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	0018835	A. BUILDING: _____ B. WING _____	R-C 06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAYTON CARE CENTER	521 59TH STREET KENOSHA, WI 53140

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 000}	Initial Comments On 06/16/2026, Surveyors completed a standard survey, verification visit, 2 complaint investigations, and 1 self-report review at Dayton Care Center. As a result, 25 deficiencies were identified. Nine of the 25 deficiencies were repeat violations (see Statement of Deficiency (SOD) Q5Z511, dated 03/24/2025, SOD JF3C11, dated 12/12/2024, and SOD JF3C12, dated 09/02/2025). One of the 25 deficiencies is being cited for a third time (see SOD JF3C12, dated 09/02/2025 and SOD JF3C13, dated 04/07/2026). Two of 2 complaints were substantiated. One of 1 self-report was substantiated. Under statutory provisions of Wis. Stat. C. 50, a $200 revisit fee is being assessed. Census: 73	{N 000}		
N 172	83.12(6) Documentation requirements for written report All written reports required under this section shall include, at a minimum, the time, date, place, individuals involved, details of the occurrence, and the action taken by the provider to ensure residents ' health, safety and well-being. This Rule is not met as evidenced by: Based on record review and interview, the provider did not have a written report for a resident death related to a suicide for 1 of 1 resident (Resident 6) reviewed that included, at	N 172		

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

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N 172	Continued From page 1	N 172		

minimum, the time, date, place, individuals involved, details of the occurrence, and the action taken by the provider to ensure the residents' health, safety, and well-being.

Findings include:

On 04/07/2026, the department received a self-report regarding a resident's death.

On 06/16/2026 at approximately 11:00 AM, Surveyor reviewed Resident 6's record. Resident 6 was admitted into the home on 05/02/2022 with diagnoses including major depressive disorder and Schizophrenia. Within Resident 6's record, Surveyor reviewed a document titled, "Investigation to [Resident 6] suicide on 04/07/2026." The document stated the following: "On this day 04/09/2026 I, [Administrator A] investigated to see if [Resident 6] spoke to anyone about wanting to commit suicide at anytime [sic]. A couple of friends stated that it was a topic of conversation but they did not think [he/she] was going to do that because they spoke about it several times. There was no sign of anyone else being in [his/her] room or any signs of a struggle by the window in [his/her] room. Kenosha police have done their investigation and I am waiting for the police report."

On 06/16/2026 at approximately 2:25 PM, Surveyors interviewed Administrator A and Business Office Manager C. Administrator A reported completing the investigation and interviewing other residents. Administrator A acknowledged his/her investigation document did not include the time, date, place, individuals involved, details of the occurrence, and the action taken by the provider to ensure residents' health, safety, and well-being. Administrator A confirmed

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N 172	Continued From page 2 not reading Wisconsin Administrative Code Department of Health Services (DHS) Chapter 83. Therefore, Administrator A acknowledged he/she was not aware of the code requirements related to what information was to be included in a written report.	N 172		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis (TB), within 90 days before the start of employment for 2 of 3 employees reviewed (Licensed Practical Nurse (LPN) H and Caregiver G). LPN H's communicable disease screening was completed 14 days after the start of employment and TB was 5 days after start of	N 220		

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N 220	Continued From page 3 employment. Caregiver G's communicable disease screening was not signed indicated s/he was screened by a physician, physician assistant, clinical nurse practitioner, or a licensed registered nurse. Findings include: On 06/16/2026, at 11:40 AM, Surveyors reviewed staff records and identified the following: LPN H was hired on 11/12/2025. LPN H's record contained a TB test dated 11/17/2025 which was 5 days after the start of employment. LPN H's record contained a communicable disease screening dated 11/26/2025, which was 14 days after the start of employment. Caregiver G was hired on 10/24/2025. Caregiver G's record contained a TB test dated 10/20/2025. Caregiver G's record contained a communicable disease screening, dated 10/24/2025. The communicable disease screening was signed by Caregiver G. The communicable disease screening was not signed by a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse to indicate Caregiver G was free from communicable diseases. On 06/16/2026 at 2:25 PM, Surveyors interviewed Administrator A and Business Office Manager (BOM) C. Administrator A and BOM C confirmed the code requirement. BOM C reported they would ensure staff were screened as required by the code.	N 220		
N 239	83.20(2)(a)-(d) Department-approved training courses.	N 239		

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N 239	Continued From page 4 Standard Precautions. All employees who may be occupationally 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 before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 employees obtained all department approved training as required. Licensed Practical Nurse (LPN) H did not have training in fire safety within 90 days after starting employment. This is a repeat deficiency. See Statement of Deficiency (SOD) JF3C11, dated 12/12/2024.	N 239		

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N 239	Continued From page 5 Findings include: On 06/16/2026, at 11:40 AM, Surveyors reviewed LPN H's record. LPN H was hired on 11/12/2025. LPN H's record did not contain evidence of training or evidence of meeting an exemption for fire safety. On 06/16/2026, Surveyors verified LPN H was not on the Community-Based Care and Treatment training registry for fire safety. On 06/16/2026 at 2:25 PM, Surveyors interviewed Administrator A and Business Office Manager (BOM) C. BOM C reported s/he was unaware LPN H needed fire safety and thought LPN H was exempt from all training. BOM C confirmed LPN H did not meet the exemption for fire safety.	N 239		
N 243	83.21(1)-(3) All employee training. The CBRF shall provide, obtain or otherwise ensure adequate training for all employees in all of the following: Resident rights. Training shall include general rights of residents including rights as specified under s. DHS 83.32(3). Training shall be provided as applicable under ss. 50.09 and 51.61 and chs. 54, 55, and 304, Stats., and ch. DHS 94, depending on the legal status of the resident or service the resident is receiving. Specific training topics shall include house rules, coercion, retaliation, confidentiality, restraints, self-determination, and the CBRF ' s complaint and grievance procedures. Residents ' rights training shall be completed within 90 days after starting employment. Client Group. Training shall be specific to the client group served and shall include the physical,	N 243		

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N 243	Continued From page 6 social and mental health needs of the client group. Specific training topics shall include, as applicable: characteristics of the client group served, activities, safety risks, environmental considerations, disease processes, communication skills, nutritional needs, and vocational abilities. Client group specific training shall be completed within 90 days after starting employment. Client Group. In a CBRF serving more than one client group, employees shall receive training for each client group. Recognizing, preventing, managing, and responding to challenging behaviors. Specific training topics shall include, as applicable: elopement, aggressive behaviors, destruction of property, suicide prevention, self-injurious behavior, resident supervision, and changes in condition. Challenging behaviors training shall be completed within 90 days after starting employment. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 employees reviewed, obtained all training as required within 90 days after starting employment. Caregiver G did not have training in required client groups within 90 days of starting employment. This is a repeat deficiency. See Statement of Deficiency (SOD) JF3C11, dated 12/12/2024.	N 243		

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N 243	Continued From page 7 Findings include: The facility was licensed to provide care and services to residents within the client groups of irreversible dementia/Alzheimer's, advanced aged, traumatic brain injury and developmentally disabled. On 06/16/2026, at 11:40 AM, Surveyors reviewed Caregiver G's file. Caregiver G was hired on 10/24/2025. Caregiver G's record indicated s/he received training in Alzheimer's/dementia and intellectual disability. Caregiver G's record did not contain evidence of client group training or evidence of meeting an exemption for client group training in the topics of advanced aged and traumatic brain injury. On 06/16/2026 at 2:25 PM, Surveyors interviewed Administrator A and Business Office Manager (BOM) C. BOM C confirmed all residents who resided at the facility did not fall into those client groups. BOM C reported s/he was surprised they did not have emotionally disturbed/mental illness listed as a client group. BOM C reported they would ensure all client groups within the facility were trained as required.	N 243		
N 277	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5)	N 277		

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N 277	Continued From page 8 Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 staff (Licensed Practical Nurse (LPN) D) reviewed received 15 hours annual training in all required areas. LPN D did not receive training in medications and all required client groups in 2025. LPN D did not receive training in medications, all required client groups, resident rights and fire safety, 1st aid and emergency procedures in 2024. Findings include: The facility was licensed to provide care and services to residents within the client groups of irreversible dementia/Alzheimer's, advanced aged, traumatic brain injury and developmentally disabled. On 06/16/2026, at 11:40 AM, Surveyors reviewed LPN D record. LPN D was hired on 05/02/2022. LPN D's record contained the following trainings: 2026 - Life skills for adults with intellectual disabilities - 2 hours - Preventing and reporting abuse and neglect - 2 hours - Evacuation procedures in long term care - 2 hours - Prevention and detection of fraud, waste and abuse - 2 hours - HIPPA: requirements and compliance - 2 hours	N 277		

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N 277	Continued From page 9 - Standard precautions when caring for adults - 2 hours - Skin care basics for caregivers - 2 hours 2025 - [Community based residential facility] (CBRF) Resident rights - Changes to condition - Behavior that challenges - Misconduct, neglect, and misappropriation - Disaster plan policy and procedure - Evacuation plan - Job responsibilities - Understanding Alzheimer's and dementia Surveyors were unable to locate evidence of LPN D's 2024 continuing education training in her/his file. At 1:00 PM Business Office Manager (BOM) C handed Surveyor a packet and confirmed it was the packet they use for continuing education. The packet contained the following trainings: Life skills for adults with intellectual disabilities - 2 hours, Preventing and reporting abuse and neglect - 2 hours, Evacuation procedures in long term care - 2 hours, Prevention and detection of fraud, waste and abuse - 2 hours, HIPPA: requirements and compliance - 2 hours, Standard precautions when caring for adults - 2 hours, Skin care basics for caregivers - 2 hours. At 2:25 PM, BOM C handed Surveyor a booklet which was titled "2026 Adult Care Training for WI Community-Based Residential Facilities 15 Hours". On 06/16/2026 at 2:25 PM, Surveyors interviewed Administrator A and BOM C. BOM C reported the booklet was used to create the training for staff.	N 277		

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N 277	Continued From page 10 BOM C confirmed the training document which was created did not match all of the topics listed as required by the code. BOM C and Administrator A confirmed they had not reviewed the codes to ensure they were compliant. BOM C stated, "We went off our last survey and thought we were good." BOM C reported s/he would review the code to ensure they were in compliance with all staff training.	N 277		
N 283	83.26(1) Documentation of required employee training The CBRF shall maintain documentation of all employee training under s. DHS 83.21 and task specific training under s. DHS 83.22 and shall include the name of the employee, the name of the instructor, the dates of training, a description of the course content, and the length of the training. This Rule is not met as evidenced by: Based on record review and interview, the provider did not maintain documentation of all employee training under Wis. Admin Code § DHS 83.21 in 1 of 1 staff (Caregiver G) record reviewed. Caregiver LM record did not contain documentation of the name of the instructor, the date(s) of the training, or a description of the course content for training under Wis. Admin Code § DHS 83.21. Wis. Admin Code § DHS 83.21 states, "All employee training. The CBRF shall provide, obtain or otherwise ensure adequate training for all employees in all of the following: (1) Resident Rights...(2) Client Group...(3) Recognizing, preventing, managing and responding to	N 283		

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N 283	Continued From page 11 challenging behaviors." Findings include: The facility was licensed to provide care and services to residents within the client groups of irreversible dementia/Alzheimer's, advanced aged, traumatic brain injury and developmentally disabled. On 06/16/2026, at 11:40 AM, Surveyors reviewed Caregiver G's file. Caregiver G was hired on 10/24/2025. Caregiver G's record indicated s/he received training in Alzheimer's/dementia and intellectual disability. Caregiver G's record did not have documentation in his/her record which identified the name of the instructor, the dates of the training, or a description of the course content of those trainings. On 06/16/2026 at 2:25 PM, Surveyors interviewed Administrator A and Business Office Manager (BOM) C. BOM C reported s/he handed out a packet to staff when they start employment. BOM C reported they did not have an instructor to complete the trainings with staff as the trainings were self-directed. BOM C reported s/he signs off on the sheets when staff return them to her/him. BOM C reported s/he would review the code to ensure compliance.	N 283		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the	N 352		

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N 352	Continued From page 12 right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure residents received all prescribed medications in the dosage and at intervals prescribed by a practitioner for 1 (Resident 7) of 4 residents reviewed. Resident 7 did not receive his/her medications on 04/30/2026. This is a repeat deficiency. See Statement of Deficiency Q5Z511, dated 03/24/2025. Findings include: On 06/05/2026, the department received a complaint alleging a resident was not provided with prescribed medication. On 06/16/2026 at approximately 11:00 AM, Surveyor reviewed Resident 7's record. Resident 7 was admitted on 04/28/2026 with diagnoses including hypertension and major depression. Resident 7's temporary individual service plan (ISP), dated 04/28/2026, indicated staff assisted Resident 7 with medication management and administration. Resident 7 had physician orders for the following medications: Amlodipine - 10 milligrams, take 1 tablet by mouth daily. Aripiprazole - 5 milligrams, take 1 tablet by mouth daily. Fluoxetine - 40 milligram capsules, take 1 capsule by mouth daily. Gabapentin - 300 milligrams, take 1 capsule by mouth every 12 hours.	N 352		

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N 352	Continued From page 13	N 352		

Mirtazapine - 15 milligrams, take 1 tablet by mouth nightly.
Valsartan - 160 milligrams, take 1 tablet by mouth daily.

Resident 7's April 2026 medication administration record (MAR) indicated Resident 7 was not provided with their prescribed amlodipine, aripiprazole, fluoxetine, gabapentin, mirtazapine, and valsartan on 04/31/2026 as no initial was observed on the MAR.

On 06/16/2026 at approximately 2:25 PM, Surveyors interviewed Administrator A, Business Office Manager C, and Case Manager B. Case Manager B reported receiving a phone call from Resident 7's family member as Resident 7 disclosed he/she was not given their amlodipine due to the medication falling into the garbage. Case Manager B had a conversation with Resident 7 who confirmed the incident. Resident 7 denied the caregiver offered a replacement medication. Case Manager B then had a conversation with Caregiver G who confirmed he/she dropped the medication into the garbage as he/she was administering Resident 7's medication. Caregiver G reported asking Resident 7 if he/she would like the medication from a different pack, and Resident 7 declined. Case Manager B stated he/she provided additional medication administration training to Caregiver G as the protocol was to obtain the medication from a different pack, and to contact the pharmacy to have a replacement medication delivered.

Case Manager B confirmed Caregiver G should not have asked Resident 7 if he/she would have liked Caregiver G to obtain medications from another packet. Instead Caregiver G should have

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 352	Continued From page 14 obtained Resident 7's medication from another packet to give to Resident 7.	N 352		
N 370	83.34(3) More than $200 personal funds from resident Funds in excess of $200. A CBRF receiving more than $200 of personal funds from a resident shall deposit funds in excess of $200 in an interest-bearing account in the resident ' s name in a savings institution insured by an agency of, or a corporation chartered by, this state or the United States. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 (Resident 6) of 1 resident's funds in excess of $200 was placed in an interest-bearing account in the resident's name. Resident 6's "Allowance Ledger" indicated Resident 1 had a balance of $11,048.92, managed by the provider, was not placed in an interest-bearing savings account in Resident 6's name. Resident 6's funds were placed in a trust account. Findings include: On 06/14/2026, the department received a complaint regarding concerns with resident funds. On 06/16/2026 at approximately 11:00 AM, Surveyor reviewed Resident 6's record. Resident 6 was admitted into the home on 05/02/2022 and discharged on 04/07/2026. Resident 6's record contained an "Allowance Ledger." The "Allowance Ledger" indicated Resident 6 had over $200	N 370		

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N 370	Continued From page 15 between 01/02/2026 to 04/08/2026. At the time of Resident 6's discharge, Resident 6's "Allowance Ledger" indicated Resident 6 had $11,048.92. On 06/16/2026 at approximately 2:25 PM, Surveyors interviewed Administrator A, Business Office Manager C, and Case Manager B. Business Office Manager C denied Resident 6's funds were in an interest-bearing account in the resident's name. Business Office Manager C disclosed all residents' funds are placed in 1 trust account in the facility's name. Business Office Manager C confirmed not reading Wisconsin Administrative Code Department of Health Services (DHS) Chapter 83. Therefore, Business Office Manager B was not aware of the code requirement that indicated residents' funds in excess of $200 were to be placed in an interest-bearing account in the resident's name.	N 370		
N 371	83.34(4) Provide written final accounting Final accounting. Within 14 days after a resident is discharged, the CBRF shall provide to the resident or the resident ' s legal representative a written final accounting of all the resident ' s funds held by the CBRF and shall disburse any remaining money to the resident or to the resident ' s legal representative. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that any remaining money was disbursed to the resident or resident's legal representative within 14 days of discharge. Resident 6's remaining funds were dispersed 65 days after he/she was discharged.	N 371		

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N 371	Continued From page 16 Findings include: On 06/14/2026, the department received a complaint regarding concerns with resident funds. On 06/16/2026 at approximately 11:00 AM, Surveyor reviewed Resident 6's record. Resident 6 was admitted into the home on 05/02/2022 and discharged on 04/07/2026. Resident 6's record contained an "Allowance Ledger." At the time of Resident 6's discharge, Resident 6's "Allowance Ledger" indicated Resident 6 had $11,048.92 in remaining funds. Per "Allowance Ledger," Resident 6's funds was "returned" to Resident 6's next of kin on 06/16/2026. On 06/16/2026 at approximately 2:25 PM, Surveyors interviewed Administrator A, Business Office Manager C, and Case Manager B. Business Office Manager C disclosed he/she mailed the check to Resident 6's next of kin on 06/12/2026. Business Office Manager C confirmed not reading Wisconsin Administrative Code Department of Health Services (DHS) Chapter 83. Therefore, Business Office Manager B was not aware of the code requirement that indicated residents' funds were to be dispersed within 14 days after a resident discharged from the facility.	N 371		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the	N 386		

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N 386	Continued From page 17 resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 (Resident 7) of 4 residents reviewed had a complete individualized service plan (ISP) within 30 days of admission. Findings include: On 06/16/2026 at approximately 11:00 AM, Surveyor reviewed Resident 7's record. Resident 7 was admitted on 04/28/2026. Resident 7's record contained a temporary ISP, dated 04/28/2026. Surveyor did not locate evidence of an ISP completed within 30 days of Resident 7's admission. On 06/16/2026 at approximately 2:25 PM, Surveyors interviewed Administrator A and Business Office Manager C. Administrator A reported Case Manager B was responsible for completing care plans for each resident. Administrator A could not state why Resident 7's ISP was not completed within 30 days of Resident 7's admission. Business Office Manager C disclosed Case Manager B was aware Resident 7's ISP was not completed and that Resident 7's name was on a list of ISPs that needed to be completed.	N 386		

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N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not have the resident or resident's legal representative sign the Individual Service Plan (ISP) acknowledging their involvement in, understanding of, and agreement with the plan for 3 of 4 residents (Resident 6, Resident 8, Resident 9) reviewed. Residents 6's, Resident 8's and Resident 9's ISP did not have all required signatures. Findings include: On 06/16/2026 at approximately 11:00 AM, Surveyor reviewed resident's record. The following was identified:	N 387		

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N 387	Continued From page 19 Resident 6 was admitted on 05/02/2022. Resident 6's record indicated Resident 6 was their own decision maker. Resident 6's ISP, dated 05/08/2025, did not contain his/her signature acknowledging their involvement, understanding of, and agreement with the ISP. Resident 8 was admitted on 05/08/2025. Resident 8's record indicated Resident 8 was their own decision maker. Resident 8's ISP, dated 10/16/2025, did not contain his/her signature acknowledging their involvement, understanding of, and agreement with the ISP. Resident 9 was admitted on 03/09/2023. Resident 9's record indicated Resident 9 was their own decision maker. Resident 9's ISP, dated 08/08/2025, did not contain his/her signature acknowledging their involvement, understanding of, and agreement with the ISP. On 06/16/2026 at approximately 2:25 PM, Surveyors interviewed Administrator A and Business Office Manager C. Administrator A reported Case Manager B was responsible for completing care plans for each resident and ensuring each care plan was signed by the appropriate parties. Administrator A could not state why each care plan was not signed by the appropriate parties.	N 387		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based	N 389		

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N 389	Continued From page 20 on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each individual service plan (ISP) for 1 of (Resident 9) 4 residents reviewed was reviewed on an annual basis. Resident 9's ISP was not reviewed in 2024. Findings include: Resident 9 was admitted on 03/09/2023. Resident 9's file contained an ISP, dated 09/27/2023 and 08/28/2025. Resident 9's file did not contain an ISP from 2024. At minimum, Resident 9's ISP should have been reviewed on or before 09/27/2024. On 06/16/2026 at approximately 2:25 PM, Surveyors interviewed Administrator A and Business Office Manager C. Administrator A reported Case Manager B was responsible for completing care plans for each resident. Administrator A did not state why Resident 9's ISP was not reviewed in 2024, but reported Case Manager B was not the case manager at the time Resident 9's ISP was due to be reviewed in 2024.	N 389		

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N 401	Continued From page 21	N 401		
N 401	83.37(1)(b) Medication label permanently attached. Medications. Prescription medications shall come from a licensed pharmacy or a physician and shall have a label permanently attached to the outside of the container. Over-the-counter medications maintained in the manufacturer ' s container shall be labeled with the resident ' s name. Over-the-counter medications not maintained in the manufacturer ' s container shall be labeled by a pharmacist. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure medications were labeled to ensure proper and safe usage for 73 of 73 residents. Census: 73 This is a repeat deficiency. See Statement of Deficiency JF3C12, dated 09/02/2025. Findings include: On 06/16/2026 at approximately 10:45 AM, Surveyors toured the medication room. Surveyor observed a total of 3 trays: 2 silver trays and 1 green tray. One silver tray contained 2 clear medication cups, stacked on top of one another. (Photo 1). One clear medication cup contained 20 milliliters of a white powdery substance. The 2nd medication cup contained 25 milliliters of a white powdery substance. Neither medication cup that contained the white powdery substance had a permanent label attached to the clear medication cup. On 06/16/2026 at approximately 10:45 AM, Surveyor interviewed Licensed Practical Nurse (LPN) H. LPN H reported the white powdery	N 401		

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substance was Miralax. LPN H stated, "someone probably refused their Miralax." LPN H could not state who the Miralax belonged to or who refused the Miralax.

The second silver tray contained multiple clear medication cups. Within the clear medication cups were loose tablets/capsules of medication. (Photo 2). Surveyor observed a sheet of paper placed behind each clear medication cup. Some medication cups had more than 1 sheet of paper placed behind the medication cups. Each piece of paper contained the resident's name, resident's bedroom number, and the medication name, and instructions for use. Each piece of paper was not permanently attached to the clear medication cup.

Surveyors observed 5 in-use insulin pens stored within the medication cabinet. The following was identified:
One Lantus Solostar with a pharmacy label attached to the pen. The pharmacy label indicated the insulin belonged to Resident 10. No open date was observed on the insulin pen.

Two Novolin FlexPens. One of the 2 Novolin FlexPens did not have a permanent label attached to the pen. Resident 11's last name was written on the insulin pen. No open date was observed on the insulin pen. The second Novolin FlexPen had a permanent label attached to the pen. The permanent label stated the insulin pen belonged to Resident 11. Resident 12's last name was written on the insulin pen. No open date was observed on the insulin pen.

Two NovoLog FlexPens. One of the 2 NovoLog FlexPens did not have a permanent label attached to the pen. Resident 12's last name was

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written on the insulin pen. No open date was observed on the insulin pen. The second NovoLog FlexPen had a permanent label attached. The permanent label indicated the insulin pen belonged to Resident 11. No open date was observed on the insulin pen.

On 06/16/2026 at approximately 2:25 PM, Surveyors interviewed Administrator A, Business Office Manager C, and LPN D. LPN D was not aware the insulin pens did not contain a permanent label or was not labeled with an open date. Surveyor showed LPN D the insulin pens. LPN D confirmed 5 of 5 insulin pens did not contain an open date and 2 of the 5 insulin pens did not contain a permanent label.

In regard to the clear medication cups, LPN D reported the following: LPN D became the lead LPN in 2025. Since becoming the lead LPN, LPN D tried multiple different methods of passing medication. At this time, LPN D found it more efficient to categorize the medications. One silver tray was for residents who received medications from the Veteran's Affairs (VA) pharmacy. The second silver tray was for residents who received medications from Good Value Pharmacy. The green tray was filled with residents who were prescribed noon and 2:00 PM medications. For residents who received medications from the VA pharmacy, their medications were sent to Good Value Pharmacy to be repackaged into blister packs. Given the amount of time it took to take the medication out of the blister packs, LPN D and LPN H prepared 3 to 4 days' worth of prescribed medications, twice a week. LPN D and LPN H would remove the medications from the blister pack and place them into a clear medication cup. Each clear medication cup would contain one days' worth of medication. LPN D

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N 401	Continued From page 24 confirmed LPN D and LPN H would stack 3 to 4 clear medication cups on top of one another, twice a week. LPN D confirmed each medication cup was not attached with a permanent label.	N 401		
N 410	83.37(1)(k) Medication error or adverse reaction. Medication error or adverse reaction. 1. The CBRF shall document in the resident ' s record any error in the administration of prescription or over-the-counter medication, known adverse drug reaction or resident refusal to take medication. 2. The CBRF shall report all errors in the administration of medication and any adverse drug reactions to a licensed practitioner, supervising nurse or pharmacist immediately. Unless otherwise directed by the prescribing practitioner, the CBRF shall report to the prescribing practitioner, supervising nurse or pharmacist as soon as possible after the resident refuses a medication for 2 consecutive days. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report to the prescribing practitioner, supervising nurse or pharmacist, as soon as possible, after 1 of 4 residents (Resident 6) reviewed missed medications for more than 2 consecutive days. Findings include: On 06/16/2026 at approximately 11:00 AM, Surveyor reviewed Resident 6's record. Resident 6 was admitted on 05/02/2022 with diagnoses including major depressive disorder and	N 410		

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N 410	Continued From page 25 schizophrenia. Resident 6's individual service plan (ISP), dated 10/16/2025, indicated staff assisted Resident 6 with medication management and administration. Resident 6's record did not identify correspondence from the provider with Resident 6's prescribing physician about missed medications. Resident 6's medication administration record (MAR) indicated Resident 6 was prescribed trazodone - 200 milligrams at bedtime (QHS). Resident 6's January 2026 MAR indicated Resident 6 refused trazodone between January 25, 2026, to January 31, 2026. Resident 6's February 2026 MAR indicated Resident 6 refused their trazadone between February 1, 2026, to February 28, 2026. Resident 6's March 2026 MAR indicated Resident 6 refused their trazadone between March 1, 2026, to March 31, 2026. Resident 6's April 2026 MAR indicated Resident 6 refused their trazadone between April 1, 2026, to April 6, 2026. On 06/16/2026 at approximately 2:25 PM, Surveyors interviewed Administrator A, Business Office Manager C, and Case Manager B. Case Manager B denied Resident 6's physician was notified when Resident 6 refused their trazadone for more than 2 consecutive days. Administrator A confirmed not reading Wisconsin Administrative Code Department of Health Services (DHS) Chapter 83. Therefore, Administrator A was not aware of the code requirement that indicated prescribing physicians should be notified as soon as possible, after a resident missed medications for more than 2 consecutive days.	N 410		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As	N 415		

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required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not have documentation of the time of medication administration, the person administering the medication or treatment and the name, dosage, date and time of medication taken or treatments performed and initialed in the medication administration record (MAR) for 2 (Resident 6 and Resident 7) of 4 residents reviewed.

The provider did not accurately document when Resident 6 and Resident 7 was administered or refused their medications.

Findings include:

On 06/16/2026 at approximately 11:00 AM, Surveyor reviewed resident's records. The following was identified:

Resident 6 was admitted on 05/02/2022 with diagnoses including major depressive disorder and schizophrenia. Resident 6's individual service plan (ISP), dated 10/16/2025, indicated staff assisted Resident 6 with medication management

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and administration. Resident 6 had a physician order for the following medication:

Empagliflozin - 10 milligrams, take once in the morning

Resident 6's January 2026 medication administration record (MAR) indicated Resident 6 did not receive his/her empagliflozin on 01/24/2026 as there were no initials observed on the MAR. No other documentation was observed on the MAR that provided a reason as to why no initials were observed on the MAR.

Surveyor reviewed Resident 7's record. Resident 7 was admitted on 04/28/2026 with diagnoses including hypertension and major depression. Resident 7's temporary ISP, dated 04/28/2026, indicated staff assisted Resident 7 with medication management and administration. Resident 7 had a physician order for the following medications:

Amlodipine - 10 milligrams, take 1 tablet by mouth daily.
Aripiprazole - 5 milligrams, take 1 tablet by mouth daily.
Fluoxetine - 40 milligram capsules, take 1 capsule by mouth daily.
Gabapentin - 300 milligrams, take 1 capsule by mouth every 12 hours.
Mirtazapine - 15 milligrams, take 1 tablet by mouth nightly.
Valsartan - 160 milligrams, take 1 tablet by mouth daily.

Resident 7's April 2026 medication administration record (MAR) indicated Resident 7 was not provided with their prescribed amlodipine, aripiprazole, fluoxetine, gabapentin, mirtazapine,

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 415	Continued From page 28 and valsartan on 04/31/2026 as no initial was observed on the MAR. No other documentation was observed on the MAR that provided a reason as to why no initials were observed on the MAR. Resident 7's May 2026 MAR indicated Resident 7 was not provided with their prescribed aripiprazole, gabapentin and mirtazapine on 05/01/2026 as no initials were observed on the MAR. In addition, on 05/01/2029, Resident 7 was not provided with their aripiprazole as there were no initials observed on the MAR. No other documentation was observed on the MAR that provided a reason as to why no initials were observed on the MAR. On 06/16/2026 at approximately 2:25 PM, Surveyors interviewed Administrator A, Business Office Manager C, and Licensed Practical Nurse (LPN) D. LPN D reported that if a resident refused their medication, the staff member would put their initial on the MAR and circle their initial. The staff member would then write on the back of the MAR stating why their initial was circled.	N 415		
N 417	83.37(3)(a) Medication storage: original containers. Original containers. The CBRF shall keep medications in the original containers and not transfer medications to another container, unless the CBRF complies with all of the following: 1. Transfer of medications from the original container to another container shall be done by a practitioner, registered nurse, or pharmacist. Transfer of medication to another container may be delegated to other personnel by a practitioner, registered nurse or pharmacist. 2. If a medication is administered by CBRF employees	N 417		

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N 417	Continued From page 29 and the medication is transferred from the original container by a registered nurse, or practitioner or other personnel who were delegated the task, the CBRF shall have a legible label on the new container that includes, at a minimum, the resident ' s name, medication name, dose and instructions for use. The CBRF shall maintain the original pharmacy container until the transferred medication is gone. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure the person transferring medications from the original container to another container was a practitioner, registered nurse, or pharmacist, or someone delegated by a practitioner, registered nurse, or pharmacist for 27 of 27 residents. Findings include: On 06/16/2026 at approximately 10:45 AM, Surveyors toured the medication room. Surveyor observed a total of 3 trays: 2 silver trays and 1 green tray. The green tray consisted of 6 clear medication cups with loose tablets/capsules of medications. One of the two silver trays contained 27 clear medication cups. Within the 27 clear medication cups, Surveyor observed loose tablets/capsules of medication. On 06/16/2026 at 11:40 AM, Surveyors reviewed staff records. The following was identified: LPN D was hired on 05/02/2022. LPN D's record did not contain documentation that indicated he/she was delegated by a practitioner, registered nurse or pharmacist to transfer medications from the original container to another container.	N 417		

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N 417	Continued From page 30 LPN H was hired on 11/12/2025. LPN H's record did not contain documentation that indicated he/she was delegated by a practitioner, registered nurse or pharmacist to transfer medications from the original container to another container. On 06/16/2026 at approximately 2:25 PM, Surveyors interviewed Administrator A, Business Office Manager C, and Licensed Practical Nurse (LPN) D. LPN D reported that since he/she became the lead LPN, LPN D tried multiple different methods of passing medication. At this time, LPN D found it more efficient to categorize the medications. For residents who received medications from the Veteran's Affairs (VA) pharmacy, their medications were sent to Good Value Pharmacy to be repackaged into blister packs as the VA only dispensed medications in bottles. Given the amount of time it took to take the medication out of the blister packs, LPN D and LPN H prepared 3 to 4 days' worth of prescribed medications, twice a week. LPN D and LPN H would remove the medications from the blister pack and place them into a clear medication cup. Each clear medication cup would contain one day's worth of medication. LPN D stated he/she was delegated to transfer medications from the original container into the clear medication cups by a registered nurse. Administrator A was not able to locate any delegation document for LPN D or LPN H.	N 417		
N 431	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined	N 431		

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N 431	Continued From page 31 under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure health monitoring for 1 of 1 (Resident 6) resident reviewed. The provider did not monitor the health of Resident 6's mental health when Resident 6 disclosed the prescribed medication to treat his/her symptoms of psychiatric diagnoses was not effective. Resident 6 began feeling anxious and reported only getting 4 hours of sleep. Findings include: On 06/14/2026, the department received a complaint alleging the provider did not follow up	N 431		

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N 431	Continued From page 32	N 431		

on a resident's mental health.

On 06/16/2026 at approximately 11:00 AM, Surveyor reviewed Resident 6's record. Resident 6 was admitted on 05/02/2022 with diagnoses including major depressive disorder and schizophrenia.

Resident 6's record contained an individual service plan (ISP), dated 05/08/2025, and ISP, dated 10/16/2025. Resident 6's ISP dated, 05/08/2025, stated: " ...Mental Health Conditions and goals ...[He/She] says [his/her] appetite is "all right", [sic] his/her mood is "good" and [he/she] is still sleeping about 10 hours at night and sometimes takes naps during the day. [His/Her] trazadone was changed to 150 mg (milligrams) nightly ..." Resident 6's ISP, dated 10/16/2025, stated, " ...[He/She] says [his/her] appetite is "pretty good", [sic] [his/her] mood is "anxious" (level 2 out of 10) and [he/she] is having some trouble sleeping at night and sometimes takes naps during the day. [His/Her] trazadone was changed to 150 mg nightly, but [he/she] states it only works for about 4 hours. [He/She] will discuss this with [his/her] doctor at [his/her] next appointment which is scheduled for next week ..."

Resident 6's January 2026 to April 2026 Medication Administration Record (MAR) indicated Resident 6 consistently refused their trazadone between January 25, 2026, to April 6, 2026. There was no evidence the provider contacted Resident 6's physician to notify them of the refusals.

Resident 6's record contained an incident report, dated on 04/07/2026. The incident report stated, " ...Type of incident: Fall from 8th floor building/window ...a resident informed staff of

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N 431	Continued From page 33 someone being on the ground behind bldg (building). [Administrator A] went to the area and found [Resident 6] face down on the ground not breathing and bleeding very heavy in the head area. [Administrator A] called 911 right away. EMT (emergency medical technicians) and law enforcement arrived. Took report - coroner took resident to the morge [sic] ..." On 06/16/2026 at approximately 2:25 PM, Surveyors interviewed Administrator A, Business Office Manager C, and Case Manager B. Case Manager B denied calling Resident 6's physician after Resident 6 informed him/her of being anxious, trazadone was no longer effective and reporting he/she was only getting 4 hours of sleep. Case Manager B denied following-up with Resident 6 at any time after Resident 6 informed Case Manager B of being anxious, trazadone no longer being effective and reporting he/she was only getting 4 hours of sleep. Case Manager B stated he/she only asked Resident 6 at the time of the ISP review on 10/16/2025 if Resident 6 wanted to increase his/her trazadone. At that time, Resident 6 did not. Case Manager B confirmed s/he did not contact Resident 6's physician after s/he refused trazodone consecutively from January 2026 through April 6, 2026. Cross Reference: N0410 DHS 83.37(1)(k) Medication Error or Adverse Reaction	N 431		
N 452	83.41(3)(b) Food safety. Food safety. Whether food is prepared at the CBRF or off-site, the CBRF shall store, prepare, distribute and serve food under sanitary conditions for the prevention of food borne	N 452		

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N 452	Continued From page 34 illnesses, including food prepared off-site, according to all of the following: 1. The CBRF shall refrigerate all foods requiring refrigeration at or below 40°F. Food shall be covered and stored in a sanitary manner. 2. The CBRF shall maintain freezing units at 0°F or below. Frozen foods shall be packaged, labeled and dated. 3. The CBRF shall hold hot foods at 140°F or above and shall hold cold foods at 40°F or below until serving. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all foods were properly stored. Food in the walk-in freezer was not sealed or dated. Food located in the kitchen refrigerator was not labeled. This is a repeat deficiency. See Statement of Deficiency JF3C12, dated 09/02/2025. Findings include: On 06/10/2026 between approximately 8:48 AM and 11:00 AM, Surveyors toured the facility kitchen, walk-in freezer, and walk-in refrigerator with Administrator A. The following was observed: Walk-in freezer: The container of a one gallon bucket of ice-cream was broken and not dated with an open date. (Photo 3)	N 452		

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N 452	Continued From page 35 Kitchen refrigerator: A container covered with aluminum foil, not labeled. (Photo 4). Three readily made sandwiches in quart size Ziploc bags with no label. (Photo 5). Three plates of food with no label. (Photo 6 and Photo 7). According to the Wisconsin Food Code, the Federal Department of Agriculture's Food Code, and ServSafe standards, date marking is necessary to indicate when food must be consumed or discarded. These standards indicate refrigerated, ready to eat (RTE), potentially hazardous food (PHF), and time/temperature controlled for safety (TCS) foods that are removed from manufacturer packaging and/or prepared for consumption must be date marked and discarded within 7 days. Refrigerated, RTE, PHF, and TCS foods prepared and packaged in a food processing plant shall also be date-marked when opened in the facility (date not to exceed 7 days). (ServSafe Coursebook, 7th Ed., 2017, p. 5-23) As Surveyors toured the facility kitchen, walk-in freezer, and walk-in refrigerator with Administrator A, Surveyor interviewed Administrator A. Administrator A acknowledged the above food was not labeled.	N 452		
{N 481}	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room.	{N 481}		

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{N 481}	Continued From page 36 This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the living environment was safe, clean, comfortable, and homelike. The shower rooms and toilet rooms were in disrepair. The kitchen area had personal items touching kitchen equipment. This requirement is being cited for the third time. See Statements of Deficiency (SOD) JF3C12, dated 09/02/2025 and SOD JF3C13, dated 04/07/2026. Findings include: On 06/10/2026 between approximately 8:48 AM and 11:00 AM, Surveyors toured the facility with Administrator A. The following was identified: Kitchen: Pads of paper were observed sitting on the meat slicing machine. (Photo 8). The paper towel dispenser was empty. Backpack placed next to and touching the soup ladles. (Photo 9). 8th floor toilet room: The wall behind the toilet appeared to have been patched due to the different colors of the wall. One of 2 toilet paper rolls was observed on the floor touching the plunger. The 2nd toilet paper roll was observed sitting on the toilet paper dispenser. White debris was observed throughout the bathroom. Brown matter was observed on the wall behind the door. (Photo 10). 7th floor shower room:	{N 481}		

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{N 481}	Continued From page 37 Above the outlet, paint was observed peeling off the wall. (Photo 11). The wall under the window appeared to be cracked, and a piece of the wall was missing near the trim. (Photo 12). The caulk around the shower area was observed to be brown and black. (Photo 13). Six bars of soap were observed next to or on top of one another. (Photo 14). 6th floor toilet room: Brown matter was observed on the wall behind the door. The toilet paper was sitting on the toilet paper dispenser. (Photo 15). Debris was observed throughout the toilet room. (Photo 16). 4th floor shower room: The paint on the windowsill was peeling off. (Photo 17) The sitting area board was detaching from the wall. (Photo 18). 4th floor toilet room: No toilet paper was observed in the toilet room. The toilet paper roll was observed in a basket on the wall. Holes where a toilet paper dispenser used to be were observed on the wall. (Photo 19). 3rd floor shower room: White debris was observed on the floor under the sitting area. (Photo 20) The window was duct taped closed. (Photo 21). Black spots, consistent with what appeared to be mold, were observed next to the window. (Photo 22). Shower tiles were missing on the floor of the shower area. (Photo 23). Black spots, consistent with what appeared to be mold, were observed on the ceiling of the bathroom. On 06/16/2026 at approximately 2:25 PM, Surveyors interviewed Administrator A and Business Office Manager C. Administrator A	{N 481}		

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{N 481}	Continued From page 38 acknowledged the environmental concerns. Administrator A reported the 3rd floor shower room is used the most, but would have maintenance address the black spots right away.	{N 481}		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure quarterly fire drills were completed for 3 of 4 quarters in 2024, 2 of 4 quarters in 2025, and 1 quarter in 2026. The fire drills which were completed did not document a total evacuation time in the reports for the 3 of 4 drills conducted in 2024 and in 2025. This is a repeat deficiency. See Statement of Deficiency (SOD) JF3C11, dated 12/12/2024.	N 525		

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N 525	Continued From page 39 Findings include: On 06/16/2026, at 2:00 PM, Surveyors reviewed the facility's fire drill documentation and identified the following: 08/22/2024 at 4:45 PM; no evacuation time documented 03/27/2025 at 1:15 PM; no evacuation time documented 06/12/2025 at 6:30 AM; no evacuation time documented Surveyors were unable to locate evidence of completed fire drills in the 1st, 2nd and 4th quarters of 2024, the 3rd and 4th quarters of 2025, and the 1st quarter of 2026. On 06/16/2026 at 2:25 PM, Surveyors interviewed Administrator A and Business Office Manager (BOM) C. Administrator A and BOM C confirmed the code requirement. Administrator A reported s/he was unaware of all the required information in the documentation of the completed fire drills.	N 525		
N 526	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure tornado, flooding, or other emergency or disaster drills were conducted	N 526		

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N 526	Continued From page 40 semi-annually for 1 of 2 years. There was only 1 other emergency or disaster drills conducted in 2025. This is a repeat deficiency. See Statement of Deficiency (SOD) JF3C11, dated 12/12/2024. Findings include: On 06/16/2026, at 10:50 AM, Surveyors reviewed the facility safety file and identified the following: 04/25/2025 at 1:45 PM Tornado Drill 04/14/2026 Tornado Drill 04/15/2026 Tornado Drill 04/17/2026 Tornado Drill 06/11/2026 Tornado Drill Surveyor was unable to locate evidence of a second other evacuation drill for 2025. On 06/16/2026 at 2:25 PM, Surveyors interviewed Administrator A and Business Office Manager (BOM) C. Administrator A and BOM C confirmed the code requirement. Administrator A and BOM C did not offer any explanation to the missed other drill evacuation.	N 526		
N 530	83.47(3) Fire inspection. Fire inspection. The CBRF shall arrange for an annual inspection by the local fire authority or certified fire inspector and shall retain fire inspection reports for 2 years. This Rule is not met as evidenced by: Based on record review and interview, the	N 530		

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N 530	Continued From page 41 provider did not arrange for an annual fire inspection for 2 of 2 years reviewed (2024, 2025, and to date in 2026). This is a repeat deficiency. See Statement of Deficiency (SOD) JF3C11, dated 12/12/2024. Findings include: On 06/16/2026, at 10:50 AM, Surveyors reviewed the facility safety file. Surveyor did not locate evidence of a fire inspection conducted in 2024, 2025, and to date in 2026. On 06/16/2026 at 2:25 PM, Surveyors interviewed Administrator A and Business Office Manager (BOM) C. Administrator A and BOM C confirmed the code requirement. BOM C reported s/he had a phone call out to the fire department and left a message. BOM C reported s/he thought all inspections were completed.	N 530		
N 538	83.48(3)(a) Fire detection systems inspected annually. After the first year following installation, fire detection systems shall be inspected, cleaned and tested annually by certified or trained and qualified personnel in accordance with the specifications in NFPA 72 and the manufacturer ' s specifications and procedures. This Rule is not met as evidenced by: Based on record review and interview, the provider did not arrange for an annual fire detection system to be inspected for 1 of 2 years (2025).	N 538		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018835	A. BUILDING: _____ B. WING _____	R-C 06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAYTON CARE CENTER	521 59TH STREET KENOSHA, WI 53140

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 538	Continued From page 42 This is a repeat deficiency. See Statement of Deficiency (SOD) JF3C11, dated 12/12/2024. Findings include: On 06/16/2026, at 10:50 AM, Surveyors reviewed the facility safety file. The documentation indicated the fire alarm system was last inspected 04/11/2026 and 04/15/2026. There was no documentation indicating the fire system had been inspected in 2025. On 06/16/2026 at 2:25 PM, Surveyors interviewed Administrator A and Business Office Manager (BOM) C. Administrator A and BOM C confirmed the code requirement. BOM C reported s/he was unsure of where the paperwork was.	N 538		
N 558	83.48(8)(b) Sprinkler system installation and maintenance Installation and maintenance. 1. All sprinkler systems shall be installed by a state licensed sprinkler contractor. All sprinkler systems shall be maintained, inspected and tested at least annually or at intervals determined by the requirements in NFPA 25. 2. In facilities with sprinklers, sprinkler heads shall be placed at the top of each linen or trash chute and in the rooms where the chutes terminates. 3. The sprinkler system flow alarm shall be connected to the CBRF ' s fire alarm system. This Rule is not met as evidenced by: Based on record review and staff interview, the provider did not ensure the sprinkler system was inspected for 2 of 2 calendar years (2024 and 2025).	N 558		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 558	Continued From page 43 Findings include: On 06/16/2026, at 10:50 AM, Surveyors reviewed the facility safety file. The sprinklers were inspected 04/15/2026. There was no documentation indicating the sprinkler system had been inspected in 2024 and in 2025. On 06/16/2026 at 2:25 PM, Surveyors interviewed Administrator A and Business Office Manager (BOM) C. Administrator A and BOM C confirmed the code requirement. BOM C reported s/he thought all inspections were completed but was unsure of where the inspection paperwork was.	N 558		
N 617	83.55(6)(b) Bath and toilet areas: water temperature The CBRF shall set the temperature of all water heaters connected to sinks, showers and tubs used by residents at a temperature of at least 140°F. The temperature of water at fixtures used by residents shall be automatically regulated by valves and may not exceed 115°F, except for CBRFs serving residents recovering from alcohol or drug dependency or clients of a government correctional agency. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the temperature of water at fixtures used by residents did not exceed 115 degrees Fahrenheit (F) in 1 of 5 bathrooms and 2 of 3 shower rooms. The activity room bathroom measured at 134 degrees F. Seventh floor shower room measured at 132.4 degrees F. Fourth floor shower room	N 617		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018835	A. BUILDING: _____ B. WING _____	R-C 06/16/2026

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DAYTON CARE CENTER	521 59TH STREET KENOSHA, WI 53140

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N 617	Continued From page 44 measured at 120.2 degrees F. Findings include: The facility is a class CS semi-ambulatory community based residential facility licensed to serve up to 90 residents in the areas of developmentally disabled, traumatic brain injury, advanced aged, and irreversible dementia/Alzheimer's. On 06/10/2026 between approximately 8:48 AM and 11:00 AM, Surveyors toured the facility with Administrator A. The following was identified: Seventh floor shower room measured at 132.4 degrees F. Fourth floor shower room measured at 120.2 degrees F. The activity room bathroom, located on the first floor, measured at 134 degrees F. On 06/16/2026 at approximately 2:25 PM, Surveyors interviewed Administrator A and Business Office Manager C. Administrator A confirmed not reading Wisconsin Administrative Code Department of Health Services (DHS) Chapter 83. Therefore, Administrator A acknowledged he/she was not aware of the code requirements related to water temperature.	N 617		