STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019817	A. BUILDING: _____ B. WING _____	C 05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLISS HOMES	1012 N BEL AYR DR WAUKESHA, WI 53188

(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
M 000	INITIAL COMMENTS On 04/23/2026, with information gathered through 05/12/2026, the Bureau of Assisted Living, Southern Regional Office conducted a standard licensing survey and complaint investigation at Bliss Homes located at 1012 North Bel Ayr Drive in Waukesha, WI. Sixteen citations of noncompliance were issued. The complaint was substantiated. Census: 3	M 000		
M 114	88.03(3)(b) CRIMINAL RECORDS CHECK Criminal records check. Prior to an initial license the licensing agency shall ask the Wisconsin department of justice to conduct a criminal records check on the license applicant and on any other adult household member. The licensee shall arrange for a criminal records check of all service providers. At least every second year following issuance of an initial license the licensing agency shall request a criminal records check on the licensee and all other adult household members and the licensee shall arrange for a criminal records check on any service provider. In addition, during the period of the licensure, the licensee shall arrange for a criminal records check on any new service provider. If any of these persons has a conviction record or a pending criminal charge which substantially relates to the care of a dependent population, the funds or property of adults or minors or	M 114		

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

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M 114	Continued From page 1 activities of the adult family home, the licensing agency may deny, revoke, refuse to renew or suspend a license, initiate other enforcement action provided in this chapter or in ch. 50, Stats., or place conditions on the license. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure service providers had complete background checks. A complete background check consists of the following: - A completed Background Information Disclosure (BID) form - A report on findings from the Department of Justice (DOJ) - A Governmental Findings Report from DHS that reports the person's status, including administrative findings or licensing restrictions. House Manager B and Caregiver C did not have complete background checks. The findings include: On 04/23/2026 at approximately 10:15 AM, Surveyors interviewed Licensee A, who stated employee records would all be located in the binder for employee records, which was available in the home. House Manager B provided the	M 114		

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M 114	Continued From page 2 binder to Surveyors. On 04/23/2026 Surveyor reviewed employee records for House Manager B and Caregiver C. House Manager B was hired in October of 2025. His/her record did not include a BID form, a report on findings from the DOJ, or a Governmental Findings Report. Caregiver C was hired in December of 2025. His/her record did not include a BID form, a report on findings from the DOJ, or a Governmental Findings Report. On 04/23/2026 at approximately 12:00 PM, Surveyor interviewed House Manager B. House Manager B stated s/he thought s/he completed a BID upon hire, but was not sure where else it may be located.	M 114		
M 232	88.04(2)(g)1 HEALTH SCREENING FOR STAFF The licensee shall obtain documentation from a physician, a registered nurse or a physician's assistant indicating that the licensee and any service provider has been screened for illness detrimental to residents, including for tuberculosis. The documentation is to be completed within 90 days before the start of providing service. The documentation shall be kept confidential except that the licensing agency shall have access to the documentation for verification. This Rule is not met as evidenced by:	M 232		

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M 232	Continued From page 3	M 232		

Based on observation, record review, and interview, the provider did not ensure each service provider was screened for illness detrimental to residents, including tuberculosis (TB), by a physician, a registered nurse, or a physician's assistant, within 90 day before the start of providing service for 2 of 2 caregivers.

House Manager B and Caregiver C were not screened for illness, including tuberculosis, within 90 days before the start of providing service.

The findings include:

On 04/23/2026, at approximately 8:30 AM, Surveyor arrived at the facility where Caregiver B was observed as the staff on duty. At approximately 9:35 AM, Surveyor interviewed House Manager B. House Manager B stated s/he regularly visits the facility to assist with tasks in the home and for the residents.

On 04/23/2026 at approximately 10:15 AM, Surveyors interviewed Licensee A, who stated employee records would all be located in the binder for employee records, which was available in the home. House Manager B provided the binder to Surveyors.

On 04/23/2026 Surveyor reviewed employee records for House Manager B and Caregiver C. House Manager B was hired in October of 2025. His/her record did not include a screening for illness or a tuberculosis test.

Caregiver C was hired in December of 2025. His/her record did not include a screening for illness or tuberculosis test.

On 04/23/2026 at approximately 12:45 PM,

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M 232	Continued From page 4 Surveyor interviewed House Manager B. House Manager B stated s/he had a TB skin test that s/he submitted to Licensee A upon time of hire. S/he provided a copy of the test for review on his/her phone. The TB skin test was dated 12/19/2024, which was approximately 10 months prior to time of hire, and it did not include a screening for other illnesses or communicable diseases.	M 232		
M 244	88.04(5)(a) TRAINING-15 HOURS WITHIN 6 MONTHS The licensee and each service provider shall complete 15 hours of training approved by the licensing agency related to health, safety and welfare of residents, resident rights and treatment appropriate to residents served prior to or within 6 months after starting to provide care. This training shall include training in fire safety and first aid. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 service providers reviewed received 15 hours of training, including fire safety and first aid, prior to or within 6 months of hire. House Manager B and Caregiver C did not receive any documented training. The findings include: On 04/23/2026 at approximately 10:15 AM,	M 244		

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M 244	Continued From page 5 Surveyors interviewed Licensee A, who stated employee records would all be in the binder for employee records, which was available in the home. House Manager B provided the binder to Surveyors. On 04/23/2026 Surveyor reviewed employee records for House Manager B and Caregiver C. House Manager B was hired in October of 2025. His/her record did not include documentation of training on any topic. Caregiver C was hired in December of 2025. His/her record did not include documentation of training on any topic. On 04/23/2026 at approximately 12:45 PM, Surveyor interviewed House Manager B. House Manager B did not recall completing any documented training. House Manager B was not aware of an alternate location training records may have been stored. On 04/23/2026 at approximately 2:00 P.M., House Manager B said s/he was not aware of DHS 88 regulations.	M 244		
M 246	88.04(5)(b) TRAINING-8 HOURS ANNUALLY Except as provided in pars. (c) and (d), the licensee and each service provider shall complete 8 hours of training approved by the licensing agency related to the health, safety, welfare, rights and treatment of residents every year beginning with the calendar year after the year in which the initial training is received.	M 246		

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M 246	Continued From page 6 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 employees reviewed completed 8 hours of training approved by the licensing agency related to the health, safety, welfare, rights, and treatment of residents, every year beginning with the calendar year after the year in which their initial training occurred. Licensee A had not completed continuing education in 2025. The findings include: On 04/23/2026 at approximately 10:15 AM, Surveyors interviewed Licensee A, who stated employee records would all be in the binder for employee records, which was available in the home. House Manager B provided the binder to Surveyors. On 04/23/2026 Surveyor reviewed employee records for Licensee A. Licensee A has been licensee of the facility since it's opening in April of 2024. Licensee A should have had at minimum, 8 hours of continuing education training on the required topics, in 2025. Licensee A's record did not include documentation of any continuing education training, or other applicable training within that timeframe. Licensee A told Surveyor s/he had completed CBRF [community-based residential facility] training listed on registry as all completed within 2023, including medication administration training, standard precautions, fire safety, and first aid. Licensee A told Surveyor s/he was not required to have any more training, including training related to personal cares for residents	M 246		

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M 246	Continued From page 7 because it was not required. Cross Reference: M0580 DHS 88.10(3)(p) Prompt And Adequate Treatment	M 246		
M 276	88.05(3)(a) Homelike Environment An adult family home shall be safe, clean and well-maintained and shall provide a homelike environment. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the facility was safe, clean, well maintained, and provided a homelike environment. There were several areas of concern related to cleanliness of the home, and maintaining the home in good repair. The findings include: On 04/23/2026 at approximately 9:00 AM, Surveyor toured the home and observed the following: -The resident bathroom had a medicine cabinet/ mirror that was mounted above the sink. Surveyor attempted to open the cabinet door, and the cabinet shifted away from the wall. Surveyor	M 276		

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M 276	Continued From page 8 looked from the side and observed that the medicine cabinet was not fully secured, and the screws and anchors were being pulled out from the wall. -The resident bathroom also had damage to the flooring. Behind the bathroom door, along the wall, there was roughly 5 squares worth of linoleum tile that started peeling away and rolling up, exposing unfinished flooring beneath it. -The doors to the kitchen drawers and cupboards were dirty with splatters, spills, and other discoloration/ dirt build up around the handles. -The kitchen garbage was full and left uncovered for roughly 2 hours. The garbage contained soiled incontinent products. Staff and residents were using the kitchen space to prepare food. -Two vents in the common area between the dining room and the back sitting room were dirty, covered in what appeared to be dust and splatter. On 04/23/2026 at approximately 2:45 PM, Surveyor interviewed House Manager B. House Manager B stated s/he was unaware of the concern with the bathroom medicine cabinet. House Manager B stated the flooring in the bathroom was scheduled to be repaired. S/he stated the residents enjoy helping to clean the kitchen, but the staff could complete more thorough cleaning. House Manager B stated that soiled incontinent products are usually put into a bag and taken directly to the outside garbage and was unsure why they were placed in the kitchen garbage today. S/he stated there was no cleaning schedule for cleaning the face of the vents, but they would address the concern.	M 276		

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M 332	Continued From page 9	M 332		
M 332	88.05(4)(a) FIRE SAFETY-FIRE EXTINGUISHERS Fire extinguishers. Every adult family home shall be equipped with one or more fire extinguishers on each floor. Each required fire extinguisher shall have a minimum 2A, 10-B-C rating. All required fire extinguishers shall be mounted. A fire extinguisher is required at the head of each stairway and in or near the kitchen except that a single fire extinguisher located in close proximity to the kitchen and the head of a stairway may be used to meet the requirement for an extinguisher at each location. Each required fire extinguisher shall be maintained in readily usable condition and shall be inspected annually by the authorized dealer or the local fire department and have an attached tag showing the date of the last dealer or fire department inspection. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 2 of 2 fire extinguishers were inspected annually by an authorized dealer or the local fire department. The home's fire extinguishers had not been inspected since September 2023. The findings include: On 04/23/2026 at approximately 9:00 AM, Surveyor toured the provider's home. Surveyor	M 332		

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M 332	Continued From page 10 observed 1 fire extinguisher near the kitchen, which was tagged for inspection as of September 2023. There was a 2nd fire extinguisher, located in the basement, which was also tagged for inspection as of September 2023. On 04/23/2026 at approximately 10:00 AM, Surveyor interviewed House Manager B. House Manager B stated s/he was not aware of the requirement to have the extinguishers inspected. S/he said s/he would ensure it is completed annually.	M 332		
M 334	88.05(4)(b)1 FIRE SAFETY-SMOKE DETECTORS Every adult family home shall be equipped with one or more single station battery operated, electrically interconnected or radio signal emitting smoke detectors on each floor level. Required smoke detectors shall be located in each habitable room except the kitchen and bathroom and specifically in the following locations: at the head of each open stairway, at the door leading to every enclosed stairway, on the ceiling of the living room or family room, on the ceiling of each sleeping room and in the basement. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a smoke detector was located in each habitable room, specifically at the door leading to an enclosed stairway and on the ceiling	M 334		

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M 334	Continued From page 11 of each sleeping room. The findings include: On 04/23/2026 at approximately 9:00 AM, Surveyor toured the provider's home. Surveyor was unable to locate a smoke detector at the entrance to the enclosed stairway which led to the basement. On 04/23/2026 at approximately 9:15 AM, Surveyor observed Resident 3's bedroom and was unable to locate a smoke detector. Surveyor asked Resident 3 if s/he had a smoke detector. Resident 3 stated s/he did, but s/he took it down a while ago. On 04/23/2026 at approximately 10:30 AM, Surveyor observed Resident 2's bedroom and was unable to locate a smoke detector. Surveyor asked Resident 2 if s/he had a smoke detector. Resident 2 stated s/he did, but s/he took it down because it started beeping a while ago so he took the batteries out. On 04/23/2026 at approximately 10:45 AM, Surveyor interviewed House Manager B. House Manager B stated s/he was aware of Resident 3's smoke detector being down and stated s/he removed it because s/he was burning sage. House Manager B stated s/he was not aware Resident 2's smoke detector was down, and that there were not extra batteries in the home, but that s/he would go purchase some. House Manager B stated s/he was unaware of the requirement to have a smoke detector at the entrance to an enclosed stairway, but that they would get one installed.	M 334		

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M 336	Continued From page 12	M 336		
M 336	88.05(4)(b)2 SMOKE DETECTORS-TESTING AND MAINTENANCE The licensee shall maintain each required smoke detector in working condition and test each smoke detector monthly to make sure that it is operating. If a unit is found to be not operating, the licensee shall immediately replace the battery or have the unit repaired or replaced. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the home's smoke detectors were tested monthly to make sure they were operating. The provider had no documentation of monthly smoke detector testing for the past 2 years. The findings include: On 04/23/2026 at approximately 9:45 AM, Surveyor reviewed the home's environmental records. The record did not include any documentation of smoke detector testing or maintenance. On 04/23/2026 at approximately 10:00 AM, Surveyor interviewed House Manager B. House Manager B stated s/he had checked the smoke detectors maybe twice since starting employment at the facility in October 2025. S/he stated s/he did not document those checks and could not recall the dates. House Manager B stated s/he was not aware of the requirement for monthly checks, or to maintain records for the checks.	M 336		

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M 348	88.05(4)(d)2.c SEMI-ANNUAL FIRE DRILLS The licensee shall conduct semi-annual fire drills with all household members with written documentation of the date and the evacuation time for each drill maintained by the home. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure fire drills were conducted semi-annually. The provider did not complete any fire drills in 2024. The provider did not have documentation to support a completed fire drill in the 2nd half of 2025. The findings include: On 04/23/2026 at approximately 9:35 AM, Surveyor interviewed House Manager B. House Manager B stated they complete fire drills. S/he stated they have maybe completed 3 since s/he started employment at the facility in October 2025. S/he stated there was no documentation of fire drills and s/he was unaware of the dates the drills were completed. House Manager B was also unable to tell Surveyor where the meeting point was outside of the home. On 04/23/2026 at approximately 10:15 AM, Surveyor reviewed the provider's environmental records for the home. The record did not include any fire drills for 2024. The record included 3 fire drills for 2025, dated 04/30/2025, 05/30/2025, and 06/30/2025. The notes on each fire drill were identical. There was no documentation of fire drills in the 2nd half of 2025, and none completed for 2026 thus far. On 04/23/2026 at approximately 2:30 PM,	M 348		

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M 348	Continued From page 14 Surveyor interviewed House Manager B. House Manager B stated s/he was unaware fire drills needed to be documented. S/he made a note to make sure they are documented in the future.	M 348		
M 380	88.06(2)(a) ADMISSION-HEALTH EXAM Except as provided in subd. 2., the licensee shall ensure that a new resident of an adult family home receives a health examination by a physician to identify health problems and is screened for communicable disease, including tuberculosis. Screening for communicable disease may be provided by a physician, a registered nurse or a physician assistant. The health examination and screening shall take place within 90 days prior to admission to the home or within 7 days after admission. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 3 residents reviewed, received a health examination by a physician within 90 days prior to his/her admission or within 7 days after his/her admission, or that s/he was screened for communicable diseases, including tuberculosis, by a physician, registered nurse, or physician assistant within that same timeframe. Resident 3 and Resident 4 did not receive health examinations and were not screened for communicable diseases, including tuberculosis. The fiindings include:	M 380		

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M 380	Continued From page 15 Example 1: Resident 3 On 04/23/2026, Surveyor reviewed Resident 3's record. Resident 3 admitted to the provider on 10/13/2025. There was no evidence of a health examination being completed for him/her, including evidence that s/he was screened for communicable disease. Example 2: Resident 4 On 04/23/2026, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the provider on 09/24/2025. There was no evidence of a health examination being completed for him/her, including evidence that s/he was screened for communicable disease. On 04/23/2026 at approximately 12:00 PM, Surveyor interviewed House Manager B. House Manager B was not aware of the requirements for a new resident admission. House Manager B stated any resident records they had obtained should be in the resident binders. Both Resident 3 and Resident 4 were admitted to the provider's home before House Manager B started, so s/he was unable to provide further explanation.	M 380		
M 384	88.06(2)(b) SERVICE AGREEMENT EXCEPT RESPITE An adult family home shall have a service agreement with each person to be admitted to the home except a person being admitted for respite care. The service agreement shall be completed prior to admission and revised at least 30 days prior to any change. The service agreement shall	M 384		

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be dated and signed by the licensee and the person being admitted or the persons guardian or designated representative. Copies shall be provided to all parties and to the placing agency, if any.
This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure a service agreement was completed prior to admission for 2 of 3 residents reviewed.

The provider did not have a service agreement completed with signatures prior to Resident 1's and Resident 4's admission to the facility.

The findings include:

Example 1: Resident 1

On 04/23/2026 at approximately 10:15 A.M., House Manager B told Surveyor s/he had called Licensee A on his/her phone to include an interview regarding Resident 1's admission to the facility on 09/11/2025 until 09/18/2025. Licensee A introduced self to Surveyor and said s/he would be out of the country for approximately 3 months. Licensee A told Surveyor all documentation regarding residents discharged from the facility were handwritten and kept in the medication storage closet located near the rear exit of the facility. Licensee A said each discharged resident's record would be rolled up and secured with a rubber band. Licensee A said House Manager B would be able to provide Resident 1's record to Surveyor.

On 04/23/2026 at approximately 10:50 A.M., Surveyor observed House Manager B remove a roll of documents secured with a rubber band

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from the medication closet near the facility's rear exit. House Manager B told Surveyor s/he was unable to locate any additional documentation for Resident 1.
Resident 1's record included a hospital discharge summary including Resident 1's dates of hospitalization. Resident 1 was hospitalized from 05/24/2025 through 09/11/2025. Resident 1 was admitted to the facility on 09/11/2025. Resident 1 had an activated power of attorney, Legal Representative F. Resident 1's record did not include a completed service agreement.

On 04/23/2026 at approximately 12:43 P.M., House Manager B told Surveyor s/he had called Licensee A on his/her phone to include an interview regarding Resident 1's service agreement. Licensee A told Surveyor no service agreement was completed for Resident 1 because Resident 1 was not a private pay resident so Licensee A did not complete a service agreement with Legal Representative F. Licensee A said Resident 1's public funding agency would have taken care of the service agreement.

On 04/30/2026 at 10:37 A.M., Surveyor interviewed Legal Representative F. Legal Representative F told Surveyor s/he visited Resident 1 everyday at different times between his/her admission to the facility on 09/11/2025 and his/her discharge to the hospital on 09/18/2025. Legal Representative F said no service agreement was completed and/or provided to him/her from Licensee A or anyone affiliated with the facility.

Example 2: Resident 4

On 04/23/2026 Surveyor reviewed Resident 4's

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M 384	Continued From page 18 record. Resident 4 was admitted to the provider's home on 09/24/2025. Resident 4 had a court appointed guardian. Resident 4's record included a service agreement that was not signed by Resident 4's guardian. On 04/23/2026 at approximately 12:00 PM, Surveyor interviewed House Manager B. House Manager B stated all resident records should be in the resident binders. S/he was not aware of an alternate location a signed service agreement could have been. On 04/23/2026 at approximately 12:35 PM, Surveyor interviewed Guardian D. S/he stated s/he will receive information including paperwork and records from the managed care organization, but not from the provider. Cross Reference: M0580 DHS 88.10(3)(p) Prompt And Adequate Treatment	M 384		
M 404	88.06(3)(a) INDIVIDUAL SERVICE PLAN & ASSESSMENT The licensee shall ensure that a written assessment and individual service plan is completed and developed for each resident within 30 days after placement. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a written assessment and an individual service plan (ISP) was completed	M 404		

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for 2 of 2 residents within 30 days of placement.

Resident 3 did not have an assessment or ISP completed prior to, upon, or within 30 days after admission.

Resident 4 did not have an assessment or ISP completed prior to, upon, or within 30 days after admission.

The findings include:

Example 1: Resident 3

On 04/23/2026 Surveyor reviewed Resident 3's record. Resident 3 admitted to the provider's home on 10/13/2025. Resident 3's record did not contain any assessments. Resident 3's record only had 1 ISP, which was dated 03/27/2026.

Example 2: Resident 4

On 04/23/2026 Surveyor reviewed Resident 4's record. Resident 4 admitted to the provider's home on 09/24/2025. Resident 4's record did not contain any assessments. Resident 4's record included only 1 ISP, which was dated 03/25/2026.

On 04/23/2026 at approximately 10:15 AM, Surveyor interviewed Licensee A. Licensee A stated all resident records would be in the resident binders within the home.

On 04/23/2026 at approximately 12:05 PM, Surveyor interviewed House Manager B. House Manager B agreed that all resident records should be located within the resident binders, including assessments and ISPs. House Manager B stated Resident 3 and Resident 4 admitted prior to his/her date of hire, so s/he

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M 404	Continued From page 20 would not have been involved with development of an initial assessment or ISP.	M 404		
M 420	88.06(3)(d)5 SIGNED STATEMENT OF AGREEMENT A statement of agreement with the plan, dated and signed by all persons involved in developing the plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that 2 of 2 residents' individual service plans (ISP) reviewed included a statement of agreement with the plan, was dated, and signed by all persons involved with developing the plan. Resident 3's ISP did not include a signed statement of agreement with all parties involved. Resident 4's ISP did not include a signed statement of agreement with all parties involved. The findings include: Example 1: Resident 3 On 04/23/2026 Surveyor reviewed Resident 3's record. Resident 3 admitted to the provider's home on 10/13/2025. Resident 3's record only had 1 ISP, which was dated 03/27/2026. The ISP did not have signatures indicating agreement with the plan. Example 2: Resident 4	M 420		

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M 420	Continued From page 21 On 04/23/2026 Surveyor reviewed Resident 4's record. Resident 4 admitted to the provider's home on 09/24/2025. Resident 4's record included only 1 ISP, which was dated 03/25/2026. The ISP did not have signatures indicating agreement with the plan. On 04/23/2026 at approximately 12:20 PM, Surveyor interviewed House Manager B. House Manager B stated s/he knew signatures were required on the ISP due to the ISPs having signature lines. House Manager B stated s/he was not sure how to obtain the signatures from the parties involved though, specifically POAs and guardians, because they did not usually come in person to do the review meetings. House Manager B also expressed s/he was under the impression the managed care organizations would acquire signatures from the necessary people.	M 420		
M 458	88.07(3)(a) PRESCRIPTION MEDICATIONS Every prescription medication shall be securely stored, shall remain in its original container as received from the pharmacy and be stored as specified by the pharmacist.	M 458		

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M 458	Continued From page 22 This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure Resident 2's, Resident 3's, and Resident 4's medications were securely stored. The findings include: On 04/23/2026 at 8:45 A.M., Surveyor observed Caregiver C enter the unlocked medication closet located near the rear exit door of the facility. Surveyor the door was not locked and did not include a functional locking mechanism of any kind. Surveyor observed the standard, push-button type door knob appeared to be jammed. Caregiver C removed an unlocked "Milwaukee" stackable toolbox with 3 separate compartments from the medication closet containing Resident 2's, Resident 3's, and Resident 4's medications. The toolbox did not include any type of locking mechanism. Caregiver C demonstrated there was one compartment for each resident's medications. Photo 1. On 04/23/2026 at approximately 2:00 P.M., House Manager B told Surveyor the facility had a medication cart up until approximately 2 to 3 months prior to this date. House Manager B said the cart was locked with resident medications inside and the key was missing. House Manager B said s/he had to break the cart's lock to gain access to the residents medications. House Manager B told Surveyor the medications have been stored in the unlocked tool box in the closet since s/he broke the medication cart's lock. House Manager B told Surveyor s/he was not aware the medication closet door's lock was not working.	M 458		

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M 570	Continued From page 23	M 570		
M 570	88.10(3)(l) Safe Physical Environment Individuals, except for correctional residents, have basic rights which they do not lose when they enter an adult family home. A resident shall have a safe environment in which to live. The adult family home shall safeguard residents who cannot fully guard themselves from environmental hazards to which they are likely to be exposed, including conditions which would be hazardous to anyone and conditions which would be or are hazardous to a particular resident because of the resident's condition or disability. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a safe physical environment with residents safeguarded from environmental hazards from which they were likely to be exposed. The water faucet temperatures of the resident bathroom and kitchen sinks exceeded 120 ° Fahrenheit (F). The home does not have a carbon monoxide detector near a gas burning appliance. The findings include: Example 1: Water temperature The provider is licensed to serve up to 4 individuals in particular client groups including advanced aged, physically disabled, developmentally disabled, traumatic brain injury, and irreversible dementia/Alzheimer's.	M 570		

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M 570	Continued From page 24 On 04/23/2026 at approximately 9:10 AM, Surveyor tested the water temperature of the sink in the kitchen, which reached 128° F. At approximately 9:20 AM, Surveyor tested the water temperature of the sink in the resident bathroom, which reached 133° F. According to the Wisconsin Department of Health Services, "Exposure to hot water is a potential environmental danger for residents. Elderly residents and residents with mental and physical disabilities may have neurological conditions that prevent instant recoil from hot water. Because these individuals do not instantly react to dangerous temperature levels, they are at particular risk for injury. Hot water can cause scalding; e.g., second and third degree burns in which the skin blisters and swells. In such instances, skin does not return to normal and forms scar tissue upon healing. These burns may lead to permanent disability." Sustained contact with water at or above 140° F can result in second or third-degree burns in approximately 6 seconds (DQA Publication-01942, Hot Water Temperatures in Adult Family Homes, August 2017). On 04/23/2026 at approximately 2:30 PM, Surveyor interviewed House Manager B. House Manager B stated s/he was not aware of the requirement to maintain water temperatures that do not exceeded 120 ° F. House Manager B stated the concern would be addressed. Example 2: Carbon monoxide detector On 04/23/2026 at approximately 9:00 AM, Surveyor toured the provider's home. Surveyor noted a gas burning furnace in the basement of	M 570		

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M 570	Continued From page 25 the home. There was not a carbon monoxide detector near the furnace/ utility room, or anywhere else in the home. On 04/23/2026 at approximately 9:55 AM, Surveyor interviewed House Manager B. House Manager B stated s/he could not recall having a carbon monoxide detector in the home. S/he stated if there was one, s/he did not know where it was. House Manager B stated s/he was unaware of the requirement but could address the concern.	M 570		
M 580	88.10(3)(p) Prompt and Adequate Treatment Prompt and adequate treatment. To receive prompt and adequate treatment and services appropriate to the resident's needs. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure Resident 1 received prompt and adequate treatment and services appropriate to Resident 1's needs. The findings include: The department received a complaint alleging Resident 1 was not provided with services appropriate to Resident 1's needs. On 04/23/2026 at approximately 9:15 A.M., Surveyor conducted an interview with House Manager B. House Manager B told Surveyor Licensee A was currently traveling out of the country and would not be available in-person at the facility. House Manager B said s/he had been employed at the facility since October 2025, after	M 580		

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Resident 1 was discharged from the facility. House Manager B told Surveyor all documentation was handwritten and kept at the home regarding resident records.

On 04/23/2026 at approximately 10:15 A.M., House Manager B told Surveyor s/he had called Licensee A on his/her phone to include an interview regarding Resident 1's admission to the facility on 09/11/2025 until 09/18/2025. Licensee A introduced self to Surveyor and said s/he would be out of the country for approximately 3 months. Licensee A told Surveyor Resident 1 moved to the facility after being hospitalized for several months. Licensee A said s/he spoke to Resident 1's Legal Representative F and a hospital nurse prior to Resident 1's admission to the facility. Licensee A said the hospital nurse told him/her it was critical Resident 1 find placement at a facility following the long hospitalization. Licensee A said s/he did not conduct an in-person visit with Resident 1 in the hospital. Legal Representative F visited the facility prior to Resident 1's admission. Licensee A said s/he did not document an assessment of Resident 1's condition or needs and services prior to Resident 1's admission to the facility. Licensee A said s/he "wanted to help [Resident 1] out." Licensee A said Resident 1 had an open wound on Resident 1's "bottom, buttock" and the plan was for dressing changes to be completed by nurses. Licensee A said Resident 1's funding agency had to reach out to and partner with home care agency nurses. Licensee A said Resident 1's wound was not healing when the home care nurses came to the facility. Licensee A said s/he believed s/he documented Resident 1's open wound within Resident 1's record including contact with Resident 1's funding agency case managers. Licensee A said s/he only saw a

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wound on Resident 1's buttock during his/her stay at the facility, not on Resident 1's foot. Licensee A said s/he was not aware Resident 1 had any skin breakdown on either of Resident 1's feet. Licensee A said s/he did not have a documented individual service plan prior to Resident 1's discharge from the facility.

Licensee A said Resident 1 was not able to ambulate and s/he was the only caregiver working at the home during Resident 1's stay at the facility. Licensee A said Resident 1 was incontinent of bowel movements and had an urinary catheter. Licensee A said s/he fed Resident 1 and utilized a Hoyer mechanical lift to lift Resident 1 up in bed to dress Resident 1, to wipe his/her face and body, and attempt to reposition Resident 1 in bed. Licensee A said s/he was unable to reposition Resident 1 in bed without the Hoyer lift and used pillows to hold Resident 1's position from side to side. Licensee A said s/he repositioned Resident 1 every 2 hours and believed s/he documented repositioning Resident 1 in a daily report document within Resident 1's record.

Licensee A told Surveyor all documentation regarding residents discharged from the facility were handwritten and kept in the medication storage closet located near the rear exit of the facility. Licensee A said each discharged resident's record would be rolled up and secured with a rubber band. Licensee A said House Manager B would be able to provide Resident 1's record to Surveyor.

Licensee A told Surveyor s/he had completed CBRF [community-based residential facility] training listed on registry, including medication administration training, standard precautions, fire safety, and first aid. Licensee A told Surveyor s/he was not required to have any more training, including training related to personal cares for

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residents because it was not required.

On 04/23/2026 at approximately 10:50 A.M., Surveyor observed House Manager B remove a roll of documents secured with a rubber band from the medication closet near the facility's rear exit. House Manager B told Surveyor s/he was unable to locate any additional documentation for Resident 1.

Resident 1's record included a hospital discharge summary including Resident 1's dates of hospitalization. Resident 1 was hospitalized from 05/24/2025 through 09/11/2025. Resident 1's diagnoses included delirium (an acute state of confusion), cerebrovascular accident (CVA; stroke), coronary artery disease, obstructive sleep apnea, seizure disorder, atrial fibrillation (abnormal heart rhythm), type 2 diabetes, and history of falls. The documentation included, "Slowed thought process and slowed psychomotor activity; no hallucinations." The documentation included Resident 1's "Condition at discharge: [Resident 1] was discharged to hospice at group home, in a guarded (uncertain outcome) but hemodynamically stable (blood pressure) condition."

Resident 1's record included a hospital after visit summary dated 09/11/2025. The documentation included a "home health care services referral" including "Skilled nursing for wound care and [urinary] catheter care and management." The documentation included, "Wound care treatment plan to right heel: 1. Cleanse wound with [a gauze dressing] and soak [for 5] minutes. 2. Pat dry with gauze. 3. Protect [with skin barrier dressing]. 4. Apply heel [dressing covering] **keep heel lift boots on while in bed.** RN [registered nurse] to assess wound and change dressing twice weekly on Tuesdays and Fridays."

Resident 1's record included hospital physical

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therapy evaluation and discharge documentation. The documentation included, "Since [Resident 1's] CVA 06/17/[2025], [Resident 1] has required Hoyer [mechanical lift] for transfers and dep [dependent] for all cares."
Resident 1's record included a 7 page document titled, "[Resident 1]: Repositioning sheet." Each page included, "Current position - current state: Lying in bed, on [his/her] back." Each page included the date, Resident 1's "reaction" and 2-hour increments starting with "6 A.M. - 8 A.M. and ending with "2 A.M. - 4 A.M." for the 24-hour timeframe. Each page dated from 09/12/2025 through 09/17/2025 included, "Client reaction: refused" documented for each 2-hour time increment for each 24-hour timeframe. The page dated 09/18/2025 included "Client reaction: refused" documented for "6 A.M. - 8 A.M." and no further documentation. Each page included Licensee A's signature.
Resident 1's record included a document titled, "Incident Report." The documentation included Resident 1's name and "Date of incident: September 14, 2025 [09/14/2025]" at "6 A.M." The documentation included, "Location: On [his/her] right buttock." The "incident description" documentation included, "[Resident 1] developed a bed sore on [09/14/2025]. The bed sore was identified during a routine assessment, and measures are being taken to promote healing and prevent further skin breakdown through informing [his/her] care team and requesting wound supplies which only arrived on 09/18/2025 at 10 A.M." The documented "details of the incident" included, "Stage of bed sore: Stage 1" and "Size and depth: [blank]." The documented "Contributing factors" included, "Immobility and pressure because of a double stroke suffered by [Resident 1]." The documented "Actions taken - wound care" included, "Implemented wound care

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treatment plan, including dressing changes and wound cleaning. [Licensee A] implemented pressure redistribution measures, such as turning and repositioning but [Resident 1] was not corporative [sic] and resisted repositioning. Notification: [Licensee A] notified [Legal Representative F] and [Resident 1's funding agency RN Case Manager (CM) G] of the bed sore and treatment plan. As a result, wound supply materials were sent and hospice was through [agency name] was informed for a change of condition assessment." The documented "Follow-up actions" included, "We [facility] continue to monitor the bed sore for signs of healing or deterioration. [Resident 1] was taken to the hospital for intense wound care on 09/18/2025 at 12:45 P.M." This document included Licensee A's signature dated 09/14/2025 at the bottom of the document, 4 days before Resident 1 was hospitalized, as documented.

On 04/30/2026 at 10:37 A.M., Surveyor conducted an interview with Resident 1's Legal Representative F. Legal Representative F told Surveyor Licensee A conducted a virtual "Zoom" call with him/her and a hospital nurse prior to Resident 1 being discharged from the hospital to the facility. Legal Representative F said Licensee A did not visit Resident 1 at the hospital before Resident 1's admission to the facility. Legal Representative F said both s/he and the hospital nurse told Licensee A Resident 1 would require a lot of attention related to Resident 1 being "basically paralyzed...[s/he] could do nothing." Legal Representative F said Licensee A was informed Resident 1 required full assistance with all personal cares, with all repositioning, and with all transfers. Legal Representative F said s/he visited the facility on 09/11/2025 prior to Resident 1's admission and Licensee A told him/her

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Licensee A could provide all personal cares to Resident 1.
Legal Representative F told Surveyor s/he was aware a home care agency nurse visited Resident 1 at the facility on 09/12/2025 for an assessment. Legal Representative F said s/he was made aware Resident 1 had no open areas when s/he was discharged from the hospital and admitted to the facility. Legal Representative F said s/he was informed the home care agency nurse instructed Licensee A Resident 1 would need to be repositioned every 2 hours to off load Resident 1's weight to prevent any skin breakdown and for Resident 1's comfort. Legal Representative F said Resident 1's right heel wound was resolved prior to his/her discharge from the hospital and bilateral, pressure relieving heel boots were provided for Resident 1 wear.
Legal Representative F told Surveyor s/he visited Resident 1 everyday at different times between his/her admission to the facility on 09/11/2025 and his/her discharge to the hospital on 09/18/2025. Legal Representative F said Resident 1 was always in the same position in bed during each visit. Legal Representative F said Resident 1 was mostly on his/her back except his/her head was contracted to the left. Legal Representative F said s/he believed his/her shirt was only changed once and personal hygiene and basic personal cares were not appropriately provided to Resident 1 during his/her stay at the facility. Legal Representative F said s/he observed Resident 1's face and hands were not clean and Resident 1 had developed a bad body odor during his/her stay at the facility. Legal Representative F said s/he observed there were no gloves in Resident 1's room and no garbage receptacle in Resident 1's room. Legal Representative F said s/he would have to use the garbage receptacle in the facility's kitchen which

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M 580	Continued From page 32 s/he observed was always stuffed full of incontinence products. Legal Representative F said s/he discussed his/her concerns with Licensee A during his/her daily visits regarding Licensee A's care of Resident 1. Legal Representative F said Licensee A told him/her Resident 1 would complain about having too much pain and tell Licensee A not to touch Resident 1 when s/he attempted to reposition Resident 1. Legal Representative F said s/he told Licensee A Resident 1 still needed to be repositioned and provided with personal hygiene cares. Legal Representative F said Resident 1 was unable to be move independently and was not able to be aggressive physically at that point. Legal Representative F said Resident 1's was "basically paralyzed" after his/her last stroke in June 2025. On 04/17/2026 at 9:38 A.M., Surveyor received Resident 1's home care agency documentation, as requested. The documentation included a home care agency admission assessment completed by Resident 1's Home Care Agency RN (Registered Nurse) E on 09/12/2025. The documentation included Resident 1 was "bedfast - confined to bed" requiring full assistance with and dependent with all cares, bathing, toileting, grooming needs, dressing, and repositioning. The documentation included Resident 1 had a Foley (urinary) catheter, experienced impaired decision making, and was at high risk for skin breakdown. The documentation included Resident 1 experienced "responds to verbal commands but cannot always communicate discomfort or need to be turned, or has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities." The documentation included, "[Resident 1's] skin is often moist but not always moist. Linen must	M 580		

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be changed as often as 3 times in 24 hours." The documentation included, "Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures, or agitation leads to almost constant friction." The documentation included, "[Licensee A] present during admission and able to answer some of [Home Care Agency RN E's] questions. [Licensee A] states [Resident 1] is completely dependent, bed bound, incontinent, and has episodes of hallucinations." The documentation included, "During skin assessment, [Home Care Agency RN E] found no open wounds or rashes. [Resident 1's] skin is dry and flaky. [Home Care Agency RN E] educated [Licensee A] [sic] importance of repositioning [Resident 1] every 2 hours anf [sic] floating [Resident 1's] heels or wearing foam boots to help prevent pressure injury." The documentation included, "[Home Care Agency RN E] educated [Licensee A] when to call home health nurse/doctor's office/911. [Licensee A] verbalized understanding."
The documentation included Resident 1's "Home health certification and plan of care" completed by Home Care Agency RN E and dated 09/12/2025. The documentation included, "Changes in skin integrity will be identified and reported to the physician for prompt intervention."

On 04/30/2026 at 3:41 P.M., Surveyor conducted an interview with Home Care Agency RN E. Home Care Agency RN E verbalized s/he conducted the home care agency assessment, home care certification, and home care plan of care on 09/12/2025, as documented. Home Care Agency RN E said s/he observed Resident 1 did not have any skin breakdown or open areas

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during this visit. As a result, the original order or plan was changed from 3 times a week visits for wound care to monthly visits only for urinary catheter monitoring and changing. Home Care Agency RN E said s/he did observe foam pads on Resident 1's bilateral heels as a preventative cushion-type dressing. Home Care Agency RN E said s/he partially removed the foam pads from both of Resident 1's heels and observed neither heel had open skin. Home Care Agency RN E said she reapplied the foam dressings, both booties to Resident 1's feet, and instructed Licensee A Resident 1 needed to have bilateral heel booties on and/or a pillow under Resident 1's lower legs to off-load pressure to Resident 1's heels. Home Care Agency RN E said Licensee A stated s/he understood. Home Care Agency RN E said s/he instructed Licensee A that Resident 1 would need to be repositioned by caregiver every 2 hours at minimum to prevent skin breakdown related to Resident 1 being completely dependent and unable to repositioned self in bed. Home Care Agency RN E said s/he discussed the plan with Licensee A of monthly visits to change Resident 1's urinary catheter since Resident 1 had no skin breakdown. Home Care Agency RN E said s/he provided Licensee A with his/her work cell phone number and the agency's home care/hospice 24 hour phone number. Home Care Agency RN E said s/he encouraged Licensee A to call him/her directly on work cell phone between 8:00 A.M. and 4:30 P.M. if s/he had any questions, concerns, or changes in Resident 1's condition that did not require 911 [emergency medical services]. Home Care Agency RN E said Licensee A told him/her Licensee A understood. Home Care Agency RN E said s/he did not receive any calls from Licensee A or from the facility until 09/18/2025.

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M 580	Continued From page 35 On 05/06/2026 at 3:22 P.M., Surveyor conducted an interview with Resident 1's funding agency's Case Coordinator I. Case Coordinator I said s/he and RN CM G were Resident 1's funding agency case management team when Resident 1 transitioned from the hospital to being admitted to the facility on 09/11/2025. Case Coordinator I said RN CM G was no longer employed by the funding agency, "for a while." On 05/07/2026 at 4:47 P.M., Surveyor received Resident 1's funding wellness assessment and agency case notes. The documentation included a wellness assessment dated 08/13/2025. The documentation included, "[Resident 1] is not resistive to cares. Due to dementia, [Resident 1] may need verbal reminders of what [s/he] is doing and why." The documentation included a note dated 09/04/2025 by Case Coordinator I including, "RN CM G will start auth [authorization] process for Hoyer lift, hospital bed, and incontinence supplies" regarding "what [Resident 1] will need to successfully transition to [facility]." This note did not include any documentation regarding wound care supplies, and there were no notes regarding Resident 1's skin condition until 09/11/2025. The documentation included a note dated 09/11/2025 by RN CM G including, "[RN CM G] informed of need of DME [durable medical equipment] wound care as member not being admitted for wound care for nursing as it is closed and non-draining. [Licensee A] states that this was not told to [facility] and that not all staff will know how to care for wound. But, that [Licensee A] will learn [sic] oversee what [s/he] can as well care staff at [facility]." The next note including Resident 1's skin	M 580		

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condition was dated 09/15/2025 by RN CM G included, "Call placed to [Licensee A]. [Resident 1] was admitted for Foley [urinary] catheter nursing care only. [Resident 1] will be seen once monthly as needed. [RN CM G] confirmed re: pressure ulcer [sore; wound], [Resident 1] not admitted for this service. [Licensee A] doesn't [sic] believe this is needed at this time as area is closed and the application as [s/he] understands it will be preventative only. [RN CM G] stated understanding of this. [RN CM G] informed [Licensee A] items shipped on Friday [09/15/2025] and should be delivered by Wednesday [09/17/2025]. [RN CM G] asked [Licensee A] to return call on Wednesday if not received. [Licensee A] states [s/he] will and informed [RN CM G] that [s/he] will contact [Resident 1's home care agency] if needed." The following note was dated 09/17/2025 by RN CM G and included, "[RN CM G] placed call to [Licensee A]. [Licensee A] states that [Resident 1] now has shearing to buttock. [RN CM G] encouraged [Licensee A] to call [Resident 1's home care agency] for an evaluation. [RN CM G] informed [Licensee A] that evaluation is needed. [Licensee A] states that [s/he] would like a newer hospital bed for [Resident 1]. [RN CM G] informed [Licensee A] that maybe a pressure relieving matress [sic] is needed first. [Licensee A] states understanding."

On 04/30/2026 at 10:37 A.M., Legal Representative F told Surveyor s/he met with Resident 1's funding agency's Screener H and Licensee A at the facility on 09/17/2026 for a screening following admission to the facility. Legal Representative F said Licensee A mentioned Resident 1 had developed "a small open area on [Resident 1's] butt [buttock region]." Legal Representative F said that was the first

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s/he heard from Licensee A or anyone else Resident 1 had developed an open area at the facility. Legal Representative F said s/he recalled Licensee A asking Screener H if s/he could get an air mattress for Resident 1 and recalled Screener H asking Licensee A if s/he had notified Resident 1's home care agency about Resident 1's skin breakdown. Legal Representative F said s/he recalled Licensee A replied "No" to Screener H, whom suggested Licensee A do so right away.

On 05/04/2026 at 11:22 A.M., Surveyor conducted an interview with Resident 1's funding agency's Screener H. Screener H told Surveyor s/he visited Resident 1 at the facility on 09/17/2026 and observed Resident 1 positioned on his/her back during the visit. Screener H said s/he met with Licensee A and Legal Representative F during this visit. Screener H said s/he recalled Licensee A discussed an open area that had developed on Resident 1's right heel and lower back, or buttocks. Screener H said Licensee A said Resident 1 required daily wound cleansing and dressing changes. Screener H said s/he did not observe Resident 1's skin breakdown and Resident 1's funding agency case management team was not present during this visit. Screener H said Licensee A did not request any wound care supplies from Resident 1's funding agency during this visit. Screener H said s/he noted Resident 1 required assistance with all transfers, repositioning, and the use of a "lift mechanism."

On 05/07/2026 at 4:47 P.M., Surveyor received Screener H's documentation of Resident 1's screen on 09/17/2026. The documentation included, "[Resident 1] need [sic] assistance with all ADL [activities of daily living] tasks due to side effects from stroke, memory loss, osteoarthritis,

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weakness, and imbalance." The documentation included, "[Resident 1] is not able to ambulate, [s/he] uses a wheelchair for all mobility tasks and is not able to propel [self]. [Resident 1] needs assistance with all mobility tasks at this time." The documentation included, "[Resident 1] has a Foley [urinary] catheter that needs to [sic] emptied daily, and wears incontinent products and needs to be checked every 2 hours and as needed for all toileting needs and cleansing after a bowel movement." The documentation included "[Resident 1] has pressure sores on [his/her] ankle and lower back which need to be cleansed and bandages changed daily."

On 04/30/2026 at 3:41 P.M., Home Care Agency RN E told Surveyor s/he received a call from Licensee A on the morning of 09/18/2025 requesting a visit. Home Care Agency RN E said Licensee A told him/her Licensee A thought there was a wound open on Resident 1's heel and wanted an assessment done. Home Care Agency RN E said Licensee A did not report a sacral (lower back) or buttock open area and made no mention Resident 1 had been experiencing hallucinations. Home Care Agency RN E said s/he went to the facility on the morning of 09/18/2025 with Home Care Agency RN J to assess Resident 1. Home Care Agency RN E said a home care/hospice liaison staff later joined Home Care Agency RNs E and J at the facility and Legal Representative F was at the facility visiting Resident 1 upon their arrival. Home Care Agency RN E said s/he observed Resident 1 in bed positioned flat on his/her back with foam booties on both feet, appearing to be in the same position s/he observed him/her to be in on 09/12/2025. Home Care Agency RN E said s/he observed the same cushion-type preventative dressings to both of Resident 1's heels, removing

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both dressings and observing an open area on Resident 1's right heel. Home Care Agency RN E said s/he discussed Resident 1's heel wound with Licensee A and Licensee A said not many people worked at the facility and s/he really did not have the resources to deal with Resident 1's personal cares, repositioning, and wound care. Home Care Agency RN E said Licensee A said s/he had been repositioning Resident 1 but Home Care Agency RN E did not believe him/her. Home Care Agency RN E said s/he observed no pillows in Resident 1's room that would have been used for repositioning Resident 1. Home Care Agency RN E said Licensee A left the room and returned with a couple of pillows without pillowcases. Home Care Agency RN E said s/he observed Resident 1 had a strong body odor of old sweat, feces, and active wound infection. Home Care Agency RN E said s/he and Home Care Agency RN J repositioned Resident 1 on his/her side and observed an open area larger than the average-sized woman's palm of hand on Resident 1's bottom, sacral region. Home Care Agency RN E verbally described the open area had macerated (wrinkled), darkened edges, with malodorous drainage. Home Care Agency RN E said the pad under Resident 1's bottom was stuck to Resident 1's wound and included wound drainage and fecal matter. Home Care Agency RN E said Resident 1 was screaming the entire time during this repositioning and wound observation. Home Care Agency RN E said Resident 1 said s/he had not been repositioned regularly and s/he had been left in bed to rot. Home Care Agency RN E said s/he observed no gloves available and no garbage receptacle located in Resident 1's room. Home Care Agency RN E said the home health team, including the liaison staff, determined Resident 1 needed to be discharged immediately from the

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facility to a local hospital. Home Care Agency RN E said the liaison staff spoke with Legal Representative F and set up immediate transport of Resident 1 to a local hospital that morning of 09/18/2025.

On 04/17/2026 at 9:38 A.M., Surveyor received Resident 1's home care agency documentation, as requested.
The documentation included a home care agency PRN (as needed) assessment completed by Resident 1's Home Care Agency RN E on 09/18/2025. The documentation included, "PRN visit being made per [Licensee A's] request. [Licensee A] states [Resident 1] has pressure injury on heel that is open and would like nurse to make visit to come assess. [Home Care Agency RN E] brought another nurse with [him/her] to [facility] to assist in cares. Upon arrival, [Legal Representative F] visiting with [Resident 1] . [Legal Representative F] appeared upset but greatfull [sic] nurses were there for assessment. [Resident 1] had heel boots on and foam [bandage] on heels. When removing foam bandage, nurse noticed small new stage one [1] wound on right heel. Nurse inquired if [Licensee A] was concerned about any other pressure injuries [s/he] believes to be forming before nurse continued assessment. [Licensee A] denied any other pressure injuries just that [s/he] did not want [Resident 1] to get any. Nurse rolled [Resident 1] on side and [Resident 1's] saccrum [sic] also had new pressure injury. When inquiring if [Resident 1] has been being [sic] repositioned every 2 hours, [Licensee A] states [s/he] has been trying to. Nurse noticed no pillows or supplies were present in [Resident 1's] room to help weight-shift [Resident 1]. Nurse requested [Licensee A] get extra pillow so nurse could place underneath [Resident 1's] right side to take pressure off new

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	0019817	A. BUILDING: _____ B. WING _____	C 05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLISS HOMES	1012 N BEL AYR DR WAUKESHA, WI 53188

(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
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pressure injury." The documentation included, "Nurse also changed [Resident 1's] chucks [pad] and brief d/t [due to] them being dirty." The documentation included, "[Legal Representative F] very upset during visit stating [facility] has not been repositioning [Resident 1] at all and [Resident 1] did not have sacrum pressure injury at hospital discharge. [Legal Representative F] also states [facility] has not been taking care of [Resident 1] and wants [Resident 1] moved out of location." The documentation included, "During visit when providing cares [Resident 1] shouted [s/he] wants to leave because [facility] has not been taking care of [him/her] properly. When inquiring more [Resident 1] stated they do not know what they are doing, they hurt [him/her] in the morning when getting up and [s/he] is in a lot of pain and they just left [him/her] 'lay in bed to rot.' Nurse reached out to supervision [sic] regarding concerns of visit. Nurse received email after visit that [Resident 1] is being transferred to [local hospital] to get assessed and then use their resources to find new care facility for [Resident 1]."

On 04/30/2026 at 1:28 P.M., Surveyor conducted an interview with Home Care Agency RN J. Home Care Agency RN J told Surveyor s/he accompanied Home Care Agency RN E on the PRN visit at the facility on 09/18/2025. Home Care Agency RN J said s/he observed Resident 1 on his/her back in bed upon entering Resident 1's room. Home Care Agency RN J s/he assisted Home Care Agency RN E to reposition Resident 1 to his/her side in bed. Home Care Agency RN J said Licensee A was in Resident 1's room at this time but did not offer to help reposition Resident 1. Home Care Agency RN J said Resident 1 was difficult to reposition. Home Care Agency RN J told Surveyor s/he observed a large open area on

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Resident 1's sacral region once s/he was repositioned on his/her side. Home Care Agency RN J said Resident 1's sacral wound appeared infected with drainage and a foul odor. Home Care Agency RN J said the pad under Resident 1 was stuck to Resident 1's wound until Home Care Agency RN E carefully removed it to observe the wound, the pad included wound drainage from what s/he was able to observe. Home Care Agency RN J said s/he observed Home Care Agency RN E say to Licensee A s/he had instructed him/her Resident 1 needed repositioning during Home Care Agency RN J's visit on 09/12/2025. Home Care Agency RN J said s/he observed Licensee A respond s/he had difficulty repositioning Resident 1, but did reposition him/her. Home Care Agency RN J said s/he observed no pillows or repositioning devices in Resident 1's room, and heard Licensee A say s/he would have to look for pillows to reposition Resident 1. Home Care Agency RN J said Licensee A did return with a couple of pillows but they did not have pillow cases on them.

On 04/30/2026 at 10:37 A.M., Legal Representative F told Surveyor s/he was in Resident 1's room when Home Care Agency RNs E and J were visiting Resident 1 on 09/18/2025. Legal Representative F said s/he observed the wound on Resident 1's sacrum and described it as "large." Legal Representative F said s/he observed the wound to have darkened, wrinkled edges with a foul smelling drainage. Legal Representative F said Licensee A was in the room observing and s/he said to him/her "I [Legal Representative F] thought you [Licensee A] said the open area was small on his/her bottom on 09/17/2025." Legal Representative F said s/he told Licensee A this was not acceptable and s/he felt hurt and upset because Licensee A said s/he

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could care for Resident 1. Legal Representative F said Licensee A did not respond to him/her. Legal Representative F told Surveyor Resident 1 was discharged to the hospital on 09/18/2025 where Resident 1's wound worsened, Resident 1 was diagnosed with sepsis (a life-threatening response to infection), and died at the hospital on 10/04/2025.

On 05/07/2026 at 4:47 P.M., Surveyor received Resident 1's funding agency case notes.
The documentation included a note dated 09/18/2025 by RN CM G including, "[RN CM G] was updated by Case Coordinator I that [Legal Representative F] has concerns regarding [Resident 1's] lack of care at [facility] and that [Resident 1] is heading to [local hospital] because [s/he] has an open bleeding area to buttock area. [RN CM G] called [Licensee A]. [Licensee A] states that [Legal Representative F], [Screener H], and [home care agency] nurses all came to see [Resident 1] and [Licensee A] was told [Resident 1] was going to the hospital for emergency care related to blooding [sic] to buttock. [RN CM G] reminded [Licensee A] that they had a conversation and area was closed. [Licensee A] stated it was closed but is now bleeding. [Licensee A] states that [Legal Representative F] is really unhappy with care and that [Legal Representative F] moved all items from [facility]..."

On 04/17/2026 at 9:38 A.M., Surveyor received Resident 1's hospice agency documentation, as requested.
The documentation included a note by Hospice Nurse K on 10/02/2025 upon Resident 1's admission to in-patient hospice care at local hospital. The documentation included, "[Resident 1] admitted to hospice services on [10/01/2025],

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M 580	Continued From page 44 due to sepsis. [Resident 1] currently obtunded [altered, reduced consciousness] with no response to verbal stimuli or gentle touch, except when dressing change to sacral wound." The documentation included a note by Hospice Nurse K on 10/04/2025, including Resident 1's death while receiving in-patient hospice services. The documentation included, "APS [adult protective services] involved due to suspected neglect which led to sepsis 2/2 [secondary to] sacral decubti [wound]." On 04/23/2026 at approximately 2:00 P.M., Surveyor discussed this noncompliance with House Manager B. House Manager B told Surveyor s/he would discuss this noncompliance with Licensee A related to his/her absence from the facility. Cross Reference: M0246 DHS 88.04(5)(b) Training - 8 Hours Annually M0384 DHS 83.06(2)(b) Service Agreement Except Respite	M 580		