STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015199	A. BUILDING: _____ B. WING _____	C 10/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE SUN PRAIRIE	LIGHTHOUSE OF SUN PRAIRIE SUN PRAIRIE, WI 53590

(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 10/20/2026, the bureau of assisted living southern regional office conducted 3 complaint investigations at New Perspective Sun Prairie a CBRF located in Sun Prairie, WI. As a result, 4 violations of DHS Chapter 83 were identified. Two of 3 complaints were substantiated. Census: 29	N 000		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on record review and interview, the licensee did not ensure the CBRF and its operation complied with all laws governing the CBRF. From 11/15/2024 to 10/20/2026, the provider did not comply with all the laws governing the CBRF as evidenced by identification of 25 deficiencies, 4 repeat violations and 8 substantiated complaints. This is a repeat deficiency of statement of deficiency (SOD) ZZI813 dated 08/28/2024 and SOD B8VW11 dated 10/14/2021. FINDINGS INCLUDE: Facility is a Class CNA non-ambulatory facility.	N 196		

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

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N 196	Continued From page 1 Has a capacity of 50 residents and serves advanced aged, irreversible dementia & Alzheimer's. On 10/20/2026, Surveyor arrived at facility for 3 complaint investigations. Example 1: Obtain and maintain compliance with laws governing the CBRF: On 11/15/2024, Surveyor conducted a survey. As a result, 8 violations were identified and 1 complaint was substantiated in statement of deficiency (SOD) DS4J11: 1.) 83.12(3)(a) Investigate Injuries Of Unknown Source 2.) 83.12(4)(a) Reporting When Resident's Whereabouts Unknown 3.) 83.12(4)(b) Reporting When Law Enforcement Is Called 4.) 83.15(3)(a) Administrator Shall Supervise Daily Operation 5.) 83.37(1)(i) Prn Psychotropic Medication 6.) 83.38(1)(b) Supervision 7.) 83.38(1)(h) Medication Administration 8.) 83.38(1)(i) Behavior Management On 01/29/2025, Surveyor conducted a survey. As a result, 2 violations were identified and 1 complaint was substantiated in SOD ZZI814: 1.) 83.32(3)(h) Right Of Residents: Receive Medication 2.) 83.36(1)(a) Adequate Staff To Meet Residents Needs On 04/30/2025, Surveyor conducted a survey. As a result, 2 violations were identified and 1 complaint was substantiated in SOD DS4J12: 1.) 83.14(2)(i) Not Permit A Condition Of Substantial Risk	N 196		

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N 196	Continued From page 2 2.) 83.35(3)(d) Service Plans Updated Annually Or On Changes On 12/02/2025, Surveyor conducted a survey. As a result, 7 violations were identified and 2 complaints were substantiated in SOD QRT911: 1.) 83.20(2)(a)-(d) Department Approved Training Courses 2.) 82.21(1)-(3) All Employee Training 3.) 83.22(1)-(4) Task Specific Training 4.) 83.35(3)(d) Service Plans Updated Annually Or On Changes 5.) 83.38(1)(a) Supervision 6.) 83.38(1)(g) Health Monitoring 7.) 83.39(3) Hand Washing On 04/07/2026, Surveyor conducted a survey. As a result, 1 violation was identified and 1 complaint was substantiated in SOD QRT912: 1.) 83.20(2)(a)-(d) Department Approved Training Courses On 08/25/2026, Surveyor conducted a survey. As a result, 1 violation was identified in SOD OR8N11: 1.) 83.32(3)(i) Rights Of Residents: Adequate Treatment On 10/20/2026, Surveyor conducted a survey. As a result, 4 violations were identified and 2 complaints were substantiated in SOD OSI411: 1.) 83.14(2)(a) Licensee Ensure Facility Complies With Laws 2.) 83.32(3)(i) Rights Of Residents: Adequate Treatment 3.) 83.38(1)(i) Behavior Management 4.) 83.44(2)(a) Rooms Clean And Free From Odors Example 2: Repeat violations of laws governing	N 196		

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N 196	Continued From page 3 the CBRF. 1.) 83.20(2)(a)-(d) Department Approved Training Courses 2.) 83.32(3)(i) Rights Of Residents: Adequate Treatment 3.) 83.35(3)(d) Service Plans Updated Annually Or On Changes 4.) 83.38(1)(i) Behavior Management Example 3: Number of Complaints Substantiated. 1.) DS4J11 dated 11/15/2024, 1 complaint substantiated 2.) ZZI814 dated 01/29/2025, 1 complaint substantiated 3.) DS4J12 dated 04/30/2025, 1 complaint substantiated 4.) QRT911 dated 12/02/2025, 2 complaints substantiated 5.) OR8N11 dated 08/25/2026, 1 complaint substantiated 6.) OSI411 dated 10/20/2026, 2 complaints substantiated. EXIT INTERVIEW: On 10/20/2026 at 11:30 AM, Surveyor discussed concerns identified with Wellness Director A and Administrator B. Administrator B acknowledged that Resident 2's room was observed to have a urine-like malodor, sticky residue on flooring, and brown-colored stain on the bathroom wall. Wellness Director A and Administrator B acknowledged staff reported Resident 2 became combative during cares as reasoning for the condition of the room. Wellness Director A and Administrator B acknowledged Resident 2's individualized service plans didn't have an individualized behavioral plan documented.	N 196		

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N 196	Continued From page 4 Wellness Director A and Administrator B acknowledged Resident 1's hospice provider reported 2 occasions of finding Resident 1 in soiled incontinence care products, clothing, and/or bedding. Wellness Director A stated his/her staff couldn't explain why Resident 1's hospice provider had found him/her in that condition on 2 separate occasions during their internal investigation.	N 196		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment 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 Rule is not met as evidenced by: Based on record review and interview, the provider did not provider Resident 1 prompt and adequate treatment that was appropriate to his/her needs. On 08/28/2026, a hospice caregiver entered Resident 1's room and noticed a strong smell of urine that made him/her tear up. The hospice caregiver found Resident 1 to be wearing the same clothes s/he had been changed into the previous day. Resident 1's incontinence brief, chucks pad (incontinence mattress pad), shirt and bed sheets were extremely saturated with urine. Resident 1 reported to hospice caregiver and hospice nurse that s/he hadn't been assisted to the bathroom yet that day. Facility staff, when questioned, couldn't recall the last time Resident 1 had been assisted to the bathroom.	N 353		

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N 353	Continued From page 5 On 08/31/2026, a hospice caregiver found Resident 1 to be wearing the same clothes s/he was changed into during the visit on 08/28/2026. The hospice caregiver found Resident 1's incontinence brief to be disintegrating leaving the bed sheets also soiled. Hospice caregiver identified a reddened mark developing on skin that was in contact with the soiled brief. On 09/03/2026, Resident 1 was moved to a new facility to obtain adequate care. This is a repeat violation of previous statement of deficiency ND1D11 dated 06/24/2022. FINDINGS INCLUDE: Facility is a Class CNA non-ambulatory facility. Has a capacity of 50 residents and serves advanced aged, irreversible dementia & Alzheimer's. On 09/10/2026 and 10/01/2026, Department received complaints regarding care concerns provided to Resident 1 by facility staff. On 10/20/2026, Surveyor arrived at the facility for complaint investigation. RECORD REVIEW: On 10/20/2026, Surveyor reviewed Resident 1's facility records. Resident 1 was admitted to facility on 01/31/2019. Resident 1 was moved out of the facility on 09/03/2026. Resident 1 had an activated power of attorney (APOA). Resident 1 had an assigned managed care organized (MCO) and outside hospice provider. Resident 1 diagnosed with but not limited to: dementia.	N 353		

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N 353	Continued From page 6 10/20/2026, Surveyor reviewed Resident 1's individualized service plan (ISP) signed by Resident 1's APOA (Family Member C) on 06/18/2026. Under the subsection titled, "DRESSING & GROOMING, COMPRESSION GARMENTS," the following was documented, "Resident's need for assistance with dressing and undressing - Setup assistance only ..." Under the subsection titled, "GASTROINTESTINAL, BOWEL, & BLADDER, " Resident 1 was documented independent with bladder and bowel management. Under the subsection titled, "INSTRUMENTAL ACTIVITIES OF DAILY LIVING," the following was documented, " ...Resident's need for assistance with caregivers completing weekly laundry and linen services - Caregiver washes resident's linens and personal laundry weekly ... Resident requests the Community provides an apartment refresh which includes trash removal and bed making - Resident requests daily apartment refresh ...Resident's need for assistance with caregivers performing weekly housekeeping service - Resident's housekeeping service is managed by housekeeper(s) ..." On 10/20/2026, Surveyor reviewed Resident 1's ISP dated 08/31/2026. Under the subsection titled, "DRESSING & GROOMING, COMPRESSION GARMENTS," the following was documented, "Resident's need for assistance with dressing and undressing - Setup assistance only ..." Under the subsection titled, "GASTROINTESTINAL, BOWEL, & BLADDER," it was documented that Resident 1 needed 1 staff person to assist with toileting 1-2 times per shift, and that s/he utilized an incontinence brief between toileting episodes. Under the subsection titled, "INSTRUMENTAL ACTIVITIES OF DAILY	N 353		

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LIVING," the following was documented, " ...Resident's need for assistance with caregivers completing weekly laundry and linen services - Caregiver washes resident's linens and personal laundry weekly ... Resident requests the Community provides an apartment refresh which includes trash removal and bed making - Resident requests daily apartment refresh ...Resident's need for assistance with caregivers performing weekly housekeeping service - Resident's housekeeping service is managed by housekeeper(s) ..."

On 10/20/2026, Surveyor reviewed Resident 1's grievances:
1.) On 08/27/2026 at 4:38 PM, Hospice Nurse D sent Wellness Director A the following email, "Hi, [Wellness Director A], I just wanted to bring something to your attention that occurred this afternoon with [Resident 1]. Our CNA (certified nursing assistant) arrived to do [his/her] routine visit, and when [s/he] walked into the room, [s/he] instantly smelled strong urine that was making our CNA tear up. [S/he] went to check on [Resident 1] and [s/he] was in bed, in the same clothes [s/he] had put on [him/her] on [him/her] (sic.) yesterday morning, around 5/6am. [His/Her] brief was soiled with urine and feces ...The concern that we discovered was that [his/her] brief was soiled through [his/her] sheets, and [his/her] brief was disintegrating. [His/Her] shirt was also disintegrating into [his/her] brief and the chuck underneath [him/her]. Meaning that it had been a while, unsure how long, that [s/he] has been changed. Staff were unable to tell our CNA how long it had been since [s/he] had been changed and rolled their eyes at our CNA. [Resident 1] also mentioned that [s/he] was not taken to the bathroom all day, which I know [s/he] is intermittently confused but [s/he] told that to our

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N 353	Continued From page 8 CNA and myself. Our CNA also mentioned to the staff yesterday to see if they could wash his/her soiled sheets from yesterday, the sheets were still in the same place as yesterday and not washed as of this afternoon ..." The facility grievance report form documented that Previous Manager E had investigated Hospice Nurse D's allegations. Under the subsection titled, "Corrective actions implemented (as warranted)," documented the following, corrective action as warranted for staff involved. Staff education on care skills ...". 2.) On 08/31/2026 at 5:26 PM, Hospice Nurse D sent Wellness Director A the following email, "Hi, I just wanted to reach out due to another concern that was brought up to my attention about [Resident 1] today ...Our CNA reached out to me and stated [s/he] was found in bed, about the same situation that happened last week. [S/he] was in the same clothes that out CNA put [him/her] in last Thursday, and [his/her] brief was soiled through [his/her] sheets and was disintegrating, meaning that it was a while since [Resident 1] has been toileted/changed. [S/He] also has a new reddened mark from [his/her] brief due to breakdown. I am concerned on how long [s/he] was like that to cause such break down as well as how [his/her] brief looked ...I am concerned about this incident and how an incident like this happened again. I was wondering if staff have been talked to since the incident last week, and if there are any resources you need from us at this time ...I think we can all agree that [Resident 1] is unable to take [himself/herself] to the restroom and this time, so if staff are stating [s/he] can, I would remind them that [s/he] indeed needs assistance and should be provided assistance. I would say at this time,	N 353		

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that [Resident 1] is in fact unable to get [himself/herself] up when [she] is incontinent to change [his/her] brief as well ..."

The facility grievance report form documented that Previous Manager E had investigated Hospice Nurse D's allegations. Under the subsection titled, "Corrective actions implemented (as warranted)," documented the following, "corrective action as warranted for staff involved ..."

On 10/20/2026, Surveyor reviewed an email from MCO Nurse F to Hospice Nurse D and Wellness Director A. On 09/02/2026 at 9:13 PM, MCO Nurse F sent the following message, "I wanted to let you all know what I saw when I went to do a Health Safety visit at [Family Name] today ...I went to see [Resident 1] next and [s/he] was in bed with [his/her] bare legs and brief showing while [s/he] was lying on [his/her] bed. [His/Her] room had a strong order (sic.) of urine and I saw a soiled brief was in [his/her] waste basket and dirty clothes were on [his/her] chair and in [his/her] bathroom with an empty laundry basket. I saw [his/her] snacks there, but no evidence of [him/her] have (sic.) eaten anything in [his/her] room today. [S/He] appeared to be sleeping soundly, so I went back to the main area ...I spoke with the RA (resident assistant) who had been sitting at the counter prior and asked [him/her] if [Resident 1] had eaten lunch. [S/He] said no. I asked about breakfast; [s/he] said no. I was told that this was common ...I left the building around 145p and then returned with [MCO Case Manager G] at around 230p. I went to see [Resident 1] and [s/he] was still in the same position and no changes were made to the environment ...We stopped to if [Wellness Director A] was in [his/her] office and [s/he] wasn't

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(sic.), so we went to [Administrator A's] office and told them that [Family Member C] wanted [Resident 1] moved and [s/he] would be moved to another CBRF tomorrow ..."

On 10/20/2026, Surveyor reviewed Resident 1's hospice provider record. The following entries were documented:
1.) On 08/11/2026, Doctor K signed a plan of care which documented, " ...FALL PREVENTION: Conference with facility staff/family/caregiver focused on falls. Educate/reinforce facility staff on keeping call light within reach of patient. Educate facility staff on increasing frequency of visual checks on patient ...Educate facility staff/caregiver on scheduled toileting regimen ..."

2.) On 08/26/2026 at 6:29AM, Hospice Caregiver H documented, "Patient whole bed wet. ADLs done. Patient has a new shirt in and refuses pants. Staff updated. And patient back to sleep."

3.) On 08/28/2026 at 1:19PM, Hospice Nurse D documented, "Visit summary- received notification from HCA (Hospice Care Aide) that patient was in a very soiled brief. HCA concerned that no one assisted [him/her] to restroom or checked [his/her] brief since [s/he] was there the day prior. Stated that [his/her] room smelled so soiled it was making [him/her] tear up. Stated that the brief was disintegrating and that [his/her] shirt was the same as yesterday. Stated patients brief was colored from [his/her] shirt as well as the color from the shirt was being bleed into the brief from being soiled for a long period of time. Bedding was soiled all the way through as well as patients chuck underneath [him/her] had coloring from [his/her] shirt on it as well. Writer went for a visit to check on patient due to condition, concerns with being left in a soiled brief for a long

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period of time. HCA stated facility staff were unsure how long it has been since patient has been changed. HCA stated [s/he] was helping patient change and changing [his/her] sheet. Patient had no sheets, dirty sheets from yesterday were in the same spot in the basket as day prior, HCA stated [s/he] asked staff to clean them yesterday, in which they were not and in the same position. Writer brought new sheets for patient ... Upon arrival patient was sitting in a chair in her room, HCA present. Patient awake and alert, no complaints of pain, PAINAD 0 during visit. Stated that [s/he] was sorry [s/he] went to the bathroom. Patient stated [s/he] was not helped to the bathroom all day, HCA stated [s/he] also told [him/her] the same thing. Vitals- 122/86, HR-88 RR-20, temp- 97.6. Had a cough, writer asked staff to give PRN cough medication, med aide stated they don't have any in but have an order, med aide stated [s/he] will request a refill. Patient getting cough medicine with night medications. No complaints of SOB, patient able to answer questions appropriately. Writer updated clinical leaders on situation. Updated [Managed Care Organization (MCO) Provider] team as well as [Wellness Director A] via email as writer was unable to find a nurse. Writer having another nurse visit tomorrow before weekend to check on patient due to situation and being in soiled brief for an extended period of time ..."

4.) On 08/28/2026 at 4:45PM, Hospice Nurse I documented, "Writer arrived to facility and greeted staff. Patient was lying in bed awake. Patient requesting something to drink. Writer got patient fresh ice water, patient took a sip then asked for juice. Care staff got patient some juice. Patient was incontinent of urine, writer did peri care. Coccyx is red and speckled-not open..."

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N 353	Continued From page 12 5.) On 08/31/2026 at 4:49PM, Hospice Nurse D documented, "Phone call from HCA- reported that patient was still in the same clothes as [s/he] was in that [s/he] changed [him/her] into last Thursday. Stated that [his/her] brief was soiled through [his/her] sheets and reporting that [s/he] has a worsening cough and appears to have new skin breakdown on [his/her] bottom due to being incontinent for an extended period of time ..." 6.) On 08/31/2026 at 6:12PM, Hospice Nurse Practitioner J documented, " ...Nursing documentation notes intermittent agitation, primarily when patient wants to be left alone. Per nursing documentation today, HCA reported patient was wearing the same clothing as last week. Increased skin breakdown to buttocks also reported ..." On 10/20/2026, Surveyor reviewed Resident 1's MCO provider record. The following entries were documented: 1.) On 09/01/2026, MCO Nurse F documented, "On 8/31, [MCO Case Manager G] updated me on report from hospice that member was found extremely incontinent and of [his/her] discussion with [Family Member C] and [his/her] decision to move member due to multiple neglect issues at [Name Of Facility]. Referrals are being sent out to [City Name] area SNF [Skilled Nursing] facilities ...[MCO Case Manager G] and I discussed situation this am and further actions taking place to support member safety, including APS (Adult Protective Services) notification. [Wellness Director A] and IDT (interdisciplinary team) were notified by [Hospice Nurse D] yesterday and [Wellness Director A] responded this am, noting [Previous Manager E], Care Team Manager as being responsible for the direct care staff and	N 353		

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included [him/her] in the response as well as [Administrator B] ..."

2.) On 09/02/2026, MCO Nurse F documented, "This RN went tom (sic.) [Name Of Facility] to complete a safety check on member. I spoke to [Wellness Director A] and told [him/her] I was there to see 4 of [his/her] residents for health and safety checks. [S/he] told me [s/he] was too busy right now to go with me as [s/he] was the only nurse in the building. I told [him/her] that I had sent [him/her] an email this am requesting these member's MAR's (medication administration records) and ISP's. I arrived to member's room around 1225p. Member was lying on [his/her] bed with [his/her] pants off and a shirt. Member had a clean incontinent brief on and was partially covered with an Afghan. Member's dirty clothing was on the seat of [his/her] chair and another dirty shirt was found in the bathroom. An empty laundry basket to collect dirty clothes was empty. I asked staff if the member had lunch or breakfast. They said [s/he] hadn't and said that they ask [him/her] and [s/he] says no. I asked the staff member if not eating breakfast or lunch was a regular thing for [him/her] and I was told yes, it was. I then asked if [s/he] eats dinner. The staff person said [s/he] didn't know as [s/he] didn't work that shift. After waiting for some time for the [Med Passer L] to come to provide me access to the medication cart. I completed a medication reconciliation of [his/her] medications in the med cart. An HS (nighttime) dose of gabapentin for 8/17/26 was found in the cart that had not been given. Later in the day, around 245p, [MCO Case Manager G] and myself returned to the facility and went to see the member again. Member was still in [his/her] bed and the same dirty items were as they were earlier when I came. [MCO Case Manager G] explained to the member that [Family

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N 353	Continued From page 14 Member C] had decided to move [him/her] to another CBRF and that would happen tomorrow, 9/3. [MCO Case Manager G] asked [him/her] if that was ok and [s/he] shook [his/her] head yes. We then went to [Administrator B's] office, and [Wellness Director A] answered the door, but blocked vision into the room. [MCO Case Manager G] told [him/her] that member would be moving 9/2 per [Family Member C's] request and informed [him/her] of what time and how member and [his/her] room items would be moved ..." INTERVIEWS: On 10/20/2026 at 11:30 PM, Surveyor discussed the above concerns with Wellness Director A and Administrator B. Wellness Director A stated the Previous Manager E had been tasked with investigating and correcting the concerns emailed to facility by Resident 1's hospice provider. Wellness Director A reported the facilities investigations hadn't produced substantial evidence that any specific caregiver had not provided timely incontinence care to Resident 1. Wellness Director A acknowledged there were 2 separate incidents on 2 different days that Resident 1 was found by hospice staff to be in soiled brief, clothing, and bedding. Wellness Director A acknowledged Resident hospice team had reported via email Resident 1's skin being reddened from the saturated brief s/he had been wearing. When asked about the urine-like odor reported by hospice staff, Administrator B stated s/he was having difficulty obtaining the appropriate cleaning kit during that time. Wellness Director A reported s/he didn't know why Resident 1 was moved out of the facility. Wellness Director A reported the MCO case manager and MCO nurse just knocked on Administrator B's door and said they were moving	N 353		

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N 353	Continued From page 15 Resident 1 out the next day. On 10/23/2026 at 8:15 AM, Surveyor interviewed Hospice Nurse D. Hospice Nurse D reported that in July 2026 Resident 1 was hospitalized after an episode of heat exhaustion from being left outside to nap in dark clothing during a heat advisory. Hospice Nurse D reported after Resident 1 returned to the facility in the beginning of August s/he's condition had declined. Hospice Nurse D reported Resident 1 was confused as baseline and not able to summon assistance from staff, that it had been established with facility that staff need to increase supervision to meet Resident 1's needs following hospitalization. Hospice Nurse D reported that a few weeks after returning to the facility, the hospice caregiver reported that s/he found Resident 1 sleeping in a disintegrating incontinence brief, the brief, incontinence pad, bed linens, mattress and his/her shirt was soaked with urine. Hospice Nurse D reported that the CNA reported the fabric ink from Resident 1's shirt had bled into the wet brief. Hospice Nurse D reported s/he went to assess Resident 1 as soon as possible. Hospice Nurse D reported Resident 1 had told the hospice CNA and him/her that facility staff hadn't helped him/her to the toilet that day. Hospice Nurse D stated s/he immediately reported his/her concerns to Resident 1's care team and offered the facility additional support/training. Hospice Nurse D stated then approximately a week after the first incident, the hospice CNA found Resident 1 to be in soiled clothing/bedding with signs of skin breakdown to the coccyx. CROSS REFERENCE: DHS Chapter 83.44(2)(a) Rooms Clean And Free From Odors	N 353		

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N 433	Continued From page 16	N 433		
N 433	83.38(1)(i) Behavior management. 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: Behavior management. The CBRF shall provide services to manage resident ' s behaviors that may be harmful to themselves or others. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure Resident 2 was provided with services to manage his/her behaviors that may be harmful to themselves or others. This is a repeat from previous statement of deficiency (SOD) ND1D11 dated 06/24/2022 and SOD DS4J11 dated 11/15/2024. FINDINGS INCLUDE: On 10/20/2026, Surveyor arrived at the facility for a complaint investigation. On 10/20/2026 at 10:14AM, Surveyor observed Resident 2's room to have an overwhelming urine-like mal odor. When Surveyor entered the room his/her shoes made a sticking sound from an unidentified residue. Surveyor saw Caregiver M walking by and asked about the odor or Resident 2's room. Caregiver M reported staff were trying to clean all the furniture to remove the smell. Surveyor asked why Resident 2's room had the smell to begin with. Caregiver M stated	N 433		

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the Resident 2's had a history of refusing care from staff and becoming combative with staff. Caregiver M stated Resident 2 had a history of hitting staff during cares and there would be incontinence episodes during these refusals.

On 10/20/2026 at 10:30AM, Surveyor discussed Resident 2's behaviors with Wellness Director A. Wellness Director A reported that Resident 2 did have a history of becoming combative with staff during cares. Wellness Director A reported there was an incident where Resident 2 hit him/her with the door. Wellness Director A reported s/he had trained staff to re-approach Resident 2 when s/he refuses cares and to attempt different approaches, at times different staff to encourage compliance with care.

On 10/20/2026, Surveyor reviewed Resident 2's facility record. Resident 2 was admitted to the facility on 11/11/2025. Resident 2 had an activated power of attorney (APOA). Resident 2 was diagnosed with but not limited to: dementia.

On 10/20/2026, Surveyor reviewed Resident 2's medication orders:
1.) "QUETIAPINE TAB 25MG ...TAKE 1 TABLET BY MOUTH TWICE DAILY ...Condition: Vascular dementia, unspecified severity, with agitation ...Start: 12/10/2025 ...Last given: 10/20/2026 08:07 (8:07AM) ..."

2.) "QUETIAPINE TAB 25MG ...TAKE 1 TABLET BY MOUTH TWICE DAILY AS NEEDED ...Condition: Vascular dementia, unspecified severity, with agitation ...PRN: Max Dose: 2 tablets in 24 hours ...Start: 08/19/2025 ...Last given: Never ..."

On 10/20/2026, Surveyor reviewed Resident 2's

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N 433	Continued From page 18 individualized service plan (ISP) signed by Resident 2's APOA on 06/19/2026. Resident 2 was documented as requiring the assistance of 1 staff member for bathing, dressing, and grooming. Under the subsection titled, "GASTROINTESTINAL, BOWEL, & BLADDER," the following was documented, " ...Resident's need for assistance for bladder toileting with frequency needed per 24 hours - assist of 1, 3-4X per 24 hours. Resident needs assistance with toileting 1-2x per shift." Under the subsection titled, "MENTAL AND BEHAVIORAL HEALTH, EXPRESSIONS, AND INTERVENTIONS," Resident 2's combative behavior of hitting staff, using a door to hit staff, his/her psychotropic PRN medication Quetiapine 25 mg for agitation, nor history refusal of cares were not documented/care planned. EXIT INTERVIEW: On 10/20/2026 at 11:30 AM, Surveyor discussed the above concerns with Wellness Director A and Administrator B. Wellness Director A acknowledged that Resident 2 had a history of hitting staff and hitting him/her with door while refusing cares. Wellness Director A acknowledged that Resident 2's ISP didn't have an individualized care plan about Resident 2's history of combative behaviors or the prescribed psychotropic PRN available for agitation. Wellness Director A stated an individualized behavior plan would be documented and implemented as soon as possible. CROSS REFERENCE: DHS Chapter 83.44(2)(a) Rooms Clean And Free From Odors	N 433		

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N 489	Continued From page 19	N 489		
N 489	83.44(2)(a) Rooms clean and free from odors. The CBRF shall keep all rooms clean and shall make reasonable attempts to keep all rooms free from odors. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure all rooms were kept clean and made reasonable attempts to keep all rooms free from odors. The is a repeat from previous statement of deficiency (SOD) ND1N11 dated 06/24/2022 and SOD ZZI813 dated 08/28/2024. FINDINGS INCLUDE: On 09/10/2026 and 10/01/2026, Department received complaints about a resident's room having a urine-like mal-odor On 10/20/2026, Surveyor arrived at the facility for complaint investigation. OBSERVATION & INTERVIEW: On 10/20/2026 at 10:14AM, Surveyor observed Resident 2's room to have an overwhelming urine-like mal odor. When Surveyor entered the room his/her shoes made a sticking sound from an unidentified residue. Surveyor saw Caregiver M walking by and asked about the odor or Resident 2's room. Caregiver M reported staff were trying to clean all the furniture to remove the smell. Surveyor entered the attached bathroom and found the urine-like mal-odor to lessen in the bathroom. Surveyor observed 2 small spots of an unknown, brown-colored substance on the bathroom wall (Picture 1). Surveyor observed	N 489		

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moderate number of random debris particles on the floor near the bed (Picture 2).

On 10/20/2026 at 10:20AM, Surveyor asked Administrator B to walk into Resident 2's room with him/her. Administrator B acknowledged Resident 2's room had a mal-odor. Administrator B reported s/he had been attempting to train staff on using a fabric shampooer on mattress after incontinence episodes. Administrator B acknowledged the flooring had an unknown sticky-type residue on the floor.

On 10/20/2026 at 10:35AM, Administrator B approached Surveyor and reported that the urine-like mal-odor in Resident 2's room was coming from his/her fabric chair. Administrator B stated housekeeping had been directed to clean the room as soon as possible.

RECORD REVIEW:

EXAMPLE 1: Resident 1

On 10/20/2026, Surveyor reviewed Resident 1's facility records. Resident 1 was admitted to facility on 01/31/2019. Resident 1 was moved out of the facility on 09/03/2026. Resident 1 had an activated power of attorney (APOA). Resident 1 had an assigned managed care organized (MCO) and outside hospice provider. Resident 1 diagnosed with but not limited to: dementia.

On 10/20/2026, Surveyor reviewed Resident 1's individualized service plan (ISP) signed by his/her APOA on 06/18/2026. It was documented that staff were tasked with housekeeping and laundry.

On 10/20/2026, Surveyor reviewed Resident 1's hospice record. On 08/28/2026 at 1:19PM,

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N 489	Continued From page 21 Hospice Nurse D documented, "Visit summary-received notification from HCA (Hospice Care Aide) that patient was in a very soiled brief... Stated that [his/her] room smelled so soiled it was making [him/her] tear up ...HCA stated [s/he] was helping patient change and changing [his/her] sheet. Patient had no sheets, dirty sheets from yesterday were in the same spot in the basket as day prior, HCA stated [s/he] asked staff to clean them yesterday, in which they were not and in the same position. Writer brought new sheets for patient ..." EXAMPLE 2: Resident 2 On 10/20/2026, Surveyor reviewed Resident 2's facility record. Resident 2 was admitted to the facility on 11/11/2025. Resident 2 had an activated power of attorney (APOA). Resident 2 was diagnosed with but not limited to: dementia. On 10/20/2026, Surveyor reviewed Resident 2's individualized service plan (ISP) signed by Resident 2's APOA on 06/19/2026. It was documented that staff were tasked with housekeeping of the room. EXIT INTERVIEW: On 10/20/2026 at 11:30 AM, Surveyor discussed the above concerns with Wellness Director A and Administrator B. Administrator B acknowledged that Resident 2's room had a strong urine-like smell that was discovered to be emitting from the fabric chair in the room. CROSS REFERENCE: N0353 83.32(3)(i) Rights Of Residents: Adequate Treatment CROSS REFERENCE: N0433 83.38(1)(i) Behavior Management	N 489		

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