STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016851	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOSA HOUSE	4145 SAVANNAH DR , DE FOREST, Wisconsin, 53532

(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) COMPLETION DATE
N0000	Initial Comments From 11/02/2026 to 11/03/2026, Surveyor completed a complaint investigation at Sosa House, a CBRF in Deforest. Four deficiencies were identified. The complaint was substantiated. Census: 8	N0000		
N0120	Program statement: staffing and availability CFR(s): 83.06(1)(b) The program statement shall accurately include all of the following: Employee availability, including 24 hour staffing patterns and the availability of a licensed nurse, if any. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the provider did not ensure the program statement accurately included the employee availability, including 24 hour staffing patterns. Findings include: From 11/02/2026 to 11/03/2026, Surveyor completed a complaint investigation alleging staffing concerns at the provider's facility. RECORD REVIEW On 11/02/2026 at approximately 7:00 a.m., Surveyor reviewed the provider's program statement on file with the department. The program statement stated certified direct care staff were onsite 24/7 with 2 staff on daily during high need resident hours and evaluated routinely, 1 staff at night.	N0120		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016851	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOSA HOUSE	4145 SAVANNAH DR , DE FOREST, Wisconsin, 53532

(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) COMPLETION DATE
N0120	Continued from page 1 On 11/02/2026 at approximately 9:45 a.m., Surveyor reviewed the provider's staff schedule, dated 08/01/2026 to 10/31/2026, which documented only 1 caregiver on for each shift on the following dates: 08/01/2026 through 08/22/2026. 08/24/2026 through 10/05/2026, 10/07/2026, 10/09/2026 through 10/16/2026, 10/19/2026, 10/24/2026 through 10/25/2026 and 10/31/2026. On 11/02/2026 at approximately 10:00 a.m., Surveyor reviewed resident individual service plans (ISP), which documented the following care needs: - Resident 1 admitted to the provider's facility on 05/14/2020. Resident 1's ISP, dated 11/02/2026, indicated s/he required a hoyer lift for transfers, total assistance with dressing, bathing and toileting and supervision with cues for meals. - Resident 2 admitted to the provider's facility on 11/03/2021. Resident 2's ISP, dated 11/02/2026, indicated s/he required a hoyer lift for transfers and total assistance with dressing, bathing and toileting with a toileting schedule of 9:00 a.m., 11:00 a.m., 2:00 p.m., 5:00 p.m. and 8:00 p.m. - Resident 3 was admitted to the provider's facility on 09/23/2026. Resident 3's ISP, dated 11/02/2026, indicated s/he required assistance with pivot transfers, wheelchair mobility, dressing, bathing and toileting. - Resident 4 was admitted to the provider's facility on 12/20/2018. Resident 4's ISP, dated 11/02/2026, indicated s/he required full assistance with dressing, grooming and bathing. The ISP indicated s/he required monitoring and cuing for toileting. - Resident 5 was admitted to the provider's facility on 07/13/2026. Resident 5's ISP, dated 11/02/2026, indicated s/he required assistance with bathing and dressing. The ISP indicated s/he occasionally needed assistance with ambulation. - Resident 6 was admitted to the provider's facility on 05/19/2025. Resident 6's ISP, dated 11/02/2026, indicated s/he required full assistance with dressing,	N0120		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016851	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOSA HOUSE	4145 SAVANNAH DR , DE FOREST, Wisconsin, 53532

(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) COMPLETION DATE
N0120	Continued from page 2 grooming, positioning, toileting and bathing. The ISP indicated s/he required a hoyer lift for transfers. - Resident 7 was admitted to the provider's facility on 06/01/021. Resident 7's ISP, dated 11/02/2026, indicated s/he required full assistance with toileting, bathing, dressing and wheelchair use. The ISP indicated s/he required a mechanical lift for transfers. - Resident 8 was admitted to the provider's facility on 02/12/2018. Resident 8's ISP, dated 11/02/2026, indicated s/he was an elopement risk with a history of drug seeking. OBSERVATION On 11/02/2026 from 7:50 a.m. to 12:10 p.m., Surveyor observed Resident 2 was in the common area and did not receive assistance with toileting for 4+ hours. Surveyor observed 3 caregivers present. While 1 caregiver passed medications, Surveyor observed the other caregivers assist with activities, household tasks and resident cares. Surveyor observed Assistant Director B provide toileting assistance for Resident 1. INTERVIEW On 11/02/2026 at 12:10 p.m., Surveyor reviewed concern regarding the provider's program statement not reflecting accurate staffing patterns provided with Assistant Director A and Assistant Director B. Assistant Director B stated s/he was not familiar with the staffing patterns listed in the program statement. Surveyor reviewed the program statement on file with Assistant Director B. Assistant Director B stated s/he could not define when "high resident need hours" were. Assistant Director B confirmed caregivers were responsible for all resident care, medication administration, housekeeping tasks, dietary tasks and activity programming. Surveyor asked if it was feasible for 1 caregiver to assist Resident 2 with using the bathroom via hoyer lift, lead the 11:00 a.m. activity, prepare lunch and assist all other 7 residents. Assistant Director B stated caregivers didn't need to stick to a schedule and that times could be adjusted for 1 caregiver to manage. Surveyor shared observation that Resident 2 did not receive his/her 9:00 a.m. or 11:00 a.m.	N0120		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016851	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOSA HOUSE	4145 SAVANNAH DR , DE FOREST, Wisconsin, 53532

(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) COMPLETION DATE
N0120	Continued from page 3 toileting assistance on 11/02/2026 when there were 3 caregivers present and 2 managers. Assistant Director B stated a day when a state surveyor was present didn't reflect a typical day at the facility because staff were nervous and busy with alternate tasks.	N0120		
N0169	Notification: incident, injury, changes. CFR(s): 83.12(5)(a) The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the provider did not ensure the CBRF immediately notified the legal representative of 1 of 1 residents reviewed when the resident sustained a injury. Resident 1 was observed with bruising to his/her face on 09/30/2026. Resident 1's legal representative was not notified of the bruising until 10/02/2026. Findings include: From 11/02/2026 to 11/03/2026, Surveyor completed a complaint investigation alleging care concerns. RECORD REVIEW On 11/02/2026 at approximately 8:30 a.m., Surveyor reviewed Resident 1's records, provided by Assistant Director A and Assistant Director B. Resident 1 was admitted to the provider's facility on 05/14/2020 with diagnoses including vascular dementia, epilepsy and schizoaffective disorder. Resident 1 had an activated Health Care Power of Attorney. Resident 1's individual service plan (ISP), dated 11/03/2026, indicated s/he required a hoyer lift for all transfers and total assistance with bathing, dressing and toileting. Resident 1's record included an incident report, dated 09/30/2026, that stated "While giving [Resident 1] a shower after lunch, I noticed a small bruise on [his/her] right forehead.	N0169		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016851	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOSA HOUSE	4145 SAVANNAH DR , DE FOREST, Wisconsin, 53532

(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) COMPLETION DATE
N0169	Continued from page 4 [S/he] mentioned that [s/he] bumped [his/her] head on the wall while turning to [his/her] side in bed during care. [Resident 1] reports feeling pain and discomfort in that area when touched." The document stated family was notified on 09/30/2026 at 4:10 p.m. The incident report did not document details of the bruise. On 11/02/2026 at approximately 9:00 a.m., Surveyor reviewed hospital documentation, obtained by Surveyor. Hospital documentation included a picture, dated 10/08/2026, that showed yellow and gray bruising from Resident 1's right temple extending toward his/her edge of eye and eyebrow and extending up beyond his/her forehead and into his/her hairline. On 11/02/2026 at approximately 11:00 a.m., Assistant Director A provided Surveyor with documentation of an email, dated 10/02/2026 at 12:26 p.m., sent to Resident 1's care team, including Resident 1's Health Care Power of Attorney (HCPOA C), which stated, "[Resident 1] currently has a bruise on the right side of [his/her] forehead. This occurred while [s/he] was turning towards the wall repositioned in bed during personal care. To help prevent further incidents, staff are now placing a pillow on that side when turning [him/her] toward the wall." INTERVIEW On 11/02/2026 at approximately 11:00 a.m., Surveyor interviewed Assistant Director A and asked for clarification regarding who notified Resident 1's activated HCPOA C regarding the bruising and when HCPOA C was first notified. Assistant Director A stated Assistant Director B would have notified HCPOA C. On 11/02/2026 at approximately 11:10 a.m., Assistant Director A followed up with Surveyor and stated s/he was actually the one that notified HCPOA C, but s/he couldn't locate the call in his/her log because s/he must have called from the facility phone. Assistant Director A stated Assistant Director B was going to attempt to get verification of the call. Assistant Director A stated there was a possibility s/he forgot to call HCPOA C when the bruise was first noticed.	N0169		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016851	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOSA HOUSE	4145 SAVANNAH DR , DE FOREST, Wisconsin, 53532

(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) COMPLETION DATE
N0169	Continued from page 5 On 11/03/2026 at 9:30 a.m., Surveyor interviewed HCPOA C. HCPOA C stated s/he was not made aware of Resident 1's facial bruise until the email on 10/02/2026. HCPOA C reported to Surveyor that s/he checked his/her call log while on the phone with Surveyor to confirm s/he did not have a call from the provider on 09/30/2026 to discuss the facial bruise. On 11/03/2026 at 6:38 p.m., Assistant Director B emailed Surveyor and stated Assistant Director A had inadvertently omitted notification to Ivette until his/her email.	N0169		
N0353	Rights of Residents: Adequate treatment CFR(s): 83.32(3)(i) In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 residents reviewed received prompt and adequate treatment following a fracture. Resident 1 was observed with bruising and swelling to his/her foot on 10/04/2026; however, s/he was not evaluated and diagnosed with right foot 1st metatarsal fracture until 10/08/2026. Findings include: From 11/02/2026 to 11/03/2026, Surveyor completed a complaint investigation alleging care concerns at the provider's facility. RECORD REVIEW On 11/02/2026 at approximately 8:30 a.m., Surveyor reviewed Resident 1's records, provided by Assistant Director A and Assistant Director B. Resident 1 was admitted to the provider's facility on 05/14/2020 with diagnoses including vascular	N0353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016851	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOSA HOUSE	4145 SAVANNAH DR , DE FOREST, Wisconsin, 53532

(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) COMPLETION DATE
N0353	Continued from page 6 dementia, epilepsy and schizoaffective disorder. Resident 1 had an activated Health Care Power of Attorney. Resident 1's individual service plan (ISP), dated 11/03/2026, indicated s/he required a hoyer lift for all transfers and total assistance with bathing, dressing and toileting. Resident 1's record included the following: - Incident Report, dated 10/08/2026, that stated staff informed the director that resident's foot was swollen and they were having difficult putting on a shoe. The report indicated a bruise was observed to the right foot and Resident 1 was transferred to the hospital. - Progress Note, dated 10/08/2026, that primary care physician was notified of bruising discovered to the top of Resident 1's foot during morning cares. - Progress note, dated 10/08/2026, that documented an email to Resident 1's care team to inform of bruising and swelling that was initially discovered on 10/04/2026; however, management was not made aware of until 10/08/2026. The email indicated Resident 1 was evaluated at the emergency room and diagnosed with a fracture of the first metatarsal of the right foot. - Hospital documentation, dated 10/08/2026, documented that Resident 1 was seen for bruising and foot swelling and was diagnosed with a 1st metatarsal fracture in the right foot. The documentation indicated Resident 1 was instructed to take home pain medication as previously prescribed, wear a postop shoe as needed and follow up with his/her primary care physician in 1-2 weeks. - Resident 1's medication administration record (MAR), dated 10/04/2026 to 10/30/2026, documented the following PRN pain medication administrations: o Tramadol Hcl 50 mg 10/06/2026 11:35 a.m. - Reason not documented. o Tramadol Hcl 50 mg 10/08/2026 8:10 a.m. - Reason not documented.	N0353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016851	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOSA HOUSE	4145 SAVANNAH DR , DE FOREST, Wisconsin, 53532

(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) COMPLETION DATE
N0353	Continued from page 7 o Tramadol Hcl 50 mg 10/08/2026 7:41 p.m. - Pain o Tramadol Hcl 50 mg 10/10/2026 1:48 a.m. - Pain in right foot. o Tramadol Hcl 50 mg 10/11/2026 5:04 p.m. - Foot pain. o Tramadol Hcl 50 mg 10/14/2026 8:34 a.m. - Pain o Tramadol Hcl 50 mg 10/19/2026 10:06 a.m. - Reason not documented. o Acetaminophen 500 mg 10/23/2026 12:31 p.m. - Reason not documented. - An investigation, dated 10/08/2026, that documented the following events: o 10/04/2026 AM (before approximately 7:00 a.m.): Caregiver D observed redness and swelling to Resident 1's right foot. Caregiver D attributed the appearance to tight socks and possible circulation concern. Neither management, nor incoming caregiver were informed of observation. o 10/04/2026 at approximately 6:50 p.m.: HCPOA C visited Resident 1. During visit, Caregiver E on shift and HCPOA C observed bruise to Resident 1's right foot. Caregiver E stated HCPOA C commented that s/he would follow up with Assistant Director A, Resident 1's care team and the state regarding the bruise. o 10/04/2026 Evening Shift Change: Caregiver E reported informing Caregiver D of foot bruising. o 10/07/2026 to 10/08/2026: Caregiver F observed bruising during overnight cares. Caregiver F did not report bruising to management due to yellow discoloration and assuming the bruise was old. o 10/08/2026: Caregiver G noticed Resident 1's foot was swollen when attempting to put Resident 1's shoe on at approximately 9:00 a.m. Management	N0353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016851	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOSA HOUSE	4145 SAVANNAH DR , DE FOREST, Wisconsin, 53532

(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) COMPLETION DATE
N0353	Continued from page 8 began investigation and transferred Resident 1 to emergency room. INTERVIEW On 11/02/2026 at 12:10 p.m., Surveyor reviewed concerns regarding Resident 1's metatarsal fracture with Assistant Director A and Assistant Director B. Surveyor reviewed the observations of bruising from 10/04/2026 to 10/08/2026 with hospital evaluation not occurring until 10/08/2026. Surveyor also discussed observation of PRN pain medication administrations for foot pain once Resident 1 was diagnosed with the metatarsal fracture. Assistant Director B acknowledged Resident 1's delay in evaluation of his/her foot injury. Asistant Director B stated Caregiver E was terminated because s/he did not notify management of the injury resulting in the delay. Assistant Director B felt the provider had addressed the concern by the termination of Caregiver E and education for all other caregivers. On 11/03/2026 at 9:30 a.m., Surveyor interviewed HCPOA C. HCPOA stated Resident 1 was having pain due to the right foot injury. HCPOA C stated during his/her visit on 10/04/2026, Resident 1 kept pointing to his/her foot, which resulted in HCPOA C discovering the bruise. HCPOA C voiced frustration that the provider's staff questioned why s/he didn't explore the bruise further when it should be the provider's responsibility.	N0353		
N0425	Personal care. CFR(s): 83.38(1)(a) As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident's highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Personal care. Personal care services shall be designed and provided to allow a resident to increase or maintain independence. This LICENSURE REQUIREMENT is NOT MET as	N0425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016851	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOSA HOUSE	4145 SAVANNAH DR , DE FOREST, Wisconsin, 53532

(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) COMPLETION DATE
N0425	Continued from page 9 evidenced by: Based on observation, record review and interview, the provider did not ensure personal care services were provided to meet the needs of residents. Resident 1 and Resident 2 did not receive toileting assistance as needed. Findings include: From 11/02/2026 to 11/03/2026, Surveyor completed a complaint investigation alleging care concerns at the provider's facility. RECORD REVIEW On 11/02/2026 at approximately 9:00 a.m., Surveyor reviewed resident care plans, which documented the following: - Resident 1 admitted to the provider's facility on 05/14/2020. Resident 1's individual service plan (ISP), dated 11/02/2026, indicated s/he required assistance for toileting. - Resident 2 admitted to the provider's facility on 11/03/2021. Resident 2's ISP, dated 11/02/2026, documented s/he required assistance with toileting and staff were to assist Resident 2 with changing his/her depend at 9:00 a.m., 11:00 a.m., 2:00 p.m., 5:00 p.m. and 8:00 p.m. The ISP stated Resident 2 may be embarrassed or feel like a burden to ask staff for assistance and that staff must go to Resident 2 and bring him/her to the bathroom. The ISP indicated Resident 2 required a hoyer lift for transfers. OBSERVATION On 11/02/2026 from 7:50 a.m. to 12:10 p.m., Surveyor observed Resident 2 in the common area. Surveyor observed staff relocate Resident 2 from the dining room following breakfast to the living room, where Resident 2 remained until s/he was relocated back to the dining room for lunch. Staff did not assist Resident 2 to the bathroom at any time during	N0425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016851	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOSA HOUSE	4145 SAVANNAH DR , DE FOREST, Wisconsin, 53532

(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) COMPLETION DATE
N0425	Continued from page 10 the 4+ hour period. RECORD REVIEW On 11/02/2026 at approximately 1:00 p.m., Surveyor reviewed an investigation, dated 10/08/2026 related to Resident 1. The investigation documented an interview, dated 10/08/2026, with Caregiver E, in which Caregiver E informed staff s/he did not change or transfer Resident 1 a single time during his/her 12-hour shift on 10/03/2026 from 7:00 a.m. to 7:00 p.m. EXIT On 11/02/2026 at 12:10 p.m., Surveyor reviewed concerns regarding personal care needs being met with Assistant Director A and Assistant Director B. Assistant Director B stated the 10/03/2026 incident was isolated to 1 caregiver who was no longer employed at the facility. Assistant Director B stated s/he did believe Surveyor's observation of Resident 2 not receiving toileting assistance was a true picture of the care provided at the facility. Assistant Director B stated staff were nervous while Surveyor was present and engaged in other tasks, directed by Assistant Director B. Surveyor shared observation that there were 2 managers and 3 caregivers present during Surveyor's presence, indicating increased assistance available than the provider's typical staffing pattern of 1 caregiver for most 24-hour periods.	N0425		