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 _____	R-C 09/23/2026

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 09/15/2026, with information gathered through 09/23/2026, the Bureau of Assisted Living, Southern Regional Office conducted a verification visit of Statement of Deficiency (SOD) J0TC11 at Bliss Homes located at 1012 North Bel Ayr Drive in Waukesha, WI. Fourteen citations of noncompliance were issued, of which 9 citations were repeat violations. Census: 3 Under statutory provisions of Wis. Stat. Ch. 50, a $200.00 revisit fee is being assessed.	{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	{M 114}		

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

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{M 114}	Continued From page 1 substantially relates to the care of a dependent population, the funds or property of adults or minors or 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 interview and record review, 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. This requirement is being cited for a second time. See Statement of Deficiency (SOD) J0TC11, issued on 06/08/2026.	{M 114}		

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{M 114}	Continued From page 2 The findings include: On 09/15/2026 at 8:55 A.M., Surveyor observed Licensee A enter the facility and conducted an entrance meeting with Licensee A. Licensee A told Surveyor s/he had returned to the United States on 09/05/2026 after being out of the country for approximately 11 months. Surveyor reviewed with Licensee A the Notice and Order letter issued to Licensee A from the department on 06/08/2026, including special order #1, in association with statement of deficiency (SOD) J0TC11. Licensee A was to ensure special order #1 was to be completed within 45 days, by 07/23/2026. Licensee A verbally acknowledged receiving SOD J0TC11 and this letter while s/he was out of the country. Licensee A said s/he had "misinterpreted the letter" and s/he had not consulted with nor collaborated with a registered nurse (RN), as required, to correct each deficiency identified within SOD J0TC11, including this noncompliance. On 09/15/2026 at approximately 10:15 AM, Surveyor reviewed employee records. House Manager B did not have a BID form in his/her record. Caregiver C did not have a BID form in his/her record. On 09/15/2026 at approximately 10:30 AM, Surveyor interviewed Licensee A. Licensee A stated there was not another location the BIDs may have been stored so if they weren't in the binder s/he provided then s/he did not have them completed. Licensee A stated s/he had them completed for staff in his/her other home, so s/he was not sure why s/he did not have them for the staff in this home. On 09/15/2026 at approximately 2:00 P.M.,	{M 114}		

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{M 114}	Continued From page 3 Surveyors conducted an interview with Licensee A and House Manager B. Licensee A verbally acknowledged s/he would have benefited from having consulted and collaborated with an RN, as required in special order #1 issued to Licensee A on 06/08/2026, to work on correcting this noncompliance. Cross Reference: M0216 DHS 88.04(2)(a) Responsibilities	{M 114}		
M 216	88.04(2)(a) RESPONSIBILITIES The licensee shall ensure that the home and its operation comply with this chapter and with all other laws governing the home and its operation. This Rule is not met as evidenced by: Based on observation, interview and record review, the licensee did not ensure the AFH and its operation complied with this chapter and with all other laws governing the AFH and its operation. Since the AFH was issued an initial, regular license on 05/10/2024, the department has conducted 2 visits to the facility including 1 standard licensing survey and 1 substantiated complaint investigation resulting in 16 citations of noncompliance and a notice and order letter associated with statement of deficiency (SOD) J0TC11, and 1 verification visit for SOD J0TC11. As a result of the verification visit of J0TC11, 14 citations of noncompliance have been issued, including this noncompliance and 9 repeat citations of noncompliance, within SOD J0TC12.	M 216		

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M 216	Continued From page 4 The findings include: On 04/23/2026, with information gathered through 05/12/2026, two Surveyors conducted a standard licensing survey and a complaint investigation. Statement of deficiency J0TC11, including 16 citations of noncompliance and a notice and order letter, was electronically issued to Licensee A on 06/08/2026. The order and notice letter included special orders including Order #1. The documentation included, "Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.02(2)(am)2., EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Bliss Homes: 1. Pursuant to Wis. Admin. Code § DHS 88.03(6)(g)2.e., effective immediately, the licensee shall ensure all residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. WITHIN 45 DAYS of receipt of this notice, the licensee will correct each deficiency identified in Statement of Deficiency (SOD) J0TC11 in consultation with a Registered Nurse (RN), not currently affiliated with the licensee, at the licensee's expense. The consultant will have knowledge of assisted living regulations (e.g., Wis. Admin. Code ch. 88, Wis. Stat. ch. 50) and knowledge of the client groups served by Bliss Homes. The licensee will provide the consultant with a copy of the SOD J0TC11, along with this Notice and Order letter prior to providing consultation services. In collaboration with the RN consultant, the licensee's corrective measures will include, at a minimum, the development (or review) of procedures to address: Health Monitoring -Including how the provider will: (a) monitor and document changes in the resident's physical or	M 216		

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M 216	Continued From page 5	M 216		

mental health; (b) notify the resident's legal representative and care manager (if any) when a resident experiences a change of condition, accident, injury, or medical emergency; (c) obtain timely medical care (clinical assessments, medications, prompt medical treatment), and (d) provide or arrange services to address each resident's health care needs.
Employee Training, how the provider will ensure:
(a) Each service provider employed at least 6 months will have completed all initial training as required by Wis. Admin. Code § DHS 88.04(5)(a).
(b) Each service provider who may be exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions prior to assuming duties that may expose the service provider to such material, and annually.
(c) Each service provider shall complete 8 hours of training 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.
ADDITIONALLY, WITHIN 45 DAYS of receipt of this notice, the licensee shall provide training to all managers and all service providers on the corrective actions taken to resolve each deficiency identified in SOD J0TC11.
WITHIN 45 DAYS of receipt of this notice, continuing education requirements must be met for the licensee and all service providers, as appropriate, for calendar year 2025.
Training will be documented in personnel records and will include the date/duration of training, the signature/qualifications of the instructor, and evidence of successful completion of the training.
Consultation activities, including dates of

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M 216	Continued From page 6	M 216		

consultation, will be documented, signed, and dated by the consultant. All documentation required by Order #1 will be made available to department representatives upon request."

On 09/15/2026, with information gathered through 09/23/2026, two Surveyors conducted a verification visit for SOD J0TC11. Fourteen citations of noncompliance were identified, including this noncompliance, and 9 of which were repeat citations of noncompliance, as follows:

M0114 DHS 88.03(3)(b) Criminal Records Check
This requirement is being cited for the second time. See SOD J0TC11, issued 06/08/2026.

M0216 DHS 88.04(2)(a) Responsibilities

M0232 DHS 88.04(2)(g)1 Health Screening For Staff
This requirement is being cited for the second time. See SOD J0TC11, issued 06/08/2026.

M0244 DHS 88.04(5)(a) Training 15 Hours Within 6 Months
This requirement is being cited for the second time. See SOD J0TC11, issued 06/08/2026.

M0246 DHS 88.04(5)(b) Training - 8 Hours Annually
This requirement is being cited for the second time. See SOD J0TC11, issued 06/08/2026.

M0334 DHS 88.05(4)(b)1 Fire Safety - Smoke Detectors
This requirement is being cited for the second time. See SOD J0TC11, issued 06/08/2026.

M0336 DHS 88.05(4)(b)2 Smoke Detectors -

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M 216	Continued From page 7 Testing And Maintenance This requirement is being cited for the second time. See SOD J0TC11, issued 06/08/2026. M0380 DHS 88.06(2)(a) Admissions Health Exam This requirement is being cited for the second time. See SOD J0TC11, issued 06/08/2026. M0384 DHS 88.06(2)(b) Service Agreement Except Respite This requirement is being cited for the second time. See SOD J0TC11, issued 06/08/2026. M0424 DHS 88.06(3)(f) Review Of ISP (individual service plan) M0446 DHS 88.07(2)(b)4 Record Of Medical Visits And Reports M0466 DHS 88.07(3)(e)1 Medication-Record Keeping M0550 DHS 88.10(3)(b) Privacy M0580 DHS 88.10(3)(p) Prompt And Adequate Treatment This requirement is being cited for the second time. See SOD J0TC11, issued 06/08/2026. On 09/15/2026 at 8:30 A.M., Surveyors entered the home/facility and met with Caregiver C. Caregiver C told Surveyors s/he continued to live at the facility with 3 current residents, including Resident 2, Resident 3, and Resident 4, and was their primary caregiver. Based on observation, interview, and record review during this visit, Caregiver C continued to work at the facility and provide care services to residents without required training.	M 216		

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M 216	Continued From page 8 On 09/15/2026 at 8:55 A.M., Surveyor observed Licensee A enter the facility and conducted an entrance meeting with Licensee A. Licensee A told Surveyor s/he had returned to the United States on 09/05/2026 after being out of the country for approximately 11 months. Surveyor reviewed with Licensee A the Notice and Order letter issued to Licensee A on 06/08/2026, including special order #1. Licensee A was to ensure special order #1 was to be completed within 45 days, by 07/23/2026. Licensee A verbally acknowledged receiving statement of deficiency (SOD) J0TC11 and this letter while s/he was out of the country. Licensee A said s/he forwarded an email to House Manager B during his/her absence, including SOD J0TC11 and the Notice and Order letter. Surveyor asked to review Licensee A's consultation activities, as required with special order #1. Licensee A provided Surveyor with a binder including a copy of a driver's license and registered nurse [RN] license belonging to RN L, both of which had expired in 2025. The binder included 2 "offer" letters between Licensee A and RN L, one dated 03/03/2025 and 05/04/2025. Licensee A said s/he would consult with RN L when s/he had questions in 2025, prior to the issuance of SOD J0TC11. Surveyor was unable to locate any documentation of consultant activities, as required, within this binder and asked Licensee A to explain the purpose of the binder and the absence of requested documentation. Licensee A said neither RN L nor any other, unaffiliated RN consulted with Licensee A and/or the facility to fulfill the components within special order #1. Licensee A said s/he had "misinterpreted the letter" and s/he had not consulted with nor collaborated with a registered nurse (RN), as required, to correct	M 216		

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M 216	Continued From page 9	M 216		

each deficiency identified within SOD J0TC11, including this noncompliance. Licensee A told Surveyor his/her absence from the country and not over-seeing the facility in person contributed to the facility's "lapse in compliance." Licensee A told Surveyor House Manager B was hired to oversee the home during his/her absence from the country. Licensee A told Surveyor s/he had been trying to get the noncompliance cited within SOD J0TC11 corrected following his/her return on 09/05/2026.

On 09/15/2026 at 9:45 A.M., Surveyor interviewed House Manager B following his/her arrival to the facility. House Manager B said s/he received a copy of SOD J0TC11 and the associated Notice and Order letter from Licensee A and s/he had "done the best [s/he] could with it." At 11:36 A.M., House Manager B told Surveyor s/he did not know who RN L was and had never met/worked with him/her. House Manager B said s/he was hired by Licensee A to oversee this facility and Licensee A's other licensed adult family home at the end of October 2025 or early November 2025. Based on observation, interview, and record review during this visit, House Manager B continued to work at the facility and provide care services to residents without required training.

On 09/15/2026 at approximately 12:10 P.M., Licensee A told Surveyor s/he did not have a physical/hard copy of the DHS Chapter 88 adult family home regulations within the facility but would be able to access these regulations electronically. Licensee A told Surveyor s/he read the regulations when s/he was in the process of getting this facility and his/her other facility licensed in 2024 but had not read the regulations in depth. Licensee A told Surveyor s/he had not

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M 216	Continued From page 10 reviewed the regulations since both facilities were licensed in 2024. Licensee A said s/he did not realize running both facilities would be so much work after they were licensed by the department. Surveyor asked Licensee A if s/he had completed annual training from 2025, as required within special order #1. Licensee A explained s/he did not complete any training while s/he was out of the country including any of this required training. Licensee A stated s/he did not know, despite reading the special order #1, s/he still needed to complete the training. On 09/15/2026 at approximately 2:00 P.M., Surveyors conducted an interview with Licensee A and House Manager B. Licensee A verbally acknowledged s/he would have benefited from having consulted and collaborated with an RN, as required in special order #1 issued to Licensee A on 06/08/2026, to work on correcting the noncompliance cited within SOD J0TC11.	M 216		
{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.	{M 232}		

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{M 232}	Continued From page 11 This Rule is not met as evidenced by: Based on interview and record review, 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 days 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. This requirement is being cited for a second time. See Statement of Deficiency (SOD) J0TC11, issued on 06/08/2026. The findings include: On 09/15/2026 at 8:55 A.M., Surveyor observed Licensee A enter the facility and conducted an entrance meeting with Licensee A. Licensee A told Surveyor s/he had returned to the United States on 09/05/2026 after being out of the country for approximately 11 months. Surveyor reviewed with Licensee A the Notice and Order letter issued to Licensee A from the department on 06/08/2026, including special order #1, in association with statement of deficiency (SOD) J0TC11. Licensee A was to ensure special order #1 was to be completed within 45 days, by 07/23/2026. Licensee A verbally acknowledged receiving SOD J0TC11 and this letter while s/he was out of the country. Licensee A said s/he had "misinterpreted the letter" and s/he had not consulted with nor collaborated with a registered nurse (RN), as required, to correct each deficiency identified within SOD J0TC11, including this noncompliance.	{M 232}		

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{M 232}	Continued From page 12 On 09/15/2026 at approximately 10:15 AM, Surveyor reviewed employee records and identified the following: House Manager B was hired in October 2025. His/her record did contain a TB skin test from 12/19/2024, roughly 10 months prior to employment. The record was missing a communicable disease screen. Caregiver C was hired in February 2026. His/her record contained a Quantiferon Gold blood test from 04/30/2026. The results were "positive" but there were no further testing or statements from a medical doctor included in the record. There was not a communicable disease screen in his/her record. On 09/15/2026 at approximately 10:35 AM, Surveyor interviewed Licensee A and House Manager B. Licensee A did not recall the need for a communicable disease screening, or for testing within 3 months prior to being hired. Licensee A and House Manager B were both surprised when asked about the positive test result for Caregiver C. They stated they were unaware of the positive result and were not advised of it or advised of additional steps by the company who provided the testing. On 09/15/2026 at approximately 2:00 P.M., Surveyors conducted an interview with Licensee A and House Manager B. Licensee A verbally acknowledged s/he would have benefited from having consulted and collaborated with an RN, as required in special order #1 issued to Licensee A on 06/08/2026, to work on correcting this noncompliance.	{M 232}		

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{M 232}	Continued From page 13 Cross Reference: M0216 DHS 88.04(2)(a) Responsibilities	{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 interview and record review, 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 all required training. This requirement is being cited for a second time. See Statement of Deficiency (SOD) J0TC11, issued on 06/08/2026. The findings include: On 09/15/2026 at 8:55 A.M., Surveyor observed Licensee A enter the facility and conducted an entrance meeting with Licensee A. Licensee A told Surveyor s/he had returned to the United	{M 244}		

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 _____	R-C 09/23/2026

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{M 244}	Continued From page 14 States on 09/05/2026 after being out of the country for approximately 11 months. Surveyor reviewed with Licensee A the Notice and Order letter issued to Licensee A from the department on 06/08/2026, including special order #1, in association with statement of deficiency (SOD) J0TC11. Licensee A was to ensure special order #1 was to be completed within 45 days, by 07/23/2026. Licensee A verbally acknowledged receiving SOD J0TC11 and this letter while s/he was out of the country. Licensee A said s/he had "misinterpreted the letter" and s/he had not consulted with nor collaborated with a registered nurse (RN), as required, to correct each deficiency identified within SOD J0TC11, including this noncompliance. On 09/15/2026 at approximately 10:15 AM, Surveyor reviewed employee records. Both House Manager B and Caregiver C's records contained training on resident rights, first aid & choking, and medication administration. There were no durations recorded for how long each training took. There was no training documented for fire safety, standard/universal precautions, health, safety, and welfare of residents, or treatment appropriate for residents served. On 09/15/2026 at approximately 10:40 AM, Surveyor interviewed Licensee A and House Manager B. They both stated there was no other training aside from what was documented within the binder they provided. Licensee A was unaware of the training requirements regarding specified hours and topics. On 09/15/2026 at approximately 2:00 P.M., Surveyors conducted an interview with Licensee A and House Manager B. Licensee A verbally acknowledged s/he would have benefited from having consulted and collaborated with an RN, as	{M 244}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{M 244}	Continued From page 15 required in special order #1 issued to Licensee A on 06/08/2026, to work on correcting this noncompliance. Cross Reference: M0216 DHS 88.04(2)(a) Responsibilities M0550 DHS 88.10(3)(b) Privacy	{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. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure 1 of 1 employee 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 from 2025, which was ordered to be completed in the Special Orders from SOD J0TC11. This requirement is being cited for a second time. See Statement of Deficiency (SOD) J0TC11,	{M 246}		

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	0019817	A. BUILDING: _____ B. WING _____	R-C 09/23/2026

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{M 246}	Continued From page 16 issued on 06/08/2026. The findings include: On 09/15/2026 at 8:55 A.M., Surveyor observed Licensee A enter the facility and conducted an entrance meeting with Licensee A. Licensee A told Surveyor s/he had returned to the United States on 09/05/2026 after being out of the country for approximately 11 months. Surveyor reviewed with Licensee A the Notice and Order letter issued to Licensee A from the department on 06/08/2026, including special order #1, in association with statement of deficiency (SOD) J0TC11. Licensee A was to ensure special order #1 was to be completed within 45 days, by 07/23/2026. Special order #1 included, "Within 25 days of receipt of this notice, continuing education requirements must be met for [Licensee A] and all service providers, as appropriate, for calendar year 2025." Licensee A verbally acknowledged receiving SOD J0TC11 and this letter while s/he was out of the country. Licensee A said s/he had "misinterpreted the letter" and s/he had not consulted with nor collaborated with a registered nurse (RN), as required, to correct each deficiency identified within SOD J0TC11, including this noncompliance. On 09/15/2026 at approximately 10:15 AM, Surveyor reviewed employee records. Surveyor was unable to locate any training records for Licensee A. On 09/15/2026 at approximately 12:10 PM, Surveyor asked Licensee A if s/he had completed annual training from 2025, as required within special order #1. Licensee A explained s/he did not complete any training while s/he was out of	{M 246}		

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{M 246}	Continued From page 17 the country including any of this required training. Licensee A stated s/he did not know, despite reading the special order #1, s/he still needed to complete the training. Licensee A stated s/he should be able to complete it now that s/he is back. On 09/15/2026 at approximately 2:00 P.M., Surveyors conducted an interview with Licensee A and House Manager B. Licensee A verbally acknowledged s/he would have benefited from having consulted and collaborated with an RN, as required in special order #1 issued to Licensee A on 06/08/2026, to work on correcting this noncompliance. Cross Reference: M0216 DHS 88.04(2)(a) Responsibilities	{M 246}		
{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.	{M 334}		

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{M 334}	Continued From page 18 This Rule is not met as evidenced by: Based on observation, interview, and record review, 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 of each sleeping room. This requirement is being cited for a second time. See Statement of Deficiency (SOD) J0TC11, issued on 06/08/2026. The findings include: On 09/15/2026 at 8:55 A.M., Surveyor observed Licensee A enter the facility and conducted an entrance meeting with Licensee A. Licensee A told Surveyor s/he had returned to the United States on 09/05/2026 after being out of the country for approximately 11 months. Surveyor reviewed with Licensee A the Notice and Order letter issued to Licensee A from the department on 06/08/2026, including special order #1, in association with statement of deficiency (SOD) J0TC11. Licensee A was to ensure special order #1 was to be completed within 45 days, by 07/23/2026. Licensee A verbally acknowledged receiving SOD J0TC11 and this letter while s/he was out of the country. Licensee A said s/he had "misinterpreted the letter" and s/he had not consulted with nor collaborated with a registered nurse (RN), as required, to correct each deficiency identified within SOD J0TC11, including this noncompliance. On 09/15/2026 at approximately 8:45 AM - 9:15 AM, Surveyors toured the home and made observations. Both Resident 2 and Resident 3 were guarded about letting Surveyors into their	{M 334}		

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	0019817	A. BUILDING: _____ B. WING _____	R-C 09/23/2026

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{M 334}	Continued From page 19 bedrooms. Neither resident had his/her smoke detectors properly placed on the ceiling. Both smoke detectors were taken down and set somewhere in their room. Resident 2 and Resident 3 said the detectors would randomly go off or repeatedly beep, so they took them down. It was also noted there was not a smoke detector at the door leading to the enclosed stairway, which lead down to the basement, where laundry facilities and other mechanical equipment were in use. On 09/15/2026 at approximately 11:05 AM, Surveyor interviewed House Manager B. House Manager B stated s/he does complete monthly smoke detector tests, and s/he will reattach the smoke detectors at that time if Resident 2 or Resident 3 has taken his/her smoke detector down. House Manager B did not have an explanation for why Resident 2 may remove his/her smoke detector, but s/he reported Resident 3 may smoke in his/her bedroom at times and believes that is when s/he will remove it from the ceiling. House Manager B stated after the last survey visit s/he did add a smoke detector at the stairway, but s/he placed it inside the door of the enclosed stairway, not outside of the door that leads to the enclosed stairway. S/he thought where s/he placed it was appropriate but stated they could get it moved or add another one. On 09/15/2026 at approximately 2:00 P.M., Surveyors conducted an interview with Licensee A and House Manager B. Licensee A verbally acknowledged s/he would have benefited from having consulted and collaborated with an RN, as required in special order #1 issued to Licensee A on 06/08/2026, to work on correcting this noncompliance.	{M 334}		

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{M 334}	Continued From page 20 On 09/22/2026 at approximately 2:40 PM, Surveyor interviewed Resident 3's Case Manager (CM) M. CM M reported Resident 3 had a history of threatening to burn his/her mattress. Prior to a visit on 07/13/2026, Resident 3 had been incontinent on his/her mattress. S/he removed the mattress his/herself, and threatened to burn it if someone put it back into his/her room. Resident 3 currently uses tobacco, and manages his/her own tobacco products and lighters. S/he has a history of smoking in his/her room, or burning other things such as sage. Cross Reference: M0216 DHS 88.04(2)(a) Responsibilities M0336 DHS 88.05(4)(b)2 Smoke Detectors - Testing And Maintenance	{M 334}		
{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 observation, interview, and record review, the provider did not ensure the home's smoke detectors were tested monthly to make sure they were operating.	{M 336}		

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{M 336}	Continued From page 21 The provider had no documentation of monthly smoke detector testing for the past 2 years. This requirement is being cited for a second time. See Statement of Deficiency (SOD) J0TC11, issued on 06/08/2026. The findings include: The provider is an Adult Family Home (AFH) licensed for up to 4 non-ambulatory residents within the client groups including traumatic brain injury, alcohol/drug dependent, advanced aged, physically disabled, emotionally disturbed/mental illness, developmentally disabled, and irreversible dementia/ Alzheimer's. On 09/15/2026 at 8:55 A.M., Surveyor observed Licensee A enter the facility and conducted an entrance meeting with Licensee A. Licensee A told Surveyor s/he had returned to the United States on 09/05/2026 after being out of the country for approximately 11 months. Surveyor reviewed with Licensee A the Notice and Order letter issued to Licensee A from the department on 06/08/2026, including special order #1, in association with statement of deficiency (SOD) J0TC11. Licensee A was to ensure special order #1 was to be completed within 45 days, by 07/23/2026. Licensee A verbally acknowledged receiving SOD J0TC11 and this letter while s/he was out of the country. Licensee A said s/he had "misinterpreted the letter" and s/he had not consulted with nor collaborated with a registered nurse (RN), as required, to correct each deficiency identified within SOD J0TC11, including this noncompliance. On 09/15/2026 at approximately 9:28 A.M., Surveyor observed personal cares being provided	{M 336}		

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{M 336}	Continued From page 22	{M 336}		

to Resident 4 by Caregiver C. Surveyor observed Resident 4 required several verbal prompts by Caregiver C to stand and pivot transfer from Resident 4's bed to a wheelchair located near Resident 4's bed while Caregiver C also provided Resident 4 with physical assistance.

On 09/15/2026 at approximately 9:53 A.M., House Manager B told Surveyor Resident 4 has a diagnoses including dementia and is fully dependent on staff to transfer into his/her wheelchair and to exit the home.

On 09/15/2026 at approximately 10:45 AM, Surveyor reviewed the life safety reports provided by House Manager B. The home began completing monthly fire drills since the previous survey, which was documented in the facility records. There was no documentation of the smoke detectors being tested monthly, or at all.

On 09/15/2026 at approximately 10:55 AM, Surveyor interviewed Licensee A and House Manager B. Licensee A stated until his/her other adult family home was surveyed the week prior, s/he did not realize they had a responsibility of documenting the monthly smoke detector tests. House Manager B stated s/he did complete monthly testing but did not have any documentation about that. Licensee A took note to obtain a form to start that documentation on moving forward.

On 09/15/2026 at approximately 2:00 P.M., Surveyors conducted an interview with Licensee A and House Manager B. Licensee A verbally acknowledged s/he would have benefited from having consulted and collaborated with an RN, as required in special order #1 issued to Licensee A on 06/08/2026, to work on correcting this

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	0019817	A. BUILDING: _____ B. WING _____	R-C 09/23/2026

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{M 336}	Continued From page 23 noncompliance. On 09/22/2026 at approximately 2:40 PM, Surveyor interviewed Resident 3's Case Manager (CM) M. CM M reported Resident 3 had a history of threatening to burn his/her mattress. Prior to a visit on 07/13/2026, Resident 3 had been incontinent on his/her mattress. S/he removed the mattress his/herself, and threatened to burn it if someone put it back into his/her room. Resident 3 currently uses tobacco, and manages his/her own tobacco products and lighters. S/he has a history of smoking in his/her room, or burning other things such as sage. Cross Reference: M0216 DHS 88.04(2)(a) Responsibilities M0334 DHS 88.05(4)(b)1 Fire Safety	{M 336}		
{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 observation, interview, and record	{M 380}		

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{M 380}	Continued From page 24	{M 380}		

review, the provider did not ensure Resident 4 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 4 continued to not receive health examination for approximately one year following admission to the facility, including being screened for communicable diseases.
Resident 4 was not screened for tuberculosis until approximately one year following Resident 4's admission to the facility.

This requirement is being cited for a second time. See Statement of Deficiency (SOD) J0TC11, issued on 06/08/2026.

The findings include:

On 09/15/2026 at 8:55 A.M., Surveyor observed Licensee A enter the facility and conducted an entrance meeting with Licensee A. Licensee A told Surveyor s/he had returned to the United States on 09/05/2026 after being out of the country for approximately 11 months. Surveyor reviewed with Licensee A the Notice and Order letter issued to Licensee A on 06/08/2026, including special order #1. Licensee A was to ensure special order #1 was to be completed within 45 days, by 07/23/2026. Licensee A verbally acknowledged receiving statement of deficiency (SOD) J0TC11 and this letter while s/he was out of the country. Licensee A said s/he had "misinterpreted the letter" and s/he had not consulted with nor collaborated with a registered nurse (RN), as required, to correct each deficiency identified within SOD J0TC11,

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 _____	R-C 09/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{M 380}	Continued From page 25 including this noncompliance. On 09/15/2026 at approximately 9:28 A.M., Surveyor observed personal cares being provided to Resident 4 by Caregiver C, including assisting Resident 4 to transfer into a wheelchair. At 9:36 A.M., Surveyor observed Caregiver C administer morning medications to Resident 4 seated in a wheelchair at the dining room table. On 09/15/2026 at 9:45 A.M., Surveyor observed House Manager B arrive at the facility. On 09/15/2026 at 9:53 A.M., House Manager B told Surveyor Resident 4 was admitted to the facility without a primary care physician or practitioner, continued to not have a current primary care or psychiatric physician/practitioner, and had not had a health examination. House Manager B told Surveyor Resident 4 required full assistance with all cares, medication administration, and had experienced an increase in "violent" behavior within recent months when provided with shower and toileting assistance. House Manager B said it had become increasing difficult to provide personal cares to Resident 4 related to his/her "violent" behavior. House Manager B said Resident 4's funding agency case management team was aware Resident 4's Legal Representative D was not responsive to getting a primary care physician/practitioner established for Resident 4. House Manager B said s/he had not documented within Resident 4's record each time s/he communicated with Legal Representative D about Resident 4's ongoing need for a primary care physician/practitioner. During this interview, Licensee A told Surveyor s/he had just recently set up a heath exam appointment with a primary care physician/practitioner for Resident 4 after	{M 380}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{M 380}	Continued From page 26 Licensee A returned to the United States. On 09/15/2026 from approximately 10:00 A.M. until approximately 3:00 P.M., Surveyor observed Resident 4 seated on a couch located in the facility's shared living room. On 09/15/2026, Surveyor reviewed Resident 4's record, as provided by House Manager B. Resident 4 was admitted to the home on 09/29/2025 with diagnoses including dementia with agitation, depression, anxiety, visual hallucinations, speech disturbances, and hypertension (elevated blood pressure). Resident 4's record did not include documentation of a health examination being completed following Resident 4's admission to the facility. At approximately 10:50 A.M., House Manager B told Surveyor the only time Resident 4 was seen by a physician/practitioner since Resident 4's admission to the facility was on 02/11/2026 when Resident 4 was seen at a local urgent care center related to complaints of back pain. House Manager B said Resident 4 did not receive a complete health examination during this visit and was immediately sent back to the facility without any physician/practitioner orders. Resident 4's record included a hand-written note dated 07/01/2026 and "Zoom meeting: July 1, 2026 at 2 P.M. [date and time confirmed by House Manager B]." The documentation included, "Participants: [Resident 4], [Resident 4's Previous Funding Agency Representative O] and [House Manager B]. Object: Report about [Resident 4's] current placement [and] making recommendations about continuing [Resident 4's] placement." The documentation included, "[Resident 4] doesn't have a physician or psychiatrist" and "[Legal Representative D] is not responsive (absent)."	{M 380}		

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	0019817	A. BUILDING: _____ B. WING _____	R-C 09/23/2026

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{M 380}	Continued From page 27 Resident 4's record included a hand-written note dated 07/07/2026 and "Visit of [funding agency] about [Resident 2, Resident 3, and Resident 4]." The document included, "[Resident 4's funding agency RN Case Manager (CM) N] and [Resident 4's funding agency Case Manager (CM) P]" contact information. The documentation included, "[Resident 4] still don't [sic] have any physician, psychiatrist, and personal money as discussed during last meeting with [Funding Agency] and [Legal Representative D]. [Resident 4] is violent when staff want to give [him/her] personal care (removing pants, changing...). No changing of medication. Record each time that we [facility staff] talk or each time that the [Legal Representative D] contacts the staff about [Resident 4]." Resident 4's record included a hand-written note dated 07/08/2026 and "We went to [local clinic] with [Resident 4] for TB [tuberculosis] test. The [an] I.D. [identification] was needed. [House Manager B] spoke with the supervisor, but [s/he] insist [sic] [s/he] needed [Resident 4's] state I.D. to perform any medical assessment. [House Manager B] called [Legal Representative D], but s/he don't [sic] have any state I.D. or identification for [Resident 4]. We came back [to facility] without performing the TB test." House Manager B verbally confirmed s/he documented this note. Resident 4's record did include documentation a tuberculosis test was administered to Resident 4 on 09/11/2026 and read/completed for Resident 4 on 09/14/2026, one day before the Surveyor's onsite visit at the facility. At approximately 10:50 A.M., House Manager B told Surveyor the delay in Resident 4's tuberculosis test since his/her admission to the facility was directly related to Resident 4 not having a primary care physician/practitioner and Resident 4 not having current identification documentation. House	{M 380}		

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{M 380}	Continued From page 28	{M 380}		

Manager B said s/he recently took Resident 4 to the local department of motor vehicles [DMV] to get a current identification card for Resident 4, followed by getting Resident 4's tuberculosis test. During this interview, Licensee A said s/he understood had s/he followed Order #1, as issued on 06/08/2026, to consult/collaborate with an RN, s/he could have had assistance obtaining a primary care physician/practitioner for Resident 4, and obtaining a timely communicable disease screen, including tuberculosis, for Resident 4.

On 09/15/2026 at approximately 12:36 P.M., House Manager B told Surveyor s/he met with Resident 4's RN CM N and Resident 4's current funding agency Case Manager [CM] M at the facility with Resident 4's Legal Representative D on "Zoom" on 09/08/2026. House Manager B said s/he discussed Resident 4's continued need for a primary care physician/practitioner and a plan to assist getting an appointment set up for Resident 4. House Manager B said s/he did not have any documentation of this meeting. During this interview, Licensee A clarified with Surveyor s/he had set up an appointment for Resident 4 to visit a primary care physician/practitioner on 10/08/2026 to have a health exam.

On 09/17/2026 at 12:25 P.M., Surveyor conducted an interview with Resident 4's CM M. CM M told Surveyor s/he was newly assigned as Resident 4's funding agency case manager on 09/07/2026. CM M said s/he met with Resident 4, RN CM N, and House Manager B at the facility and with Legal Representative D on "Zoom" on 09/08/2026. CM M said Licensee A did not attend this meeting in any manner. CM M said s/he and RN CM N were aware Resident 4 has not had a primary care physician/practitioner or health examination since his/her admission to the facility

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{M 380}	Continued From page 29 in September 2025. CM M said s/he was under the impression Legal Representative D was not aware until recently Resident 4 did not have a primary care physician/practitioner since his/her admission to the facility. CM M said Legal Representative D said s/he had found a primary care physician/practitioner for Resident 4 and would be contacting them to set up an appointment. CM M said Legal Representative D requested an increase in telephone communication from the facility regarding Resident 4. CM M said it was determined during this meeting Legal Representative D was to receive weekly phone calls from the facility staff to discuss any updates related to Resident 4 and so s/he could speak with Resident 4. CM M said Legal Representative D can be difficult to get a hold of on the phone because of his/her other personal commitments and verbalized the best time to call him/her was after 9:00 A.M. during the week. CM M said s/he was not aware Legal Representative D had not been responsive to the facility. On 09/17/2026 at 4:08 P.M., Surveyor conducted an interview with Resident 4's RN CM N. RN CM N told Surveyor s/he was newly assigned as Resident 4's funding agency RN case manager within last 6 months. RN CM N said Resident 4 was admitted to a skilled nursing facility related to a hip fracture before being admitted to the facility in September 2025. RN CM N said Resident 4 likely utilized the primary care physician associated with the skilled nursing facility during his/her stay, and that coverage would have ended at the time Resident 4 was discharged from the skilled nursing facility. RN CM N told Surveyor House Manager B mentioned Resident 4 continued to be without a primary care physician/practitioner during the meeting on	{M 380}		

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{M 380}	Continued From page 30 09/08/2026. RN CM N said Legal Representative D informed us all at this meeting s/he was going to establish an appointment with a primary care physician/practitioner for Resident 4's health examination. RN CM N said s/he asked House Manager B to set up a psychiatric care appointment while Resident 4 was at the primary heath examination and House Manager B agreed to do so. On 09/23/2026 at 9:24 A.M., Surveyor conducted an interview with Legal Representative D. Legal Representative D told Surveyor s/he has been Resident 4's court appointed guardian since 2018/2019 and s/he lived an approximate 4 hour drive away from Resident 4's current location. Legal Representative D said Resident 4 originally lived in facilities near his/her home and it was easier for Legal Representative D to visit Resident 4. Legal Representative D said Resident 4 experienced increased behavioral issues at these facilities and Resident 4's funding agency moved Resident 4 to a facility closer to his/her current location in the Milwaukee metropolitan area. Legal Representative D said Resident 4 experienced a fall resulting in a fractured hip in 2025 at one of these facilities before being admitted to a skilled nursing facility in Kenosha, WI. Legal Representative D said s/he was not made aware Resident 4 had been moved from the skilled nursing facility to the current facility until s/he received a text message on his/her phone on 10/02/2025 informing him/her Licensee A would be going out of the country. Legal Representative D said s/he did not know who Licensee A was and returned a text back to Licensee A that Resident 4 did not reside at this facility. Legal Representative D said s/he contacted Resident 4's funding agency and they reported Resident 4 did not like that skilled	{M 380}		

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{M 380}	Continued From page 31 nursing home and had been moved to this current facility. Legal Representative D said s/he was not happy this decision to move Resident 4 was made without him/her being made aware, but s/he did not know what to do about it. Legal Representative D said s/he recalled a meeting in March 2026 with Resident 4's funding agency case managers at that time and House Manager B. Legal Representative D said s/he asked for weekly calls from House Manager B and/or facility staff on duty so s/he could speak to Resident 4 and receive updates from the staff. Legal Representative D said "this did not happen" and voiced the same request during the meeting with House Manager B, RN CM N and CM M on 09/08/2026. Legal Representative D said s/he was not made aware Resident 4 did not have an active/current primary care physician/practitioner until the meeting in March 2026. Legal Representative D said s/he communicated it was not easy for him/her to travel to Resident 4's current facility and Resident 4 did not have a current state I.D. card because all of his/her possessions were lost during recent moves so it may take some time. Legal Representative D said s/he was able to find a primary care physician/practitioner for Resident 4 and his/her health exam appointment was set for 10/27/2026. Legal Representative D said s/he informed House Manager B of this appointment. House Manager B said s/he would be transporting Resident 4 to this appointment and asking for a psychiatric recommendation once the primary care physician/practitioner has been established. Legal Representative D said s/he was not aware the facility had obtained a current state I.D. card for Resident 4 and that Licensee A had made an appointment on his/her own with a primary care physician/practitioner for Resident 4.	{M 380}		

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{M 380}	Continued From page 32 On 09/15/2026 at approximately 2:00 P.M., Surveyors conducted an interview with Licensee A and House Manager B. Licensee A verbally acknowledged s/he would have benefited from having consulted and collaborated with an RN, as required in special order #1 issued to Licensee A on 06/08/2026, to work on correcting this noncompliance. Cross Reference: M0216 DHS 88.04(2)(a) Responsibilities M0384 DHS 88.06(2)(b) Service Agreement Except Respite M0424 DHS 88.06(3)(F) Review Of ISP M0580 DHS 88.10(3)(p) Prompt And Adequate Treatment	{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 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 observation, interview, and record review, the provider did not ensure a service agreement was completed prior to nor following Resident 4's admission to the facility.	{M 384}		

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{M 384}	Continued From page 33 Resident 4 continued to reside at the facility without a completed service agreement for approximately one year following admission to the facility. This requirement is being cited for a second time. See Statement of Deficiency (SOD) J0TC11, issued on 06/08/2026. The findings include: On 09/15/2026 at 8:55 A.M., Surveyor observed Licensee A enter the facility and conducted an entrance meeting with Licensee A. Licensee A told Surveyor s/he had returned to the United States on 09/05/2026 after being out of the country for approximately 11 months. Surveyor reviewed with Licensee A the Notice and Order letter issued to Licensee A on 06/08/2026, including special order #1. Licensee A was to ensure special order #1 was to be completed within 45 days, by 07/23/2026. Licensee A verbally acknowledged receiving statement of deficiency (SOD) J0TC11 and this letter while s/he was out of the country. Licensee A said s/he had "misinterpreted the letter" and s/he had not consulted with nor collaborated with a registered nurse (RN), as required, to correct each deficiency identified within SOD J0TC11, including this noncompliance. On 09/15/2026 at approximately 9:28 A.M., Surveyor observed personal cares being provided to Resident 4 by Caregiver C. At 9:36 A.M., Surveyor observed Caregiver C administer morning medications to Resident 4 seated in a wheelchair at the dining room table. On 09/15/2026 at 9:45 A.M., Surveyor observed	{M 384}		

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{M 384}	Continued From page 34 House Manager B arrive at the facility. On 09/15/2026, Surveyor reviewed Resident 4's record, as provided by House Manager B. Resident 4 was admitted to the home on 09/29/2025 with diagnoses including dementia with agitation, depression, anxiety, visual hallucinations, speech disturbances, and hypertension (elevated blood pressure). Resident 4's record did not include documentation of a completed service agreement for Resident 4. Resident 4's record included a document titled, "Admission agreement between [the facility] and [Resident 4]/POA [power of attorney]. This contract for services is entered into on 09/29/2026 by and between [the facility] and [a name other than Resident 4's name] (hereinafter referred to as the client)." This document included Licensee A's signature dated 09/29/2025. This document did not include Resident 4's Legal Representative D's signature nor Resident 4's signature. At 12:36 P.M., House Manager B told Surveyor there was no documentation within Resident 4's record regarding communication with Legal Representative D requesting s/he sign Resident 4's admission/service agreement. On 09/15/2026 at 2:00 P.M., Licensee A told Surveyor s/he was unaware of any other documented service agreement for Resident 4, other than the agreement solely signed by Licensee A on 09/29/2025. On 09/23/2026 at 9:24 A.M., Surveyor conducted an interview with Legal Representative D. Legal Representative D told Surveyor s/he has been Resident 4's court appointed guardian since 2018/2019. Legal Representative D said Resident 4 originally lived in facilities near his/her	{M 384}		

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{M 384}	Continued From page 35 home. Legal Representative D said Resident 4 experienced increase behavioral issues at these facilities and Resident 4's funding agency moved Resident 4 to a facility closer to his/her current location in the Milwaukee metropolitan area. Legal Representative D said Resident 4 experienced a fall resulting in a fractured hip in 2025 at one of these facilities before being admitted to a skilled nursing facility in Kenosha, WI. Legal Representative D said s/he was not made aware Resident 4 had been moved from the skilled nursing facility to the current facility until s/he received a text message on his/her phone on 10/02/2025 informing him/her Licensee A would be going out of the country. Legal Representative D said s/he did not know who Licensee A was and returned a text back to Licensee A that Resident 4 did not reside at this facility. Legal Representative D said s/he contacted Resident 4's funding agency and they reported Resident 4 did not like that skilled nursing home and had been moved to this current facility. Legal Representative D said s/he was not happy this decision was made without him/her being made aware, but s/he did not know what to do about it. Legal Representative D told Surveyor had not received and/or signed a documented service/admission agreement for Resident 4 at this facility. On 09/15/2026 at approximately 2:00 P.M., Surveyors conducted an interview with Licensee A and House Manager B. Licensee A verbally acknowledged s/he would have benefited from having consulted and collaborated with an RN, as required in special order #1 issued to Licensee A on 06/08/2026, to work on correcting this noncompliance.	{M 384}		

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{M 384}	Continued From page 36 Cross Reference: M0216 DHS 88.04(2)(a) Responsibilities M0380 DHS 88.06(2)(a) Admissions Health Exam M0424 DHS 88.06(3)(f) Review Of ISP M0580 DHS 88.10(3)(p) Prompt And Adequate Treatment	{M 384}		
M 424	88.06(3)(f) REVIEW OF ISP The individual service plan shall be reviewed at least once every 6 months by the licensee, the resident or the resident's guardian, the service coordinator, if any, the designated representative, if any, the placing agency with the resident participating in a manner appropriate for the resident's level of understanding and method of communication. This review is to determine continued appropriateness of the plan and to update the plan as necessary. A plan shall be updated, in writing, whenever the resident's needs or preferences change substantially or when requested by the resident or the resident's guardian. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure an individual service plan [ISP] was developed and reviewed at least once every 6 months with Resident 4's Legal Representative D, and did not ensure an	M 424		

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M 424	Continued From page 37 ISP was updated, in writing, when Resident 4's needs or preferences changed substantially. The findings include: On 09/15/2026 at 8:30 A.M., Surveyors entered the home/facility and met with Caregiver C. Caregiver C told Surveyors s/he continued to live at the facility with 3 current residents, including Resident 4, and was their primary caregiver. On 09/15/2026 at 8:45 A.M., Caregiver C told Surveyor Resident 4 remained in his/her bedroom asleep with the bedroom door shut at this time. On 09/15/2026 at 8:55 A.M., Surveyor observed Licensee A enter the facility and conducted an entrance meeting with Licensee A. Licensee A told Surveyor s/he had returned to the United States on 09/05/2026 after being out of the country for approximately 11 months. On 09/15/2026 at approximately 9:28 A.M., Surveyor observed personal cares being provided to Resident 4 by Caregiver C, including incontinence care and assistance with donning an incontinence brief and clothing. Surveyor observed Resident 4 required several verbal prompts by Caregiver C to stand and pivot transfer from Resident 4's bed to a wheelchair located near Resident 4's bed while Caregiver C also provided Resident 4 with physical assistance. Caregiver C told Surveyor Resident 4 had been incontinent of urine. Caregiver C proceeded to propel Resident 4 in his/her wheelchair to the dining room table followed by serving Resident 4 breakfast and administering Resident 4's morning medications. On 09/15/2026 at 9:45 A.M., Surveyor observed	M 424		

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M 424	Continued From page 38 House Manager B arrive at the facility. On 09/15/2026 at 9:53 A.M., House Manager B told Surveyor Resident 4 required full assistance with all cares, medication administration, and had experienced an increase in "violent" behavior within recent months when provided with shower and toileting assistance. House Manager B said it had become increasing difficult to provide personal cares to Resident 4 related to his/her "violent" behavior since approximately March 2026. House Manager B said Resident 4 had been provided with shower assistance 2 times per week, but was currently being provided with "bed baths." House Manager B said Caregiver C did his/her best to provide Resident 4 with shower assistance twice per month. House Manager B said Resident 4 had been provided with physical assistance with transfers to the toilet twice a day, but s/he was not sure how often Resident 4 was currently being physically assisted to the toilet. Surveyor observed House Manager B ask Caregiver C how often s/he assisted Resident 4 to sit on the toilet and Caregiver C responded it had changed to twice a week related to Resident 4's behavior. House Manager B said Resident 4's funding agency case management team was aware of Resident 4's "violent behavior" and that Resident 4's Legal Representative D was not responsive to getting a primary care physician/practitioner established for Resident 4, including a psychiatric evaluation related to behaviors. House Manager B told Surveyor Resident 4 was not "violent" with other residents in the facility. House Manager B said Resident 4 would become violent during cares, including showers and toileting, by striking out and yelling at the caregiver providing assistance, primarily Caregiver C.	M 424		

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 _____	R-C 09/23/2026

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 424	Continued From page 39 On 09/15/2026 from approximately 10:00 A.M. until approximately 3:00 P.M., Surveyor observed Resident 4 seated on a couch located in the facility's shared living room. On 09/15/2026, Surveyor reviewed Resident 4's record, as provided by House Manager B. Resident 4 was admitted to the home on 09/29/2025 with diagnoses including dementia with agitation, depression, anxiety, visual hallucinations, speech disturbances, and hypertension (elevated blood pressure). At 11:02 A.M., House Manager B provided Surveyor with Resident 4's most recent, available individual service plan (ISP), dated 03/25/026 and not signed. The ISP included, "Primary support needs: Assistance with all activities of daily living (ADLs); behavioral support for verbal and physical aggression..." The ISP included, "To support long-term toileting readiness, [Resident 4] is seated on the toilet twice a day (morning and evening) to help [him/her] become familiar with the routine. Staff to use calm, encouraging language during toilet-sitting to build comfort and reduce resistance." The ISP included, "Behavioral Concerns: Staff should be aware that toileting and [incontinence product] changes may be moments of increased vulnerability or agitation for [Resident 4]" and included documentation related to observed "triggers," "prevention strategies," "de-escalation strategies," "safety measures," and "social and emotional support." Resident 4's ISP included "short-term goals" including, "[Resident 4] will sit on the toilet twice daily with staff support to build familiarity with toileting routines. [Resident 4] will tolerate [incontinence product] changes with fewer signs of agitation. [Resident 4] will experience fewer aggressive episodes through consistent use of prevention strategies." Resident 4's ISP included	M 424		

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 _____	R-C 09/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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M 424	Continued From page 40	M 424		

"long-term goals" including, "Improve emotional regulation with staff guidance, Increase cooperation with the daily routine." Resident 4's ISP included "Staff responsibilities" including, "Follow all ADL support procedures consistently. Use approved behavioral strategies at all times. Maintain accurate documentation of behaviors, progress, and incidents. Communicate changes or concerns with supervisor immediately." Resident 4's ISP did not include Resident 4's increased "violent" behavior impacting how cares were provided to Resident 4 including changing how often Resident 4 would be assisted to the toilet and how often Resident 4 would be provided with a shower. At approximately 11:09 A.M., House Manager B verbally clarified s/he was not sure when Resident 4's behaviors had become increasingly violent, except that it was after this ISP was documented on 03/25/2026, and that was approximately when Caregiver C reduced Resident 4's transfers to the toilet to 2 times per week. House Manager B told Surveyor this was the most recent documented ISP s/he had available for Resident 4. Surveyor observed what appeared to be an email dated 06/16/2026 sent from House Manager B to Legal Representative D with at attached copy of this ISP within House Manager B's cell phone, as provided by House Manager B. House Manager B said s/he did not have a physical copy of this ISP within Resident 4's record, nor did Resident 4 have an ISP signed by Legal Representative D since his/her admission to the facility in September 2025. House Manager B said s/he did not document when s/he sent this ISP to Legal Representative D within Resident 4's record. House Manager B said s/he did not receive a signed copy of this ISP back from Legal Representative D. House Manager B told Surveyor this was the only time s/he sent the ISP to Legal Representative D, and

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 _____	R-C 09/23/2026

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

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M 424	Continued From page 41 s/he did not follow-up with Legal Representative D after 06/16/2026 to ensure it was received by Legal Representative D and request that it be signed and returned to House Manager B. House Manager B said Resident 4's ISP was not signed by Resident 4's funding agency case management team because House Manager B was waiting for Legal Representative D to return it signed before s/he forwarded it to his/her case management team for review. On 09/17/2026 at 12:25 P.M., Surveyor conducted an interview with Resident 4's current funding agency Case Manager [CM] M. CM M told Surveyor s/he was newly assigned as Resident 4's funding agency case manager on 09/07/2026. CM M said s/he met with Resident 4, Resident 4's funding agency RN Case Manager (CM) N, and House Manager B at the facility and with Legal Representative D on "Zoom" on 09/08/2026. CM M said Licensee A did not attend this meeting in any manner. CM M said Legal Representative D requested an increase in telephone communication from the facility regarding Resident 4. CM M said it was determined during this meeting Legal Representative D was to receive weekly phone calls from the facility staff to discuss any updates related to Resident 4 and so s/he could speak with Resident 4. CM M said Legal Representative D can be difficult to get a hold of on the phone because of his/her other personal commitments and verbalized the best time to call him/her was after 9:00 A.M. during the week. CM M said s/he was not aware Legal Representative D had not been responsive to the facility. CM M said Resident 4's change in behavior was discussed during the meeting on 09/08/2026 including House Manager B informing CM M and RN CM N Resident 4 had become uncooperative	M 424		

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 _____	R-C 09/23/2026

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 424	Continued From page 42	M 424		

with pivot transfers. CM M said House Manager B discussed Resident 4 was no longer provided assistance with transfers to the toilet anymore related to behaviors including physical aggression. CM M said this was the first time s/he and RN CM N were made aware Resident 4's behavior had increased to the point the facility staff were no longer providing Resident 4 with transfer assistance to the toilet. CM M said House Manager B said Resident 4 was more "violent against" Caregiver C and Caregiver C perceived Resident 4's behavior as personal. CM M told Surveyor s/he and RN CM N communicated with House Manager B during the 09/08/2026 meeting that Resident 4's case management team, CM M and RN CM N, needed to receive communication regarding this type of condition change notification when the change initially begins to occur, which did not happen in this case regarding Resident 4's change in behavior. CM M said s/he and RN CM N captured this change in Resident 4's behavior and care within their funding agency's member centered plan and a result of the 09/08/2026 discussion with House Manager B, but did not see it updated within Resident 4's available facility ISP.

On 09/17/2026 at 4:08 P.M., Surveyor conducted an interview with Resident 4's RN CM N. RN CM N told Surveyor s/he was newly assigned as Resident 4's funding agency RN case manager within last 6 months. RN CM N said s/he was aware Resident 4's facility's ISP included documentation of Resident 4 was being provided assistance with toileting twice a day. RN CM N said s/he was under the impression after a meeting at the facility with House Manager B on 09/08/2026 that Resident 4 was no longer being assisted to the toilet related to his/her behavioral

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 _____	R-C 09/23/2026

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

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M 424	Continued From page 43	M 424		

response. RN CM N said Resident 4's behavior was described by House Manager B as being "violent."

On 09/23/2026 at 9:24 A.M., Surveyor conducted an interview with Legal Representative D. Legal Representative D told Surveyor s/he has been Resident 4's court appointed guardian since 2018/2019 and s/he lived an approximate 4 hour drive away from Resident 4's current location. Legal Representative D said Resident 4 originally lived in facilities near his/her home and it was easier for Legal Representative D to visit Resident 4. Legal Representative D said Resident 4 experienced increased behavioral issues at these facilities and Resident 4's funding agency moved Resident 4 to a facility closer to his/her current location in the Milwaukee metropolitan area. Legal Representative D said Resident 4 experienced a fall resulting in a fractured hip in 2025 at one of these facilities before being admitted to a skilled nursing facility in Kenosha, WI. Legal Representative D said s/he was not made aware Resident 4 had been moved from the skilled nursing facility to the current facility until s/he received a text message on his/her phone on 10/02/2025 informing him/her Licensee A would be going out of the country. Legal Representative D said s/he did not know who Licensee A was and returned a text back to Licensee A that Resident 4 did not reside at this facility. Legal Representative D said s/he contacted Resident 4's funding agency and they reported Resident 4 did not like that skilled nursing home and had been moved to this current facility. Legal Representative D said s/he was not happy this decision was made without him/her being made aware, but s/he did not know what to do about it.
Legal Representative D said s/he recalled a

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 _____	R-C 09/23/2026

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 424	Continued From page 44 meeting in March 2026 with Resident 4's funding agency case managers at that time and House Manager B. Legal Representative D said House Manager B mentioned Resident 4's response to cares was becoming more challenging, but not that s/he was refusing to receive cares and/or transfer assistance. Legal Representative D said s/he asked for weekly calls from House Manager B and/or facility staff on duty so s/he could speak to Resident 4 and receive updates from the staff. Legal Representative D said s/he requested the facility call him/her because Resident 4 did not have a personal phone and s/he did not want to call the facility phone in case s/he interrupted cares. Legal Representative D said "this [calls from the facility] did not happen" and voiced the same request during the meeting with House Manager B, RN CM N and CM M on 09/08/2026. Legal Representative D said s/he did receive an email from House Manager B with an ISP attached in June 2026. Legal Representative D said s/he was not sure if s/he had signed it and returned it to the facility, or that s/he was requested to do so. Legal Representative D said no one from the facility, including House Manager B, had reached out to him/her to request his/her signature for an ISP for Resident 4 since that email. Legal Representative D said the ISP sent to him/her in June 2026 was the only time anyone associated with the facility had presented him/her with an ISP for Resident 4. On 09/15/2026 at approximately 2:00 P.M., Surveyors conducted an interview with Licensee A and House Manager B. Licensee A verbally acknowledged s/he would have benefited from having consulted and collaborated with an RN, as required in special order #1 issued to Licensee A on 06/08/2026, to work on correcting this noncompliance.	M 424		

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 _____	R-C 09/23/2026

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

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M 424	Continued From page 45 Cross Reference: M0216 DHS 88.04(2)(a) Responsibilities M0244 DHS 88.04(5)(a) Training 15 Hours Within 6 Months M0380 DHS 88.06(2)(a) Admissions Health Exam M0384 DHS 88.06(2)(b) Service Agreement Except Respite M0580 DHS 8810(3)(p) Prompt And Adequate Treatment	M 424		
M 446	88.07(2)(b)4 RECORD OF MEDICAL VISITS AND REPORTS Keeping a current record of all medical visits, reports and recommendations for a resident. This Rule is not met as evidenced by: Based on interview and record review, the provider did not keep record of all medical visits, reports, and recommendations for the residents. The provider did not have any documentation of Resident 3's medical appointments or psychiatric appointments. The findings include: On 09/15/2026 Surveyors conducted a verification visit. Surveyor reviewed Resident 3's record which included the following: Resident 3 admitted to the home on 10/13/2025 with diagnosis including conduct disorder, neuroleptic malignant syndrome, bipolar disorder, and cerebral vascular accident. Resident 3's record did not include any documentation of visits with a medical doctor or a psychiatrist.	M 446		

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 _____	R-C 09/23/2026

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

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M 446	Continued From page 46 On 09/15/2026 at approximately 9:40 AM, Surveyor interviewed Resident 3. Resident 3 reported s/he recently fired his/her psychiatrist because s/he was trying to prescribe more medication, which Resident 3 did not want. Resident 3 denied any recent injuries or illnesses but stated House Manager B would get an appointment scheduled right away if a need came up. On 09/15/2026 at approximately 12:35 PM, Surveyor asked House Manager B where Resident 3's medical records were. S/he showed Surveyor appointment cards, but stated s/he does not get any other information when s/he has taken Resident 3 to doctor appointments. House Manager B stated Resident 3 has been to medical appointments and psychiatry appointments and at the most recent appointment (date unknown) the doctor told him/her they could get a copy of the record "next time". When Surveyor asked, House Manager B stated s/he did not try to explain who s/he was or why the records were needed. Cross Reference: M0216 DHS 88.04(2)(a) Responsibilities	M 446		
M 466	88.07(3)(e)1 MEDICATION- RECORD KEEPING The licensee shall keep a record of all prescription medications controlled, dispensed or administered by the licensee which show the name of the resident, the name of the particular medication, the date and time the resident took the medication and errors and omissions. The	M 466		

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 _____	R-C 09/23/2026

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

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M 466	Continued From page 47 medication controlled by the licensee shall be kept in a locked place. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure a record was kept of all prescription medications controlled, dispensed or administered by staff including the names of the medications, date and time resident took the medications for Resident 4. The findings include: On 09/15/2026 at 8:55 A.M., Surveyor observed Licensee A enter the facility and conducted an entrance meeting with Licensee A. Licensee A told Surveyor s/he had returned to the United States on 09/05/2026 after being out of the country for approximately 11 months. Licensee A told Surveyor hand-written documentation was utilized exclusively at the facility, including documentation of medication administration on medication administration records [MARs] printed by the pharmacy. On 09/15/2026 at 9:36 A.M., Surveyor observed Caregiver C administer morning medications to Resident 4 seated in a wheelchair at the dining room table. Caregiver C removed two blister pack cards labeled with Resident 4's name from a file cabinet located in the facility's medication closet. Surveyor observed Caregiver C remove the following medications from one blister on one of the blister pack cards: One (1) divalproex (Depakote; a psychotropic medication) ER (extended release) 250 mg (milligram) tablet; 1 duloxetine (Cymbalta; a psychotropic medication) 30 mg capsule; 1 Lisin (lisinopril) 20 mg/HCTZ	M 466		

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 _____	R-C 09/23/2026

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 466	Continued From page 48	M 466		

(hydrochlorothiazide) (a combination blood pressure/diuretic medication) 12.5 mg tablet; and 1 quetiapine (Seroquel; a psychotropic medication) 100 mg tablet. Surveyor observed Caregiver C remove the following medication from one blister on another of the blister pack cards: 1 divalproex ER 500 mg tablet. Surveyor observed Caregiver C did not review and or document administration of Resident 4's medications on a MAR.

On 09/15/2026 at 9:45 A.M., Surveyor observed House Manager B arrive at the facility.

On 09/15/2026, Surveyor reviewed Resident 4's record, as provided by House Manager B. Resident 4 was admitted to the home on 09/29/2025 with diagnoses including dementia with agitation, depression, anxiety, visual hallucinations, speech disturbances, and hypertension (elevated blood pressure). Surveyor was unable to locate a current MAR for Resident 4.
At 11:32 A.M., House Manager B told Resident 4's current MAR was not available at the facility because s/he had taken it to his/her private home to review it and check that everything was correct on the MAR. House Manager B said s/he took each resident's MAR home once during the middle of the pharmacy cycle and at the end of each cycle. House Manager B said all medications to be administered to residents are listed on their individual blister packs and Caregiver C documents administration of medications within each resident's daily notes at the end of the day. Surveyor reviewed Resident 4's daily notes for 09/15/2026, in which Resident 4's medication morning medications were not documented as administered. Surveyor reviewed Resident 4's daily notes for 09/14/2026 in which

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 _____	R-C 09/23/2026

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 466	Continued From page 49 the documentation included medications were administered but did not include the name of the particular medications nor the time Resident 4 took the medication. At 11:40 A.M., Surveyor observed Resident 4's evening medication blister pack card. This blister pack card included the following medications to be administered at 8:00 P.M. every evening: 1 donepezil (Aricept; a dementia-related medication); 1 duloxetine 30 mg capsule; 1 prazosin (blood pressure medication) 5mg capsule; 1 quetiapine 100 mg tablet; and 1 trazadone (a psychotropic medication) 100 mg tablet. On 09/17/2026 at 4:08 P.M., Surveyor conducted an interview with Resident 4's funding agency RN Case Manager (CM) N. RN CM N told Surveyor s/he had noticed resident MARs not being available at the facility during his/her recent visits to the home. On 09/15/2026 at approximately 2:00 P.M., Surveyors conducted an interview with Licensee A and House Manager B. Licensee A told Surveyors s/he would ensure resident MARs were available at the facility in the future. Cross Reference: M0216 DHS 88.04(2)(a) Responsibilities	M 466		
M 550	88.10(3)(b) Privacy Privacy. To have physical and emotional privacy in treatment, living arrangements and in caring for personal needs, including toileting, bathing and dressing. The resident, the resident's room, any other area in	M 550		

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 _____	R-C 09/23/2026

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 550	Continued From page 50 which the resident has reasonable expectation of privacy, and the personal belongings of a resident shall not be searched without the resident's permission or permission of the resident's guardian except when there is reasonable cause to believe that the resident possesses contraband. The resident shall be present for the search. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure Resident 4 was provided with physical and emotional privacy during Resident 4's personal care services, including incontinence care and dressing. The findings include: On 09/15/2026 at 8:30 A.M., Surveyors entered the home/facility and met with Caregiver C. Caregiver C told Surveyors s/he continued to live at the facility with 3 current residents, including Resident 4, and was their primary caregiver. On 09/15/2026 at 8:45 A.M., Caregiver C told Surveyor Resident 4 remained in his/her bedroom asleep with the bedroom door shut at this time. Surveyor observed Resident 4's bedroom door was located within sight of the kitchen and dining area of the facility. On 09/15/2026 at 8:55 A.M., Surveyor observed Licensee A enter the facility and conducted an entrance meeting with Licensee A. Licensee A told Surveyor s/he had returned to the United States on 09/05/2026 after being out of the country for approximately 11 months.	M 550		

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 _____	R-C 09/23/2026

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 550	Continued From page 51 On 09/15/2026 at approximately 9:28 A.M., Licensee A and Surveyors were seated at a table located in the home's dining area. Surveyor observed Caregiver C enter Resident 4's room and provided Resident 4 with incontinence care and assistance with donning an incontinence brief and clothing while Resident 4's bedroom door was wide open. Resident 4 was without clothing for a portion of this observation and was completely visible to Surveyors seated at the dining room table. During this time, Resident 3 was observed to walk past Resident 4's open bedroom door several times to gain access to the home's kitchen and/or to exit the back of the home to go outside. During this observation, Surveyor observed Licensee A partially shut Resident 4's bedroom door. Resident 4's body remained visible through the partially closed door. Surveyor entered Resident 4's partially closed door to observe Caregiver C provide the remainder of Resident 4's cares, including assisting Resident 4 transfer to a wheelchair. Caregiver C told Surveyor Resident 4 had been incontinent of urine. On 09/15/2026 at 9:45 A.M., Surveyor observed House Manager B arrive at the facility. On 09/15/2026, Surveyor reviewed Resident 4's record, as provided by House Manager B. Resident 4 was admitted to the home on 09/29/2025 with diagnoses including dementia with agitation, depression, anxiety, visual hallucinations, and speech disturbances. At 11:02 A.M., House Manager B provided Surveyor with Resident 4's unsigned individual service plan (ISP). The documentation included, "Plan date: 03/25/2026." The documentation included, "[Resident 4] requires full assistance with daily living tasks, including dressing, bathing,	M 550		

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 _____	R-C 09/23/2026

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

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M 550	Continued From page 52 grooming, toileting, meal preparation, mobility, and household routines." On 09/15/2026 at approximately 2:00 P.M., Surveyors conducted an interview with Licensee A and House Manager B. Licensee A told Surveyor Caregiver C considered this facility as an "all [gender]" facility so Resident 4's bedroom door was not shut when assisting Resident 4 with personal cares. Licensee A said s/he understood this was a problem and that everyone deserved privacy. Cross Reference: M0216 DHS 88.04(2)(a) Responsibilities M0244 DHS 88.04(5)(a) Training 15 Hours Within 6 Months	M 550		
{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 4 received prompt and adequate treatment and services appropriate to Resident 4's needs. Resident 4 experienced a significant change in behavior between the months of May 2026 and September 2026 impacting how often Resident 4 was assisted with toileting and/or showers. The provider did not ensure Resident 4's Legal Representative D and funding agency care team were made aware of these changes within a timely manner of occurrence. The provider did	{M 580}		

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	0019817	A. BUILDING: _____ B. WING _____	R-C 09/23/2026

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{M 580}	Continued From page 53 not ensure Resident 4's record included incident documentation related to changes in behavior and changes in cares provided, including not developing and updating an agreed upon plan regarding these changes. Resident 4 continued to not receive health examination for approximately one year following admission to the facility, to include an evaluation of Resident 4's changes in behavior. This requirement is being cited for a second time. See Statement of Deficiency (SOD) J0TC11, issued on 06/08/2026. The findings include: On 09/15/2026 at 8:30 A.M., Surveyors entered the home/facility and met with Caregiver C. Caregiver C told Surveyors s/he continued to live at the facility with 3 current residents, including Resident 4, and was their primary caregiver. On 09/15/2026 at 8:55 A.M., Surveyor observed Licensee A enter the facility and conducted an entrance meeting with Licensee A. Licensee A told Surveyor s/he had returned to the United States on 09/05/2026 after being out of the country for approximately 11 months. Surveyor reviewed with Licensee A the Notice and Order letter issued to Licensee A on 06/08/2026, including special order #1. Licensee A was to ensure special order #1 was to be completed within 45 days, by 07/23/2026. Licensee A verbally acknowledged receiving statement of deficiency (SOD) J0TC11 and this letter while s/he was out of the country. Licensee A said s/he had "misinterpreted the letter" and s/he had not consulted with nor collaborated with a registered nurse (RN), as required, to correct each deficiency identified within SOD J0TC11,	{M 580}		

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{M 580}	Continued From page 54	{M 580}		

including this noncompliance.

On 09/15/2026 at 8:45 A.M., Caregiver C told Surveyor Resident 4 remained in his/her bedroom asleep with the bedroom door shut at this time.

On 09/15/2026 at approximately 9:28 A.M., Surveyor observed personal cares being provided to Resident 4 by Caregiver C, including incontinence care and assistance with donning an incontinence brief and clothing. Surveyor observed Resident 4 required several verbal prompts by Caregiver C to stand and pivot transfer from Resident 4's bed to a wheelchair located near Resident 4's bed while Caregiver C also provided Resident 4 with physical assistance. Caregiver C told Surveyor Resident 4 had been incontinent of urine. Caregiver C proceeded to propel Resident 4 in his/her wheelchair to the dining room table followed by serving Resident 4 breakfast and administering Resident 4's morning medications.

On 09/15/2026 at 9:45 A.M., Surveyor observed House Manager B arrive at the facility.

On 09/15/2026 at 9:53 A.M., House Manager B told Surveyor Resident 4 was admitted to the facility without a primary care physician or practitioner, continued to not have a current primary care or psychiatric physician/practitioner, and had not had a health examination. House Manager B told Surveyor Resident 4 required full assistance with all cares, medication administration, and had experienced an increase in "violent" behavior within recent months when provided with shower and toileting assistance. House Manager B said it had become increasing difficult to provide personal cares to Resident 4 related to his/her "violent" behavior since

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 _____	R-C 09/23/2026

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{M 580}	Continued From page 55	{M 580}		

approximately March 2026. House Manager B said Resident 4 had been provided with shower assistance 2 times per week, but was currently being provided with "bed baths." House Manager B said Caregiver C did his/her best to provide Resident 4 with shower assistance twice per month. House Manager B said Resident 4 had been provided with physical assistance with transfers to the toilet twice a day, but s/he was not sure how often Resident 4 was currently being physically assisted to the toilet. Surveyor observed House Manager B ask Caregiver C how often s/he assisted Resident 4 to sit on the toilet and Caregiver C responded it had changed to twice a week related to Resident 4's behavior. House Manager B said Resident 4's funding agency case management team was aware of Resident 4's "violent behavior" and that Resident 4's Legal Representative D was not responsive to getting a primary care physician/practitioner established for Resident 4, including a psychiatric evaluation related to behaviors. House Manager B told Surveyor Resident 4 was not "violent" with other residents in the facility. House Manager B said Resident 4 would become violent during cares, including showers and toileting, by striking out and yelling at the caregiver providing assistance, primarily Caregiver C.

On 09/15/2026 from approximately 10:00 A.M. until approximately 3:00 P.M., Surveyor observed Resident 4 seated on a couch located in the facility's shared living room.

On 09/15/2026, Surveyor reviewed Resident 4's record, as provided by House Manager B. Resident 4 was admitted to the home on 09/29/2025 with diagnoses including dementia with agitation, depression, anxiety, visual hallucinations, speech disturbances, and

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	0019817	A. BUILDING: _____ B. WING _____	R-C 09/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{M 580}	Continued From page 56	{M 580}		

hypertension (elevated blood pressure). Resident 4's record did not include documentation of a health examination being completed following Resident 4's admission to the facility. At approximately 10:50 A.M., House Manager B told Surveyor the only time Resident 4 was seen by a physician/practitioner since Resident 4's admission to the facility was on 02/11/2026 when Resident 4 was seen at a local urgent care center related to complaints of back pain. House Manager B said Resident 4 did not receive a complete health examination during this visit and was immediately sent back to the facility without any physician/practitioner orders.
At 11:02 A.M., House Manager B provided Surveyor with Resident 4's most recent, available individual service plan (ISP), dated 03/25/026 and not signed. The ISP included, "Primary support needs: Assistance with all activities of daily living (ADLs); behavioral support for verbal and physical aggression..." The ISP included, "To support long-term toileting readiness, [Resident 4] is seated on the toilet twice a day (morning and evening) to help [him/her] become familiar with the routine. Staff to use calm, encouraging language during toilet-sitting to build comfort and reduce resistance." The ISP included, "Behavioral Concerns: Staff should be aware that toileting and [incontinence product] changes may be moments of increased vulnerability or agitation for [Resident 4]" and included documentation related to observed "triggers," "prevention strategies," "de-escalation strategies," "safety measures," and "social and emotional support." Resident 4's ISP included "short-term goals" including, "[Resident 4] will sit on the toilet twice daily with staff support to build familiarity with toileting routines. [Resident 4] will tolerate [incontinence product] changes with fewer signs of agitation. [Resident 4] will experience fewer

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	0019817	A. BUILDING: _____ B. WING _____	R-C 09/23/2026

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{M 580}	Continued From page 57	{M 580}		

aggressive episodes through consistent use of prevention strategies." Resident 4's ISP included "long-term goals" including, "Improve emotional regulation with staff guidance, Increase cooperation with the daily routine." Resident 4's ISP included "Staff responsibilities" including, "Follow all ADL support procedures consistently. Use approved behavioral strategies at all times. Maintain accurate documentation of behaviors, progress, and incidents. Communicate changes or concerns with supervisor immediately."
Resident 4's ISP did not include Resident 4's increased "violent" behavior impacting how cares were provided to Resident 4 including changing how often Resident 4 would be assisted to the toilet and how often Resident 4 would be provided with a shower. At approximately 11:09 A.M., House Manager B verbally clarified s/he was not sure when Resident 4's behaviors had become increasingly violent, except that it was after this ISP was documented on 03/25/2026, and that was approximately when Caregiver C reduced Resident 4's transfers to the toilet to 2 times per week. House Manager B told Surveyor Resident 4's record did not contain documentation of specific incidents of Resident 4's increased "violent" behavior during this time frame. House Manager B said s/he was able to locate documentation of a discussion regarding Resident 4's increased behaviors from a meeting on 07/07/2026.
Resident 4's record included a hand-written note dated 07/07/2026 and "Visit of [funding agency] about [Resident 2, Resident 3, and Resident 4]." The document included, "[Resident 4's funding agency RN Case Manager (CM) N] and [Resident 4's funding agency Case Manager (CM) P]" contact information. The documentation included, "[Resident 4] still don't [sic] have any physician, psychiatrist, and personal money as discussed

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	0019817	A. BUILDING: _____ B. WING _____	R-C 09/23/2026

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{M 580}	Continued From page 58	{M 580}		

during last meeting with [Funding Agency] and [Legal Representative D]. [Resident 4] is violent when staff want to give [him/her] personal care (removing pants, changing...). No changing of medication. Record each time that we [facility staff] talk or each time that the [Legal Representative D] contacts the staff about [Resident 4]."
House Manager B said s/he was not aware of Resident 4 experiencing any other significant change in his/her condition other than Resident 4's increased "violent" behaviors with cares.

On 09/15/2026 at approximately 12:36 P.M., House Manager B told Surveyor s/he met with Resident 4's RN CM N and Resident 4's current funding agency Case Manager [CM] M at the facility with Resident 4's Legal Representative D on "Zoom" on 09/08/2026. House Manager B said s/he discussed Resident 4's continued need for a primary care physician/practitioner and a plan to assist getting an appointment set up for Resident 4. House Manager B said s/he did not have any documentation of this meeting.

On 09/17/2026 at 12:25 P.M., Surveyor conducted an interview with Resident 4's CM M. CM M told Surveyor s/he was newly assigned as Resident 4's funding agency case manager on 09/07/2026. CM M said s/he met with Resident 4, RN CM N, and House Manager B at the facility and with Legal Representative D on "Zoom" on 09/08/2026. CM M said Licensee A did not attend this meeting in any manner. CM M said s/he and RN CM N were aware Resident 4 has not had a primary care physician/practitioner or health examination since his/her admission to the facility in September 2025. CM M said s/he was under the impression Legal Representative D was not aware until recently Resident 4 did not have a

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	0019817	A. BUILDING: _____ B. WING _____	R-C 09/23/2026

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BLISS HOMES	1012 N BEL AYR DR WAUKESHA, WI 53188

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{M 580}	Continued From page 59	{M 580}		

primary care physician/practitioner since his/her admission to the facility. CM M said Legal Representative D said s/he had found a primary care physician/practitioner for Resident 4 and would be contacting them to set up an appointment. CM M said Legal Representative D requested an increase in telephone communication from the facility regarding Resident 4. CM M said it was determined during this meeting Legal Representative D was to receive weekly phone calls from the facility staff to discuss any updates related to Resident 4 and so s/he could speak with Resident 4. CM M said Legal Representative D can be difficult to get a hold of on the phone because of his/her other personal commitments and verbalized the best time to call him/her was after 9:00 A.M. during the week. CM M said s/he was not aware Legal Representative D had not been responsive to the facility.

CM M said Resident 4's change in behavior was discussed during the meeting on 09/08/2026 including House Manager B informing CM M and RN CM N Resident 4 had become uncooperative with pivot transfers. CM M said House Manager B discussed Resident 4 was no longer provided assistance with transfers to the toilet anymore related to behaviors including physical aggression. CM M said this was the first time s/he and RN CM N were made aware Resident 4's behavior had increased to the point the facility staff were no longer providing Resident 4 with transfer assistance to the toilet. CM M said House Manager B said Resident 4 was more "violent against" Caregiver C and Caregiver C perceived Resident 4's behavior as personal. CM M told Surveyor s/he and RN CM N communicated with House Manager B during the 09/08/2026 meeting that Resident 4's case management team, CM M and RN CM N, needed

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

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{M 580}	Continued From page 60 to receive communication regarding this type of condition change notification when the change initially begins to occur, which did not happen in this case regarding Resident 4's change in behavior. CM M said s/he and RN CM N captured this change in Resident 4's behavior and care within their funding agency's member centered plan and a result of the 09/08/2026 discussion with House Manager B, but did not see it updated within Resident 4's available facility ISP. On 09/17/2026 at 4:08 P.M., Surveyor conducted an interview with Resident 4's RN CM N. RN CM N told Surveyor s/he was newly assigned as Resident 4's funding agency RN case manager within last 6 months. RN CM N said Resident 4 was admitted to a skilled nursing facility related to a hip fracture before being admitted to the facility in September 2025. RN CM N said Resident 4 likely utilized the primary care physician associated with the skilled nursing facility during his/her stay, and that coverage would have ended at the time Resident 4 was discharged from the skilled nursing facility. RN CM N said House Manager B mentioned Resident 4 was experiencing increased behaviors in or about March 2026 and RN CM N discussed, at that time, Resident 4's need to have a primary care physician/practitioner established, including a health examination and psychotropic medication review. RN CM N told Surveyor House Manager B mentioned Resident 4 continued to be without a primary care physician/practitioner during the meeting on 09/08/2026. RN CM N said Legal Representative D informed us all at this meeting s/he was going to establish an appointment with a primary care physician/practitioner for Resident 4's health examination. RN CM N said s/he	{M 580}		

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	0019817	A. BUILDING: _____ B. WING _____	R-C 09/23/2026

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BLISS HOMES	1012 N BEL AYR DR WAUKESHA, WI 53188

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{M 580}	Continued From page 61 asked House Manager B to set up a psychiatric care appointment while Resident 4 was at the primary heath examination and House Manager B agreed to do so. On 09/23/2026 at 9:24 A.M., Surveyor conducted an interview with Legal Representative D. Legal Representative D told Surveyor s/he has been Resident 4's court appointed guardian since 2018/2019 and s/he lived an approximate 4 hour drive away from Resident 4's current location. Legal Representative D said Resident 4 originally lived in facilities near his/her home and it was easier for Legal Representative D to visit Resident 4. Legal Representative D said Resident 4 experienced increased behavioral issues at these facilities and Resident 4's funding agency moved Resident 4 to a facility closer to his/her current location in the Milwaukee metropolitan area. Legal Representative D said Resident 4 experienced a fall resulting in a fractured hip in 2025 at one of these facilities before being admitted to a skilled nursing facility in Kenosha, WI. Legal Representative D said s/he was not made aware Resident 4 had been moved from the skilled nursing facility to the current facility until s/he received a text message on his/her phone on 10/02/2025 informing him/her Licensee A would be going out of the country. Legal Representative D said s/he did not know who Licensee A was and returned a text back to Licensee A that Resident 4 did not reside at this facility. Legal Representative D said s/he contacted Resident 4's funding agency and they reported Resident 4 did not like that skilled nursing home and had been moved to this current facility. Legal Representative D said s/he was not happy this decision was made without him/her being made aware, but s/he did not know what to do about it.	{M 580}		

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 _____	R-C 09/23/2026

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{M 580}	Continued From page 62 Legal Representative D said s/he recalled a meeting in March 2026 with Resident 4's funding agency case managers at that time and House Manager B. Legal Representative D said House Manager B mentioned Resident 4's response to cares was becoming more challenging, but not that s/he was refusing to receive cares and/or transfer assistance. Legal Representative D said s/he asked for weekly calls from House Manager B and/or facility staff on duty so s/he could speak to Resident 4 and receive updates from the staff. Legal Representative D said s/he requested the facility call him/her because Resident 4 did not have a personal phone and s/he did not want to call the facility phone in case s/he interrupted cares. Legal Representative D said "this [calls from the facility] did not happen" and voiced the same request during the meeting with House Manager B, RN CM N and CM M on 09/08/2026. Legal Representative D said s/he was not made aware Resident 4 did not have an active/current primary care physician/practitioner until the meeting in March 2026. Legal Representative D said s/he communicated it was not easy for him/her to travel to Resident 4's current facility and Resident 4 did not have a current state I.D. card because all of his/her possessions were lost during recent moves so it may take some time. Legal Representative D said s/he was able to find a primary care physician/practitioner for Resident 4 and his/her health exam appointment was set for 10/27/2026. Legal Representative D said s/he informed House Manager B of this appointment. House Manager B said s/he would be transporting Resident 4 to this appointment and asking for a psychiatric recommendation once the primary care physician/practitioner has been established. On 09/15/2026 at approximately 2:00 P.M.,	{M 580}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLISS HOMES	1012 N BEL AYR DR WAUKESHA, WI 53188

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{M 580}	Continued From page 63 Surveyors conducted an interview with Licensee A and House Manager B. Licensee A verbally acknowledged s/he would have benefited from having consulted and collaborated with an RN, as required in special order #1 issued to Licensee A on 06/08/2026, to work on correcting this noncompliance. Cross Reference: M0216 DHS 88.04(2)(a) Responsibilities M0244 DHS 88.04(5)(a) Training 15 Hours Within 6 Months M0246 DHS 88.04(5)(b) Training - 8 Hours Annually M0384 DHS 88.06(2)(b) Service Agreement Except Respite M0424 DHS 88.06(3)(f) Review Of ISP	{M 580}		