STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015614	A. BUILDING: _____ B. WING _____	C 02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM WISCONSIN III INC CENTENNIAL	5303 CUMMING AVENUE SUPERIOR, WI 54880

(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 02/25/2026, Surveyor conducted a complaint investigation at REM Wisconsin III Inc Centennial. One of 2 complaints was substantiated. One violation was identified. Census: 8	N 000		
N 326	83.31(4)(a) Notice of facility initiated discharges Discharge or transfer initiated by CBRF. Notice and discharge requirements. 1. Before a CBRF involuntarily discharges a resident, the licensee shall give the resident or legal representative a 30 day written advance notice. The notice shall explain to the resident or legal representative the need for and possible alternatives to the discharge. Termination of placement initiated by a government correctional agency does not constitute a discharge under this section. 2. The CBRF shall provide assistance in relocating the resident and shall ensure that a living arrangement suitable to meet the needs of the resident is available before discharging the resident. This Rule is not met as evidenced by: Based on interview and record review, the provider did not give proper notice of involuntary discharge when they would not accept Resident 1 back to the facility after his/her hospital stay. The provider did not find an alternative living arrangement and did not issue a 30-day notice in advance of discharge. Resident 1 had nowhere to go when alternative placement could not be found and the facility would not take him/her back.	N 326		

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

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N 326	Continued From page 1 Findings include: On 02/11/2026, the Department received a complaint regarding resident discharge without proper notification. On 02/25/2026, Surveyor reviewed Resident 1's records. Resident 1's individualized service plan (ISP), dated 10/15/2025, indicated the following: - Resident 1 was admitted to the facility on 10/06/2025. - Resident 1 was protectively placed and had a corporate guardian (Guardian C). - Resident 1 was diagnosed with end stage renal disease, chronic kidney disease, congestive heart failure, and mild cognitive impairment. A 2026 medical appointment log indicated Resident 1 was admitted to the hospital on 01/28/2026. Hospital progress notes, dated 02/04/2026, indicated the following: - Resident 1 was still in the hospital. - The hospital case manager had spoken with Resident 1 and his/her guardian regarding placement to a skilled nursing facility, and a referral was made. Hospital progress notes, dated 02/05/2026, indicated the following: - Resident 1 was anticipated to be ready for discharge in 2-4 days from the date of the note. - Discharge plans for Resident 1 were to a skilled nursing facility. Text communication from Administrator A to Guardian C read, in part, "Did you talk to the	N 326		

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N 326	Continued From page 2	N 326		

social worker? [S/he] left a voicemail for my nurse saying they plan to discharge [his/her] back to us tomorrow."

Hospital notes, dated 02/11/2026, indicated Resident 1 was ready for discharge from the hospital.

A 30-day discharge notice from the facility, dated 02/20/2026, and addressed to Resident 1, Guardian C, and Resident 1's managed care caseworker, indicated the following:
- The facility determined that they could no longer care for Resident 1 due to his/her medical needs.
- The notice advised Resident 1 to "consider this [notice] immediate discharge for [Resident 1]..."

At approximately 10:06 AM, Surveyor interviewed Administrator A. Administrator A stated, in late January 2026, Resident 1 was admitted to the local hospital's emergency department (ED) due to the worsening of a wound s/he had on his/her foot. Administrator A stated Resident 1 had been going to dialysis 3 times per week, was in poor health, and the wound on his/her foot had gotten infected. Administrator A stated Resident 1 ultimately had his/her foot amputated in the hospital, and that the surgical wound had gotten infected during his/her hospital stay. Administrator A stated intravenous (IV) antibiotics were prescribed to Resident 1 to be administered during his/her dialysis sessions. Administrator A stated s/he had concerns that the IV antibiotics would be missed as Resident 1 would often either refuse to go to dialysis sessions or would leave sessions early, and provider staff were unable to administer the IV antibiotics at the facility. Administrator A stated s/he thought it was in Resident 1's best interest that s/he not come

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N 326	Continued From page 3	N 326		

back to the facility. Administrator A stated Guardian C also did not want Resident 1 to return to the facility, but that no nursing facilities would admit Resident 1.

At approximately 10:27 AM, Surveyor interviewed Nurse B. Nurse B stated, in January 2026, Resident 1 was seeing a podiatrist for a sore on his/her toe and was sent to the local hospital ED due to the wound progression. Nurse B stated Resident 1's wound grew larger and most of his/her toes were amputated at the hospital on either 01/28/2026 or 01/29/2026. Nurse B stated Resident 1's wounds were open and not healing, and either his/her podiatrist or surgeon was unhopeful that the wound would close. Nurse B stated the hospital social worker was looking to place Resident 1 somewhere but was unable to find placement so wanted to send him/her back to the facility. Nurse B stated the provider could not safely take care of Resident 1.

At approximately 1:20 PM, Surveyor interviewed Administrator A and Nurse B. Nurse B stated around the date of 02/10/2026, s/he had a conversation with the hospital social worker regarding Resident 1's placement. Nurse B stated s/he had seen a hospital note which indicated the hospital was planning to send Resident 1 back to the facility. Nurse B stated s/he spoke with the hospital social worker and told him/her that the provider was unable to provide the IV treatment required for Resident 1. Administrator A stated that on 02/10/2026, Resident 1's guardian was made aware that Resident 1 could not come back to the facility.

The provider did not ensure Resident 1 had alternative placement prior to issuing a discharge notice and did not provide 30-days' notice to

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N 326	Continued From page 4 Resident 1 when discharging him/her.	N 326		