM 10.) 08/19/2026 at 12:00PM The subsection of the MAR titled, "Scheduled Med Notes," did not contain documentation of the number of sliding scale insulin units administered at the following intervals: 1.) 08/02/2026 at 5:00PM 2.) 08/04/2026 at 8:00AM 3.) 08/05/2026 at 8:00AM 4.) 08/05/2026 at 12:00PM 5.) 08/06/2026 at 8:00AM 6.) 08/06/2026 at 12:00PM 7.) 08/07/2026 at 8:00AM 8.) 08/07/2026 at 12:00PM 9.) 08/09/2026 at 12:00PM 10.) 08/10/2026 at 12:00PM 11.) 08/13/2026 at 8:00AM 12.) 08/13/2026 at 12:00PM 13.) 08/20/2026 at 12:00PM The subsection of the MAR titled, "Scheduled Med Notes," the following was documented, "08/12/2026 at 12:00PM ...Novolog Flexpen 100unit/Ml-bs211 1unit ..." INTERVIEW: On 08/21/2026 at 3:00 PM, Surveyor discussed the above concerns with Administrator A and Assistant B. Administrator A acknowledged staff had not monitored Resident 3's blood pressure	N 431		

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N 431	Continued From page 22 on a consistent daily basis, and so staff were not aware if systolic blood pressure was below parameter of 100mmHg prior to administration of Carvedilol tablet. Administrator A asked Assistant B to add the BP task for staff to perform once daily. Administrator A acknowledged on multiple occasions from 08/01/2026 to 08/20/2026 staff hadn't documented sliding scale units administered to Resident 4. Administrator A acknowledged Resident 4's blood glucose levels hadn't been consistently documented on the MAR. CROSS REFERENCE N0415 DHS Chapter 83.37(2)(d) Documentation Of Medication Administration CROSS REFERENCE N0432 DHS Chapter 83.38(1)(h) Medication Administration	N 431		
N 432	83.38(1)(h) Medication administration. 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: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide medication administration	N 432		

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practices appropriate to Resident 5's needs.

From 07/10/2026 to 07/18/2026, the provider did not administer Resident 5's Latanoprost 0.005% eye drops for his/her glaucoma. Resident 5 reported experiencing eye pain, blurry vision, and seeing double.

From 07/21/2026 to 07/23/2026, Resident 5 went without his/her prescribed transdermal fentanyl patch for approximately 48 hours.

This is a repeat violation from previous statement of deficiency (SOD) 8OI011 dated 01/07/2026.

FINDINGS INCLUDE:

Facility if a class CNA non-ambulatory license with a capacity of 19 resident and serves irreversible dementia, Alzheimer's, physically disabled, and advanced aged.

On 08/28/2026, the Department received a complaint with concerns about medication administration practices.

RECORD REVIEW:

On 08/28/2026, Surveyor looked up Fentanyl Citrate in the nurses drug handbook, "PEARSON NURSE'S DRUG GUIDE." From Page 655 to 665 the following was written, "FENTANYL CITRATE ...Classifications: ANALGESIC; NARCOTIC ...Controlled Substance: Schedule II ...ACTION & THERAPEUTIC EFFECT Synthetic, potent narcotic agonist analgesic that causes analgesia and sedation...PHARMACOKINETICS ...Duration: ...72 h (hour) transdermal ..." (PEARSON NURSE'S DRUG GUIDE, Ed., 2015, p. 655 - 656)

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N 432	Continued From page 24 On 08/28/2026, Surveyor reviewed Resident 5's facility record. Resident 5 was admitted to the facility on 07/09/2026. Resident 5 was on hospice service. Resident 5 was diagnosed with but not limited to: diaphragmatic hernia without obstruction or gangrene, fibromyalgia, spinal stenosis and glaucoma. On 08/28/2026, Surveyor reviewed Resident 5's July 2026 medication administration record (MAR). The following orders were documented: 1.) "Fentanyl Dis 100mcg/H (Every 3 days) (cii) apply 1 patch to skin on belly area every 3 days, remove old patch before applying new-don't apply heat over patch for pain ... (Starts: 07/13 09:00 AM) (Ends: 08/21/26 12:00 AM) ..." 2.) "Latanoprost 0.005% ophth (ophthalmic) Soln (solution) (Daily) Instill 1 drop in both eyes at bedtime for glaucoma **refrigerate until opened. Once opened store at room temp discard after 6 weeks* ... (Starts 07/18 12:00 AM). The following intervals were documented: 1.) From 07/09/2026 to 07/17/2026, Zero, documentation of order transcribed to MAR. 2.) On 07/18/2026 at 8:00 PM - zero, documentation (blank) 3.) From 07/19/2026 to 07/31/2026 at 8:00 PM - administered On 09/01/2026, Surveyor reviewed Resident 5's MCO comprehensive assessment dated 07/10/2026. An order for latanoprost eye drops 0.005% at bedtime for primary open angle glaucoma of both eyes was started on 12/26/2025. Documented Resident 5 as his/her own legal decision maker. On 09/01/2026, Surveyor reviewed Resident 5's	N 432		

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managed care organization (MCO) incident reports:
1.) On 07/24/2026, MCO Case Manager documented, "Concern Summary: Member's pain patch (fentanyl) fell off, and no one would place a new once for 48 hours...Member was not able to know what happened to [his/her] pain patch, and no one replaced it for 48 hours. When it fell off on Monday, the member reports [s/he] attempted to tell someone to please place a new one and they told [him/her] it was not time, or they would look into it...Summary of Findings: Concern related to medication administration - application/removal of prescription patch - is substantiated. Provider has responded by updating member's plan of care to include two staff member present for the application and removal of the patch. Both staff are to document the time and place of the patch and its removal ..."

2.) On 08/05/2026, MCO Care Manager J documented, "Concern Summary: Member recently moved and was without [his/her] eyedrops for a period of time ...The member recently moved to a new facility. [S/He] moved on the 9th, and it was reported [s/he] was not able to get [his/her] eyedrops for [his/her] glaucoma until the 18th. It was reported to [Family Member I] was told they were sent by prior facility, and the new facility reported the insurance would not give [him/her] more. No once called [Family Member I] ...[Family Member I] called [Name Of Pharmacy Provider] and paid out of pocket. The member told [Family Member I] [s/he] was having blurry vision and seeing double. The member reports [s/he] asked every day and was told it was an insurance issue ...Summary of Findings: The concern is substantiated - missed medication ...reported that follow-up discussion occurred with the provider regarding expectations for

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medication administration ..."

On 09/01/2026, Surveyor reviewed Resident 5 MCO critical incidents log. There were 2 incidents titled, "Medication Errors," the first incident was dated 07/24/2026 and the second was 08/03/2026.
1.) On 07/24/2026, the following narrative was documented, "member report to [Family Member I] about the incident: "the girl walked in, grabbed the patch saying this needs to come off. I said you can't take it off unless you put another one on. [S/He] said no this has been on since Sun (Sunday). And (sic.) you can't put another one on until Wednesday and then [s/he] walked out of the room with the old patch in [his/her] hand and no new one ...spoke with [Assistant B], the assistant director on 7/30; [s/he] report they now have some safety standards in place. [S/He] reports hospice put a sticker on, and the used patch needs to be placed into a plastic bag, and given to the RN, or placed on [his/her] desk ..."

2.) On 08/03/2026, the following narrative was documented, "... Member also reports [s/he] is given [his/her] medications in [his/her] room, and nobody tells [him/her] they drop them off, so [s/he] does not see them."

On 09/01/2026, Surveyor reviewed Resident 5's individualized service plan (ISP) that facility sent to MCO. The ISP was dated 08/25/2026, under the subsection titled, "Medication Administration," the following was documented, " ...Starts 08/25/26 ...two caregivers to sign and witness patches when placed every three days ..."

On 09/02/2026, Surveyor reviewed Resident 5's hospice record. The following entries were documented:

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N 432	Continued From page 27 1.) On 07/13/2026, Hospice Nurse M documented, " ...[S/he] did ask that writer send over an order for [his/her] eye drops that [s/he] was using at [Name Of Previous Facility] but the order must not have been sent over. I have no immediate concerns for patient." 2.) On 07/22/2026, Hospice Nurse P documented, " ...[Family Member I] called reporting pt contacted [him/her] stating Fentanyal (sic.) patch was removed yesterday at 130pm. Staff refusing to place new patch. Writer contacted facility, advised to place new patch. Med passer stating [s/he] can not place new patch. Writer reviewed orders with [him/her] and staff stated they would contact their RN on call. Provided call back # to med passer. Wrtier (sic.) updated ACHPOA Writer did call facility to check status, as no call was returned after 45 min. Med passer reported [s/he] will not apply new patch per [his/her] facility RN. Writer inquired reason and [s/he] stated RN told [him/her] it can not be placed until morning. Writer advised this is a med error. Staff said okay ..." 3.) On 07/27/2026, Hospice Clergy O documented, " ... [Resident 5] speak so (sic.) of [his/her] eyes bothering [him/her] today. [S/he] has Glaucoma and since [s/he] did some drops, they have been really bothering [him/her] ..." 4.) On 08/17/2026, Hospice Nurse M documented, " ...[S/he] was just upset with the facility only bringing [his/her] eye drops after [s/he] asks and same with [his/her] lidocaine patch. We are planning a care conference for [him/her] and the facility this week Wednesday where we can address more of these concerns ..."	N 432		

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N 432	Continued From page 28 INTERVIEW: On 08/28/2026 at 12:30 PM, Surveyor called Family Member I. Family Member I reported s/he is close with Resident 5 and speaks with him/her on the phone often. Family Member I reported Resident 5 reported that a caregiver took his/her Fentanyl patch off without replacing it. Family Member I stated Resident 5 has issues with swallowing pills and can take extended periods of time intake his/her pills/tablets. Family Member I reported that Resident 5 has complained to them several times that staff will leave cups of pills in his/her room without prompting and/or observing Resident 5 to take them. Family Member I reported this had resulted in Resident 5 not receiving medications and pills being found loose in his/her bed or room. Family Member I reported Resident 5's prescribed eye drops for treatment of glaucoma hadn't been administered for multiple weeks following admission. Family Member I stated when s/he was notified by facility that insurance wouldn't purchase new eye drops for Resident 5. Family Member I called the [Name Of Pharmacy Provider] and paid out of pocket for new prescription eye drops. Family Member I stated Resident 5 told him/her that their eyes were hurting from the increased pressure, and they were concerned about losing their more of their eyesight. On 08/28/2026 at 12:54 PM, Surveyor spoke with MCO Nurse K. MCO Nurse K stated s/he was part of Resident 5's care team. MCO Nurse K reported there had been multiple concerns related to facility medication administration practices since Resident 5's admission to facility on 07/10/2026. On 09/02/2026 at 1:00 PM, Surveyor discussed	N 432		

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the above concerns with Administrator A and Assistant B. Administrator A nor Assistant B were aware of the report of a staff removing a fentanyl patch without replacing in July 2026. Administrator A nor Assistant B recalled Resident 5 being without his/her fentanyl patch for approximately 48 hours. Administrator A nor Assistant B were aware when hospice contact provider about the missing fentanyl patch the acting facility nurse acknowledged the lack of fentanyl patch as a medication error. Administrator A acknowledged Resident 5's fentanyl patch wasn't administered as prescribed. Administrator A nor Assistant B didn't know why the physician order for administration of Latanoprost eye drops hadn't been transcribed to Resident 5's MAR until 8 post-admission on 07/18/2026. Administrator A acknowledged Resident 5's order for Latanoprost eye drops was part of the pre-admission assessment. Administrator A reported Previous Nurse N had overseen medication reconciliation in July 2026. Administrator A and Assistant B acknowledged Resident 5 reported increased eye pain, and blurry vision to his/her care team while not receiving his/her Latanoprost eye drops as prescribed. Administrator A acknowledged Resident 5 hadn't been provided with treatment adequate to his/her needs.

On 09/03/2026 at 2:00 PM, Surveyor spoke with Resident 5 over the phone. Resident 5 reported s/he on a Sunday a staff member removed his/her fentanyl patch. Resident 5 stated when the staff member attempted to leave his/her room without placing a new fentanyl patch. Resident 5 told the staff member; you need to put a new one on if you take one off. Resident 5 stated the staff member told him/her that the patch wasn't due to be replaced until Wednesday morning and left the

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N 432	Continued From page 30 room. Resident 5 stated s/he contacted hospice and the hospice nurse had told them to replace the fentanyl patch. Resident 5 stated s/he went without a fentanyl patch from Sunday evening to Wednesday morning. Resident 5 reported his/her pain was slightly increased during this period. Resident 5 reported s/he didn't get any of his/her eye drops the first week s/he was at the facility. Resident 5 stated s/he kept asking staff about the eye drops and they kept telling him/her it was an insurance issue. Resident 5 reported s/he called Family Member I, and Family Member I paid for new bottle of eye drops out-of-pocket. Resident 5 reported that after Family Member I paid for the new bottle it took a few days for the staff to start administration of the eye drops. Resident 5 reported s/he was concerned about his/her vision because s/he was seeing, "double". Resident 5 reported that since staff have started administering the eye drops as ordered, his/her vision had normalized. CROSS REFERENCE N0415 DHS Chapter 83.37(2)(d) Documentation Of Medication Administration CROSS REFERENCE N0431 DHS Chapter 83.38(1)(g) Health Monitoring CROSS REFERENCE Y3244 DHS Chapter 50.09(1)(L) Care	N 432		
N 481	83.43(1) Environment safe, clean, and comfortable 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.	N 481		

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This Rule is not met as evidenced by:
Based on observation, record review, and interview, the provider did not ensure a safe, clean, comfortable and homelike environment appropriate for residents.

This is a repeat violation from previous Statement of Deficiency (SOD) W10512 dated 11/18/2025.

FINDINGS INCLUDE:

Facility if a class CNA non-ambulatory license with a capacity of 19 resident and serves irreversible dementia, Alzheimer's, physically disabled, and advanced aged.

On 08/07/2026, the Department received a complaint with concerns related to resident living environment.

On 08/21/2026, the Department received a complaint with concerns related to resident living environment.

On 08/21/2026, Surveyor arrived at facility to conduct complaint investigations.

OBSERVATIONS:

On 08/21/2026 at approximately 8:45 AM, Surveyor initiated a tour of the facility environment and made the following observations:

1.) Two 24-pack cases of soda stored on the pantry floor a couple feet from a pest trap. One of the cases was torn opened (Picture 3).

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2.) Inside the refrigerator Surveyor observed a commercial plastic package of turkey sandwich meat with a gross amount of condensation on the inside (Picture 12). The package was approximately 40% full of sandwich meat. The bottom of the package label documented, "ONCE OPENED USE WITHIN 7 DAYS," (Picture 11). Caregiver D acknowledged the package didn't have an open date documented, and stated s/he didn't know when it had been opened.

3.) Surveyor entered Resident 1's room. Resident 1's flooring in front of television had a sticky substance on the floor, that made a velcro noise as Surveyor walked across it. The room had a stale musty-like odor.

RECORD REVIEW:

On 08/21/2026, Surveyor reviewed an emergency medical service (EMS) report from lift assist for Resident 1 on 07/29/2026. The following was documented, "Patient is known to this crew from previous 911 calls ...Patient's shirt and sweatpants are wet. Patient reports [s/he] was seated in [his/her] wheelchair. [S/He] went to reach for the television remote, while holding a glass of water. [S/He] leaned too far over, dumping the water on the floor, dropping the remote, and sliding out of [his/her] wheelchair to the floor. Patient reports [s/he] did not lose consciousness. Patient is not able to get off the floor on [his/her] own, and staff "is not helping me get up." ...Patient is lifted via a 2-person sheet lift onto [his/her] wheelchair. Patient repositioned to comfort in [his/her] manual wheelchair ...Patient's room was very unkept. Crew stuck to floor of the room, due to sticky substance all over the floor. Water from patient had not been

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cleaned up. There were multiple wheelchairs in the way of patient's path of travel. The room smelled heavily of urine. The carpet in the hallway was filthy ..."

On 08/21/2026, Surveyor reviewed police report IR#26-362087 dated 08/09/2026. The following was documented, "[Resident 2] was feeling sick and wanted to go to the hospital. Strong smell of urine radiating from [Resident 2's] room ...Room was visually tidy with strong, stale, urine small being the only noted concern ..."

INTERVIEWS:

On 08/21/2026 at 10:20 AM, Surveyor toured the kitchen with Administrator A. Surveyor showed Administrator A the kitchen floor and cabinetry. Administrator A acknowledged the debris and food-like substances on those surfaces. Surveyor showed Administrator A the thawed cod fillets and turkey sandwich meat in the refrigerator. Administrator A then threw out both the turkey sandwich meat and cod fillets into the trash bin. Administrator A acknowledged silverware drawer was broken and had moderate amount of food particles inside. Administrator A acknowledged silverware wouldn't remain clean inside that environment. Administrator A acknowledged the open bag of cookies in the pantry, soda cases on the floor, the rust-like substance on the floor and the food-like substance on the dry wall around the light switch.

On 08/21/2026 at 3:00 PM, Surveyor discussed the above concerns with Administrator A and Assistant B. Surveyor read Administrator A and Assistant B the above police and EMS report. Surveyor described his/her observations of Resident 1's room. Administrator A and Assistant

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N 481	Continued From page 34 B acknowledged history of reports of urine-like odor in Resident 1 and Resident 2's room. Administrator A and Assistant B were not aware of a sticky like substance on Resident 1's floor but stated they would look into the concern. On 08/27/2026 at 2:13 PM, Surveyor spoke with Guardian H. Guardian H stated s/he was Resident 1's legal representation. Guardian H stated s/he didn't have a working sense of smell but his/her spouse and an EMT had previously reported Resident 1's room had a strong urine-like odor. Guardian H stated s/he had emailed facility about concerns in Resident 1's room. Guardian H reported s/he had previously been a caregiver for 16 years and s/he could tell Resident 1's room wasn't being cleaned consistently. Guardian H reported s/he had previously observed a sticky like substance on Resident 1's room floor and stated it seem like they were , "using too much pine-sol to cover up the smell." CROSS REFERENCE N0499 DHS Chapter 83.45(3) Toxic Substances CROSS REFERENCE Y3244 DHS Chapter 50.09(1)(L) Care	N 481		
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 interview, the provider did not ensure that cleaning compounds and toxic	N 499		

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N 499	Continued From page 35 substances were stored in a secure area. This is a repeat violation from previous Statement of Deficiency (SOD) W10512 dated 11/18/2025. FINDINGS INCLUDE: Facility if a class CNA non-ambulatory license with a capacity of 19 resident and serves irreversible dementia, Alzheimer's, physically disabled, and advanced aged. On 08/07/2026, the Department received a complaint with concerns related to resident living environment. On 08/21/2026, the Department received a complaint with concerns related to resident living environment. On 08/21/2026, Surveyor arrived at facility to conduct complaint investigations. OBSERVATION: On 08/21/2026, Surveyor entered the resident living room, there were 2 residents watching television. On the opposite side of the half wall connected to the resident living room was a housekeeping cart . On top of the housekeeping cart were the following cleaning supplies: Lysol brand toilet bowl cleaner, Floor Science brand cleaning concentrate (Picture 13), Clorox brand multi-surface cleaner with bleach and Odoban brand disinfectant fabric air freshener (Picture 14). Surveyor asked Med Passer C about the housekeeping cart. Med Passer C reported the housekeeping cart had been left out by night shift staff.	N 499		

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N 499	Continued From page 36 INTERVIEW: On 08/21/2026 at 3:00 PM, Surveyor discussed the above concerns with Administrator A and Assistant B. Administrator A and Assistant B acknowledged multiple cleaning supplies including a cleaner with bleach had been left in a resident common area. Administrator A reported nightshift staff were tasked with housekeeping duties. CROSS REFERENCE N0481 DHS Chapter 83.43(1) Environment Safe, Clean, And Comfortable	N 499		
Y3244	50.09(1)(L) Care (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to (l) Receive adequate and appropriate care within the capacity of the facility. This Rule is not met as evidenced by:	Y3244		

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Based on record review and interview, the provider did not ensure Resident 5 was provided adequate and appropriate care within the capacity of the facility.

From 07/09/2026 to 08/16/2026, the water supply to Resident 5's ensuite bathroom wasn't warm enough to complete a shower.

FINDINGS INCLUDE:

Facility if a class CNA non-ambulatory license with a capacity of 19 resident and serves irreversible dementia, Alzheimer's, physically disabled, and advanced aged.

On 08/28/2026, Surveyor reviewed Resident 5's facility record. Resident 5 was admitted to the facility on 07/09/2026. Resident 5 was on hospice service. Resident 5 was diagnosed with but not limited to: diaphragmatic hernia without obstruction or gangrene, fibromyalgia, and spinal stenosis.

On 08/28/2026, Surveyor reviewed a comprehensive assessment dated 07/09/2026 and 08/21/2026. The comprehensive assessments documented that Resident 5 required 1 staff to assist with showers.

On 08/28/2026, Surveyor reviewed Resident 5's observation notes. On 07/29/2026 at 1:57 PM, Assistant B documented, "Hospice came to visit [Resident 5] for shower state [s/he] refused due to water not hot enough/floor mat/ toilet riser was placed in room."

On 09/01/2026, Surveyor reviewed Resident 5's managed care organization (MCO) incident reports. On 08/07/2026, MCO Care Manager J

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Y3244	Continued From page 38 documented, " ...Member reports [s/he] has not had a warm shower since [s/he] has been at the facility. [S/He] Has (sic.) been there for almost a month. [S/He] has a shower in [his/her] room, and [s/he] has a hospice aid who comes in to offer a shower once weekly. The member reports the shower aid has not been able to help, as it has been too cold. The member reports they were told to let the water run more, and it should turn warm. They have attempted that, although, they still got cold water. I was at the facility today for a safety visit, and there were no management available to discuss ...Date Resolved: 08/26/2026 ...Summary of Findings: Substantiated concern related to health and safety and environment - timely response to lack of hot water in member room. Repairs were completed on July 30th and august 10th. Member identified that the issue had been present when [s/he] moved in on July 7th. Provider did not provide member with alternative access to warm water for bathing. Provider instructed the member to run the water longer, but this was ineffective. Repairs have been completed and member now has access to hot water for bathing. Provider is on heightened oversight due to ongoing provider concerns with staff oversight and operations ..." On 09/01/2026, Surveyor reviewed a plumbing bill for facility address dated 08/17/2026. The following was documented, " ...DESCRIPTION OF WORK ...they are not getting any hot water. Turned out to be crossover, I went through every rooms bathrooms and nurse sinks to try to locate it. I found the hallway bathroom with a shower was crossover, and changed the moen positemp cartridge and that seemed to be it, I checked all the end units after and a few more in the middle in each wing and everything got hot ..."	Y3244		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - CROSS PLAINS	2620 MILITARY RD CROSS PLAINS, WI 53528

(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
Y3244	Continued From page 39	Y3244		

On 09/02/2026, Surveyor reviewed Resident 5's hospice record. The following entries were documented:
1.) On 07/15/2026, Hospice Caregiver L documented, "Shower visit complete. Water at facility was like warm cold. Gave patient a quick shower. Patient did not want to wash hair due to water temperature. Comb hair and tidy room. Staff notified ..."

2.) On 07/30/2026, Hospice Nurse M documented, "Patient told writer [s/he] never received the device for [his/her] toilet seat to make it higher for [him/her]. Writer went into DME track and it said it was delivered on 7/23/26. I spoke with the facility nurse last night and [s/he] said [s/he] would look into it. [S/he] did get back to writer this AM and said [s/he] did find it and the fall mat that was ordered for resident. There are no immediate (sic.) concerns ..."

EXIT INTERVIEW:

On 09/02/2026 at 1:00 PM, Surveyor discussed the above concerns with Administrator A and Assistant B. Administrator A and Assistant B were aware that Resident 5 hadn't had a hot shower since his/her admission to facility. Administrator A acknowledged multiple resident rooms were affected by lack of hot water for different time frames. Administrator A reported s/he has had a plumbing service out to facility 3 times in the last month to fix the hot water issue. Administrator A acknowledged Resident 5 hadn't been provided and alternative hot water option for bathing and had gone multiple weeks without washing his/her hair.

On 09/03/2026 at 2:00 PM, Surveyor spoke with Resident 5 over the phone. Resident 5 reported

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019196	A. BUILDING: _____ B. WING _____	C 09/02/2026

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Y3244	Continued From page 40 one of the reasons s/he had been excited to move into facility was the connected bathroom to his/her room. Resident 5 stated since admission the water in his/her ensuite shower had been luke-warm and reported the water in shower was still too cold for him/her to utilize. Resident 5 reported that hot water was coming to the bathroom sink for the last couple weeks and hospice staff have assisted washing him/her from the sink. CROSS REFERENCE N0481 DHS Chapter 83.43(1) Environment Safe, Clean, And Comfortable CROSS REFERENCE N0432 DHS Chapter 83.38(1)(h) Medication Administration	Y3244		