STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020768	A. BUILDING: _____ B. WING _____	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE ON HAMPTON ASSISTED LIVING F/	4615 W HAMPTON AVE MILWAUKEE, WI 53218

(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 09/30/2025, Surveyors completed a standard survey, and 2 complaint investigations. As a result, 23 deficiencies were identified, and 2 complaints were substantiated. Census: 32	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 observation, record review, and interviews, the provider and its operation did not comply with all laws governing the Community-Based Residential Facility (CBRF). The licensee did not ensure compliance with DHS 83 was achieved and maintained. As a result of the probationary survey, 23 deficiencies were identified. Findings include: The provider is licensed to provide services up to 36 residents within the client groups of irreversible dementia/Alzheimer's, traumatic brain injury, advanced age, physically disabled, developmentally disabled, terminally ill, correctional clients, alcohol/drug dependent, and emotionally disturbed/mental illness. On 09/30/2025, Surveyors completed a standard probationary survey. The following deficiencies were identified:	N 196		

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

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N 196	Continued From page 1 N0196 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0205 83.14(2)(j) Not Permit a Condition of Substantial Risk N0220 83.17(2)(a) Employees Screened For Communicable Diseases N0230 83.19 Orientation N0310 83.29(2) Admission Agreement Include Services, Charges N0327 83.31(4)(b) Allowable Reasons For Involuntary Discharge N0328 83.31(4)(c) Involuntary Discharge Notice Requirements N0352 83.32(3)(h) Rights of Residents- Receive Medication N0381 83.35(1)(a) Pre-Admission and Ongoing Assessments N0386 83.35(3)(a) Comprehensive Individualized Service Plan N0393 83.35(5)(a) Initial Evaluation of Evacuation Limitations N0401 83.37(1)(b) Medication Label Permanently Attached N0406 83.37(1)(g) Disposition of Medications 0415 83.37(2)(d) Documentation of Medication Administration N0447 83.41(1)(c) Dishwashing N0448 83.41(2)(a) Nutrition: Diet N0450 83.41(2)(a) Nutrition: Menus N0453 83.41(2)(a) Food Safety N0499 83.45(3) Toxic Substances N0507 83.46(1)(f) Combustibles N0617 83.55(6)(b) Bath and Toilet Areas: Water Temperature Z0012 50.065(2)2(bm) Out of State Background Checks Y3244 50.09(1)(L) - Care On 09/04/2025, at 2:00 PM, Surveyors interviewed Administrator B and Registered	N 196		

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N 196	Continued From page 2 Nurse (RN) Consultant C. Administrator B reported s/he and Licensee A were responsible for ensuring the facility complies with the codes. RN Consultant C reported s/he was hired to assist Administrator B and Licensee A in maintaining compliance.	N 196		
N 205	83.14(2)(j) Not permit a condition of substantial risk. The licensee may not permit the existence or continuation of any condition which is or may create a substantial risk to the health, safety or welfare of any resident. This Rule is not met as evidenced by: Based on interview and record review, the provider permitted the existence or continuation of a condition which is or may create substantial risk to the health, safety, or welfare of 5 of 5 residents. The facility elevator was no longer working because of flooding damage which occurred around 08/10/2025. The provider did not ensure a safe evacuation plan was in place for semi-ambulatory or non-ambulatory residents on the second floor. Findings include: On 09/03/2025, at 9:30 AM, Surveyors toured the facility and observed the following: The facility consisted of 3 floors, the basement or ground floor where the dining room, kitchen, activity room and laundry were located. The 1st floor and 2nd floor consisted of resident rooms. There was 1 elevator to reach the other floors.	N 205		

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N 205	Continued From page 3 The elevator was not operable during the time of the survey. Surveyors observed 2 sets of stairs to reach the 2nd floor. During the survey, Surveyors witnessed Resident 1, Resident 3 and Resident 5 utilize the stairs. Resident 1 utilized a power wheelchair for ambulation. Resident 1 was observed using a manual wheelchair to go to the center stairwell. Resident 1 was observed walking down the center stairwell with assistance from a family member. Resident 1's manual wheelchair was then carried down the stairs. Resident 3 utilized a manual wheelchair for ambulation. Resident 3 was observed walking down the center stairwell assisted by Resident 6. Resident 6 then carried Resident 3's wheelchair down the stairwell. Resident 5 had a single leg amputated and utilized a wheelchair for ambulation. Resident 5 was observed stopping her/his wheelchair at the top of the stairwell. Resident 5 then lowered herself/himself to the floor. Resident 5 was then observed sliding down the stairwell one step at a time on her/his buttocks. A staff member then carried her/his wheelchair down the stairs. On 09/03/2025, at 10:55 AM, Surveyors reviewed a document titled "Emergency and Disaster Plan Form", dated 03/06/2025. The form indicated "For Fire the fire alarm will be set off, and evacuation will proceed. Each resident is expected to evacuate~ independently in a fire emergency unless deemed otherwise per the Resident Evacuat1on (sic) Assessment. A full surprise evacuation will be conducted every month. Independent evacuations will be monitored and maintained...."	N 205		

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N 205	Continued From page 4 On 09/04/2025, at 3:25 PM, Surveyors reviewed the second-floor evacuation diagram which indicated the center stairwell, East stairwell, and West stairwell as emergency exits to the first floor. Surveyors did not observe any evidence of a procedure/plan or special equipment for semi-ambulatory or non-ambulatory residents to go from the second floor to the first floor via stairs. On 09/04/2025 at 2:00 PM, Surveyors interviewed Administrator B and Registered Nurse (RN) Consultant C. Administrator B and RN Consultant C did not offer any information regarding updated policies/procedures for transporting semi-ambulatory or non-ambulatory residents from the second floor to the first floor in the event of an emergency.	N 205		
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.	N 220		

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N 220	Continued From page 5	N 220		

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 4 of 5 caregivers reviewed (Caregiver D, Caregiver E, Caregiver F, and Caregiver G).

Findings include:

On 09/03/2025, at 1:45 PM, Surveyors reviewed staff files and identified the following:

Caregiver D was hired on 08/03/2025. Caregiver D's record did not contain any evidence of a communicable disease screening or a TB test.

Caregiver E was hired on 07/16/2025. Caregiver E's record contained the results of a TB test dated 07/10/2025. Caregiver E's record did not contain evidence of a communicable disease screening.

Caregiver F was hired on 08/29/2025. Caregiver F's record contained the results of a TB test dated 08/01/2025. Caregiver F's record did not contain evidence of a communicable disease screening.

Caregiver G was hired on 07/04/2025. Caregiver G's record contained the results of a TB test dated 07/14/2025. The TB test was dated 10 days after Caregiver G's date of hire. Caregiver G's record did not contain evidence of a

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N 220	Continued From page 6 communicable disease screening. On 09/04/2025 at 2:00 PM, Surveyors interviewed Administrator B and Registered Nurse (RN) Consultant C. Administrator B reported s/he was aware of the code requirement. Administrator B reported staff were sent to primary care and informed a TB screening and communicable disease screening were required. Administrator B reported s/he was unaware why staff files did not contain communicable disease screenings or TB test results.	N 220		
N 230	83.19 Orientation Before an employee performs any job duties, the CBRF shall provide each employee with orientation training which shall include all of the following: (1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); (5) CBRF policies and procedures; (6) Recognizing and responding to resident changes of condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 5 staff reviewed received orientation in the required topics: (1) Job Responsibilities,(2) Prevention and reporting of resident abuse, neglect, and misappropriation of resident property; (3) Information regarding	N 230		

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N 230	Continued From page 7 assessed needs and individual services for each resident for whom the employee is responsible, (4) Emergency and disaster plan and evacuation procedures under s. DHS 83.47(2), (5) Community Based Residential Facility (CBRF) policies and procedures, (6) Recognizing and responding to resident changes of condition. Prior to performing job duties, Caregiver D, Caregiver F, and Caregiver G did not receive orientation training in prevention and reporting of resident abuse, neglect, and misappropriation of resident property; information regarding assessed needs and individual services for each resident for whom the employee is responsible; emergency and disaster plan and evacuation procedures under s. DHS 83.47(2); CBRF policies and procedures; recognizing and responding to resident changes of condition. Findings include: The provider is licensed to provide services up to 36 residents within the client groups of irreversible dementia/Alzheimer's, traumatic brain injury, advanced age, physically disabled, developmentally disabled, terminally ill, correctional clients, alcohol/ drug dependent, and emotionally disturbed/mental illness. On 09/03/2025, at 1:45 PM, Surveyors reviewed staff files and identified the following: Caregiver D was hired on 08/03/2025. Caregiver D's record did not contain evidence of orientation training in prevention and reporting of resident abuse, neglect, and misappropriation of resident property; information regarding assessed needs and individual services for each resident for whom the employee is responsible; emergency	N 230		

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N 230	Continued From page 8	N 230		

and disaster plan and evacuation procedures under DHS 83.47(2); CBRF policies and procedures; recognizing and responding to resident changes of condition.

Caregiver F was hired on 08/29/2025. Caregiver F's record did not contain evidence of orientation training in prevention and reporting of resident abuse, neglect, and misappropriation of resident property; information regarding assessed needs and individual services for each resident for whom the employee is responsible; emergency and disaster plan and evacuation procedures under DHS 83.47(2); CBRF policies and procedures; recognizing and responding to resident changes of condition.

Caregiver G was hired on 07/04/2025. Caregiver G's record did not contain evidence of orientation training in prevention and reporting of resident abuse, neglect, and misappropriation of resident property; information regarding assessed needs and individual services for each resident for whom the employee is responsible; emergency and disaster plan and evacuation procedures under DHS 83.47(2); CBRF policies and procedures; recognizing and responding to resident changes of condition.

On 09/04/2025 at 2:00 PM, Surveyors interviewed Administrator B and Registered Nurse (RN) Consultant C. Administrator B reported s/he was responsible for ensuring training was completed. Administrator B reported s/he went over orientation training, policies, and procedures with new hire. Administrator B reported s/he was unable to provide evidence of completion of the orientation training. RN Consultant C reported s/he utilized a checklist for orientation training and would ensure new staff orientation was

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N 230	Continued From page 9 documented.	N 230		
N 310	83.29(2) Admission agreement include services, charges The admission agreement shall be given in writing and explained orally in the language of the prospective resident or legal representative. Admission is contingent on a person or that person ' s legal representative signing and dating an admission agreement. The admission agreement shall include all of the following: (a) An accurate description of the basic services provided, the rate charged for those services and the method of payment; (b) Information about all additional services offered, but not included in the basic services. The CBRF shall provide a written statement of the fees charged for each of these services; (c) The method for notifying residents of a change in charges for services; (d) Terms for resident notification to the CBRF of voluntary discharge. This paragraph does not apply to a resident in the custody of a government correctional agency; (e) Terms for refunding charges for services paid in advance, entrance fees, or security deposits in the case of transfer, death or voluntary or involuntary discharge; (f) A statement that the amount of the security deposit may not exceed one month ' s fees for services, if security deposit is collected; (g) Terms for holding and charging for a resident ' s room during a resident ' s temporary absence. This paragraph does not apply to a resident in the custody of a government correctional agency; (h) Reasons and notice requirements for involuntary discharge or transfer, including transfers within the CBRF. This paragraph does not apply to a resident in the custody of a government correctional agency.	N 310		

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N 310	Continued From page 10 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each resident, or their responsible party, signed an admission agreement prior to or at the time of admission for 5 of 5 residents. Resident 1, Resident 2, Resident 4, Resident 5, and Resident 12 did not have a signed admission agreement. Findings include: On 03/06/2025, the facility was undergoing a change of ownership (CHOW) and was issued a probationary license. On 09/03/2025, at 1:15 PM, Surveyors reviewed resident records and identified the following: Resident 1 was admitted on 07/02/2025. Resident 1 was her/his own decision maker. Resident 1's admission agreement was not signed. Resident 2 was admitted on 08/19/2024. Resident 2 was her/his own decision maker. Resident 2 signed a document indicating s/he had received the house rules, but there was no evidence of a signed admission agreement with the new facility under the CHOW. Resident 4 was admitted on 05/13/2025. Resident 4 was her/his own decision maker. Resident 4's admission agreement was not signed. Resident 5 was admitted on 06/11/2025. Resident 5 was her/his own decision maker. Resident 5's	N 310		

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N 310	Continued From page 11 admission agreement was signed by Administrator B. Resident 5's admission agreement was not signed by Resident 5. Resident 12 was admitted on 08/07/2025. Resident 12 had an activated power of attorney (POA). Resident 12's record did not contain an admission agreement. On 09/04/2025 at 2:00 PM, Surveyors interviewed Administrator B and Registered Nurse (RN) Consultant C. Administrator B reported s/he was responsible for completing the admission agreements. Administrator B reported Resident 4 refused to sign the admission agreement. When Surveyors inquired about the other admission agreements, Administrator B did not offer any explanation.	N 310		
N 327	83.31(4)(b) Allowable reasons for involuntary discharge. Discharge or transfer initiated by CBRF. Reasons for involuntary discharge. The CBRF may not involuntarily discharge a resident except for any of the following reasons: 1. Nonpayment of charges, following reasonable opportunity to pay. 2. Care is required that is beyond the CBRF ' s license classification. 3. Care is required that is inconsistent with the CBRF ' s program statement and beyond that which the CBRF is required to provide under the terms of the admission agreement and this chapter. 4. Medical care is required that the CBRF cannot provide. 5. There is imminent risk of serious harm to the health or safety of the resident, other residents or employees, as documented in the resident ' s record. 6. As provided under s. 50.03 (5m), Stats. 7. As otherwise permitted by law.	N 327		

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N 327	Continued From page 12	N 327		

This Rule is not met as evidenced by:
Based on record review and interview, the provider issued a 30-day discharge notice to 1 of 1 resident (Resident 5) on 06/20/2024 for reasons other than nonpayment of charges, inconsistency with the provider's program statement, care concerns, as provided under s. 50.03(5)(m) or as permitted by law.

Findings include:

This facility is licensed as a class CNA (non-ambulatory) CBRF able to serve up to 36 residents within client groups of advanced aged, correctional clients, developmentally disabled, irreversible dementia/Alzheimer's, alcohol/drug dependent, traumatic brain injury, physically disabled and emotionally disturbed/mental illness.

On 09/04/2025, at 12:00 PM, Surveyors reviewed Resident 5's record. Resident 5 was admitted on 06/11/2025 with diagnoses including post-traumatic stress disorder, high blood pressure, alcohol use, anemia, anxiety and low back pain. Resident 5's "Resident Pre-Admission Checklist", dated 06/11/2025, indicated Resident 5 had verbal behaviors due to intoxication.

Resident 5's preadmission questionnaire, undated, indicated the following:
"Attitude: Poor attitude when member drinks.
Interaction with Others: Good when not drinking.
Aggressive/Combative: yes
Verbal: Verbal [sic] abusive when intoxicated.
History of alcohol use and/or abuse: yes

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N 327	Continued From page 13 Is resident able to drink alcohol: no History of drug use and/or abuse: yes ..." Resident 5's file contained an involuntary discharge notice. The involuntary discharge notice did not contain a date or time. The notice stated, "Dear [Resident 5], This letter serves as a formal notice of termination of your residency at Heritage on Hampton, effective 30 days from the date of this letter. As per our agreement and the polices of our facility, we are providing you with a 30-day notice to vacate your current residence. The reasons for this notice are as follows: Sexually assaulting [other residents], members are scared to come out of their rooms due to members [sic] being intoxicated and verbally abusive. The member is giving members who are not supposed to drink liquor after being told multiple times to stop; there is no redirecting, the member is ripping off resident decorations from the door and walls in the member's room. The member went into a resident's room and tried to rip off [her/his] clothes and tried to lay [her/his] head in [her/his] lap. The members [sic] go into other members' rooms without their permission. Calling the police and refusing to seek help once they arrive. Every day [sic], there's an issue, and it's due to drinking. The other members are afraid to [Resident 5]; [she's/he's] bullying the other members every day [sic]. We encourage you to use this time to make necessary arrangements for your relocation. Please ensure that all personal belongings are removed from your unit by the termination date. If you require assistance during this transition, do not hesitate to reach out to our staff ...." On 09/04/2025 at 2:00 PM, Surveyors interviewed Administrator B and RN Consultant C. Administrator B reported s/he was unaware of the	N 327		

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N 327	Continued From page 14 code requirement regarding involuntary discharges. Cross-Reference N0328 DHS 83.41(4)(c) Involuntary Discharge Notice Requirements	N 327		
N 328	83.31(4)(c) Involuntary discharge notice requirements. Discharge or transfer initiated by CBRF. Notice requirements. Every notice of involuntary discharge shall be in writing to the resident or resident ' s legal representative and shall include all of the following: 1. A statement setting forth the reason and justification for discharge listed under par. (b). 2. A statement that the resident or the resident ' s legal representative may ask the department to review the involuntary discharge by sending a written request within 10 days of receipt of the discharge statement to the department ' s regional office with a copy to the CBRF. The notice shall state that the request must provide an explanation why the discharge should not take place. 3. The name, address and telephone number of the department ' s regional office director. 4. The name, address and telephone number of the regional office of the board on aging and long term care ' s ombudsman program. For residents with developmental disability or mental illness, the notice shall include the name, address and telephone number of the protection and advocacy agency designated under s. 51.62(2)(a), Stats. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure an involuntary discharge	N 328		

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N 328	Continued From page 15	N 328		

notice provided to 1 of 1 resident (Resident 5), included a statement the resident may ask the Department to review the involuntary discharge by sending a written request within 10 days of receipt of the discharge statement to the Department's regional office with a copy to the community based residential facility (CBRF). The notice did not state that the request must provide an explanation why the discharge should not take place. The notice did not include the name, address and telephone number of the Department's regional office director or the name, address, and telephone number of the regional office of the Wisconsin Board on Aging and Long-Term Care's ombudsman program.

Findings include:

On 09/04/2025, at 12:00 PM, Surveyors reviewed the involuntary discharge notice. The involuntary discharge notice did not contain a date or time. The notice stated, "Dear [Resident 5], This letter serves as a formal notice of termination of your residency at Heritage on Hampton, effective 30 days from the date of this letter. As per our agreement and the polices of our facility, we are providing you with a 30-day notice to vacate your current residence. The reasons for this notice are as follows: Sexually assaulting [other residents], members are scared to come out of their rooms due to members [sic] being intoxicated and verbally abusive. The member is giving members who are not supposed to drink liquor after being told multiple times to stop; there is no redirecting, the member is ripping off resident decorations from the door and walls in the member's room. The member went into a resident's room and tried to rip off [her/his] clothes and tried to lay [her/his] head in [her/his] lap. The members [sic] go into other members' rooms without their

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N 328	Continued From page 16 permission. Calling the police and refusing to seek help once they arrive. Every day [sic], there's an issue, and it's due to drinking. The other members are afraid to [Resident 5]; [she's/he's] bullying the other members every day [sic]. We encourage you to use this time to make necessary arrangements for your relocation. Please ensure that all personal belongings are removed from your unit by the termination date. If you require assistance during this transition, do not hesitate to reach out to our staff ...." The notice did not include a statement that the resident may ask the Department to review the involuntary discharge by sending a written request within 10 days of receipt of the discharge statement to the Department's regional office with a copy to the CBRF. The notice did not state that the request must provide an explanation why the discharge should not take place. The notice did not include the name, address and telephone number of the Department's regional office director or the name, address, and telephone number of the Wisconsin Board on Aging and Long-Term Care's ombudsman program. On 09/04/2025 at 2:00 PM, Surveyors interviewed Administrator B and RN Consultant C. Administrator B reported s/he was unaware of the code requirement to ensure the involuntary notice contained the required documentation. Cross Reference N0327 DHS 83.31(4)(b) Allowable Reasons For Involuntary Discharge	N 328		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats.,	N 352		

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N 352	Continued From page 17 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 right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on observations, record review and interview, the provider did not ensure 4 of 4 resident (Resident 1, Resident 5, Resident 8, and Resident 12) reviewed received prescribed medications in the dosage and at intervals prescribed by the practitioner. Resident 1 did not receive 5 doses of his/her Zepbound injection and 2 doses of her/his bumetanide in August 2025. Resident 5 did not receive 10 doses of duloxetine and 14 doses of amlodipine in August 2025. Resident 8 did not receive 4 doses triamcinolone between 09/01/2025 to 09/04/2025 and all her/his morning medications which consisted of aspirin, escitalopram, lamotrigine, metformin on 09/04/2025. Resident 12 did not receive at least 6 documented times of medication administration of medications which consisted of baclofen, divalproex, dorzolamide-timolol, duloxetine, famotidine, folic acid, lacosamide, latanoprost, levetiracetam, olanzapine and a stool softener between 09/05/2025 -09/12/2025. Resident 12 was admitted to the hospital with seizure activity on 09/12/2025. Findings include:	N 352		

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N 352	Continued From page 18 Observations On 09/04/2025, at 8:10 AM, Surveyors observed medication pass. During the observations, Surveyors observed Resident 5 and Resident 8 did not receive all their prescribed medications due to medications were not available in the facility. Record Review On 09/04/2025, at 9:30 AM, Surveyors reviewed resident records and identified the following: -Resident 1 was admitted on 07/02/2025, with diagnoses including acute and chronic respiratory failure with hypercapnia, chronic kidney disease, chronic obstructive pulmonary disease (COPD), congestive heart failure systolic chronic, epilepsy, obesity and stroke. Resident 1's August 2025 medication administration record (MAR) indicated s/he was prescribed Zepbound 2.5 milligrams (mg)/0.5 milliliters (ml) once a week on Friday and bumetanide 2 mg twice a day. Resident 1's MARs indicated s/he did not receive the following medications: 08/01/2025 at 8:00 AM - Zepbound "not available not [administered] 08/08/2025 at 8:00 AM - Zepbound "not available not [administered] 08/09/2025 at 2:00 PM - bumetanide 2mg "Not In Cart" 08/15/2025 at 8:00 AM - Zepbound "not available not [administered] 08/21/2025 at 8:00 AM - Zepbound "not available not [administered] 08/23/2025 2:00 PM - bumetanide 2mg "Not In	N 352		

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N 352	Continued From page 19 Cart" 08/29/2025 at 8:00 AM - Zepbound "not available not [administered] - Resident 5 was admitted on 06/11/2025 with diagnoses including post-traumatic stress disorder, high blood pressure, alcohol use, anemia, anxiety and low back pain. Resident 5's August 2025 MAR indicated s/he was prescribed duloxetine 60 mg once a day, amlodipine 10 mg once a day, gabapentin 600 mg three times a day, and ramelteon 8 mg once a day. Resident 5's MARs indicated Resident 5 did not receive the following medications: 08/07/2025 at 8:00 AM - duloxetine 60 mg and amlodipine 10 mg 08/09/2025 at 8:00 AM - duloxetine 60 mg and amlodipine 10 mg 08/10/2025 at 8:00 AM - duloxetine 60 mg and amlodipine 10 mg 08/11/2025 at 8:00 AM - duloxetine 60 mg and amlodipine 10 mg 08/18/2025 at 8:00 AM - amlodipine 10 mg 08/19/2025 at 8:00 AM - amlodipine 10 mg 08/20/2025 at 8:00 AM - amlodipine 10 mg 08/22/2025 at 8:00 AM - amlodipine 10 mg 08/23/2025 at 8:00 AM - duloxetine 60 mg and amlodipine 10 mg 08/26/2025 at 8:00 AM - duloxetine 60 mg and amlodipine 10 mg 08/27/2025 at 8:00 AM - duloxetine 60 mg and amlodipine 10 mg 08/28/2029 at 8:00 AM - duloxetine 60 mg and amlodipine 10 mg 08/30/2025 at 8:00 AM - duloxetine 60 mg and amlodipine 10 mg 08/31/2025 at 8:00 AM - duloxetine 60 mg and amlodipine 10 mg	N 352		

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N 352	Continued From page 20 - Resident 8 was admitted on 07/31/2025 with unknown diagnoses. Resident 8's MAR indicated s/he was prescribed aspirin 81 mg once a day, atorvastatin 20 mg once a day, divalproex 1000 mg once a day, escitalopram 10 mg once a day, famotidine 40 mg once a day, lamotrigine 150 mg twice a day, metformin 500 mg once a day, trazodone 100 mg once a day, and triamcinolone 0.1% cream. Resident 8's MAR indicated s/he did not receive the following medications: 09/01/2025 - 09/03/2025 at 8:00 AM - triamcinolone "refused [not administered]" [Surveyor note: Caregiver I reported they documented this entry incorrectly and the medication was not offered because it was not on the medication cart to administer.] 09/04/2025 at 8:00 AM - aspirin 81 mg, escitalopram 10 mg, lamotrigine 150 mg, metformin 500 mg and triamcinolone - On 09/30/2025, at 10:00 AM, Surveyors reviewed Resident 12's record. Resident 12 was admitted on 08/07/2025 with diagnoses including major depressive disorder, hypertension, alcohol abuse and moderate protein-calorie malnutrition. Resident 12's September 2025 MAR indicated Resident 12 was prescribed baclofen 5 mg twice a day, divalproex 250 mg twice a day, dorzolamide-timolol eye drops twice a day, duloxetine 60 mg once a day, famotidine 20 mg once a day, folic acid 1 mg once a day, lacosamide 150 mg twice a day, latanoprost 0.005% solution eye drops once a day, levetiracetam 1500 mg twice a day, olanzapine 5 mg once a day and a stool softener 8.6-50 mg twice a day. Resident 12's September 2025 MAR indicated s/he did not receive the following medications:	N 352		

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N 352	Continued From page 21 09/01/2025 - 09/12/2025 at 8:00 AM - dorzolamide-timolol eye drops "Not on cart" and caregiver initials circled. 09/05/2025 at 8:00 AM - "8am meds not on cart [not administered]" 09/08/2025 at 9:00 PM - "9pm meds [not available] order" 09/09/2025 at 8:00 AM - "All meds 8am not on cart [not administered]" 09/10/2025 at 8:00 AM - "All meds 8am not on cart [not administered]" 09/11/2025 at 8:00 PM - "All meds 8pm not on med cart [not administered]" 09/12/2025 at 8:00 AM - "All meds 8am not on med cart [not administered]" Resident 12's MAR contained circled staff initials on 09/09/2025 at 9:00 PM. Surveyors reviewed a document which was part of Resident 12's record. The documents indicated the following incidents: 09/10/2025 at 4:00 PM - "Received call from care staff indicating resident having seizure like activity and is reporting a fall. [vitals] (VSS). Small abrasion to left knee observed. Resident unable to verbalize where/when [s/he] fell. Wound cleaned with soap and water and covered with gauze. Residents sent to [emergency room] (ER) to [rule out] (r/o) further injury. Resident returned home from ER with knee brace and no new orders. Instructions to follow up with [primary care physician] (PCP) near 9/24/25. No injuries found in ER. [After visit summary] (AVS) with [medication] list sent to... pharmacy by [Administrator B]. Medication refills requested." 09/12/2025 at 12:00 PM - "Received call from	N 352		

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care staff they were sending resident out [related to] r/t [altered mental status] (ams). VSS [temperature] 99.5, [pulse] 83, [respirations] 16, [blood pressure]156/93. Care staff instructed to make PCP appointment opposed to ER per hospital instructions. [Power of Attorney] (POA) [family member] notified. [Family member] requested sending resident to ER. Residents sent to ER at [family member's] request. Resident admitted to [hospital]."

On 09/03/2025, at 9:30 AM, Surveyors interviewed Resident 1. Resident 1 reported s/he does not refuse her/his medications when offered. Resident 1 reported s/he has not received scheduled medications on various days. Resident 1 reported s/he was informed the keys for the medication cart had been "lost" and staff "can't get in the medication cart" during instances when s/he did not receive medications as scheduled.

On 09/04/2025, at 8:15 AM, Surveyor interviewed Caregiver F. Caregiver F indicated if a medication was not on the medication cart, s/he would initial the MAR, circle her/his initials, and document on the back of the MAR on "Nurse's Notes" why the medication was not administered.

On 09/04/2025, at 9:00 AM, Surveyor interviewed Caregiver I. Caregiver I reported Resident 8 did not have any medications available on the medication cart. Caregiver I reported when medications were not available for administration, s/he circled her/his initials and was to write on the back of the MAR the medication was not available. Surveyors inquired about where the "Nurse's Notes" indicated Resident 8 had refused a cream, Caregiver I reported it was an error, s/he should have documented the medication

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was not available instead of refused. Surveyors inquired how someone was to know if a resident was refusing a medication verses if a medication was not available, Caregiver I acknowledged Surveyors' concerns.

On 09/04/2025 at 2:00 PM, Surveyors interviewed Administrator B and Registered Nurse (RN) Consultant C. Administrator B confirmed the code requirement. Administrator B reported s/he was responsible for review of the medications, contacting the pharmacy for medications, and ensuring expired medication were disposed of. Administrator B reported s/he checked medication carts between cycle fills for expired or discontinued medications and s/he would reorder medications if they were not present. Administrator B did not provide any information for why Resident 1 did not receive her/his Zepbound or Bumetanide medications as prescribed by the provider.

On 09/30/2025, at 1:47 PM, Surveyors interviewed POA L. POA L reported s/he received a phone call from staff around noon on 09/12/2025, they were sending Resident 12 out to the ER. POA L reported s/he spoke with Administrator B, and s/he requested Resident 12 be sent to [specified hospital]. POA L reported s/he went to the hospital s/he requested Resident 12 go to around 4:00 PM and Resident 12 was not there. POA L reported s/he went to the facility and found Resident 12 there. POA L reported s/he took Resident 12 to the hospital, and Resident 12 had been admitted to intensive care unit and intubated since 09/12/2025.

On 09/30/2025, at 3:00 PM, Surveyors interviewed Administrator B. Administrator B reported s/he was working on the 2nd floor on

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N 352	Continued From page 24 09/12/2025. Administrator B reported s/he went down to 1st floor when staff handed her/him the phone with POA L on the other end. Administrator B reported s/he spoke with RN Consultant C afterward and RN Consultant C spoke with POA L. When Surveyors inquired why Resident 12 did not go to the ER, Administrator B first reported s/he told POA L Resident 12 did not need to go out because s/he just got back from the hospital, then Administrator B reported s/he did not know why Resident 12 did not go out to ER. Administrator B reported RN Consultant C made the decision not to send Resident 12 to the ER. Administrator B reported Resident 12's family arrived around 4:30 PM, and s/he then called the ambulance to send out Resident 12 at the family's request. Cross Reference N0415 DHS 83.37(2)(d) Documentation of Medication Administration	N 352		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission.	N 381		

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N 381	Continued From page 25 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each resident's needs, abilities, and physical and mental condition were assessed as required for 3 of 3 residents (Resident 1, Resident 3, and Resident 4). Resident 1, Resident 3, and Resident 4 did not have preadmission assessments completed. Findings include: On 09/04/2025, at 2:15 PM, Surveyors reviewed resident records and identified the following: Resident 1 was admitted on 07/02/2025 with diagnoses including acute and chronic respiratory failure with hypercapnia, chronic kidney disease, chronic obstructive pulmonary disease (COPD), congestive heart failure systolic chronic, epilepsy, obesity and stroke. Surveyors did not review any evidence of a preadmission assessment which identified Resident 1's needs, abilities, and physical and mental condition before Resident 1 was admitted to the facility. Resident 3 was admitted on 08/07/2025 with diagnoses including spinal stenosis, chronic obstructive pulmonary disease (COPD), hepatitis C, iron deficiency and hyperlipidemia. Resident 3's record contained physical therapy notes, dated 07/29/2025, which indicated Resident 3 was a fall risk due to left sided weakness and limited range of motion. Resident 3's therapy notes indicated Resident 3 required supervision or touching assistance for ambulation with a walker and all transfers. Surveyors did not review any evidence of a preadmission assessment which identified Resident 3's needs, abilities, and physical and mental condition before Resident 3 was admitted to the facility.	N 381		

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	0020768	A. BUILDING: _____ B. WING _____	09/30/2025

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N 381	Continued From page 26 Resident 4 was admitted on 05/13/2025 with diagnoses including paraplegia, and neurogenic bladder. Resident 4s file contained a form titled "Pre-Screening And Assessment For Admission to Adult Family Home" dated 09/03/2025, 110 days after s/he was admitted to the facility. Surveyors did not review any evidence of a preadmission assessment which identified Resident 4's needs, abilities, and physical and mental condition before Resident 4 was admitted to the facility. On 09/04/2025 at 2:00 PM, Surveyors interviewed Administrator B and Registered Nurse (RN) Consultant C. Administrator B reported s/he completed admission assessments for residents prior to RN Consultant C who started working 08/25/2025. Administrator B reported s/he had "some knowledge" of what was required for admission paperwork when admitting new residents. Administrator B and RN Consultant C acknowledged concerns and explained RN Consultant C would handle admission paperwork and assessments.	N 381		
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 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	N 386		

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N 386	Continued From page 27 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 4 of 4 residents (Resident 1, Resident 2, Resident 4 and Resident 5) comprehensive individual service plan (ISP) identified the residents' needs, desired outcomes, measurable goals, methods for delivering care, who was responsible for delivering the care and the frequency for the needed care. Findings include: Record Review On 09/03/2025, at 10:00 AM, Surveyors requested full resident files for Resident 1, Resident 2, and Resident 4. On 09/03/2025, at 1:15 PM, Surveyors received Resident 1, Resident 2, and Resident 4's records. Surveyors inquired to Administrator B if the files received were complete resident files. Administrator B confirmed the resident files were complete files. During record review, Surveyors did not review any evidence of an ISP for Resident 1, Resident 2, or Resident 4 in the files received. On 09/04/2025, at 10:00 AM, Surveyors received Resident 1, Resident 2, and Resident 4's files again which now contained the following information:	N 386		

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N 386	Continued From page 28 Resident 1 was admitted on 07/02/2025 with diagnoses including chronic kidney disease, acute and chronic respiratory failure, chronic obstructive pulmonary disease (COPD), epilepsy, and major depression. Resident 1's record contained a "Resident Temporary Care Plan" dated 07/02/2025. The temporary care plan indicated the following: Medications: [blank] Grooming: Independent, Assistance Dressing: Independent, Assistance Pain: Frequency - less than daily Resident 1's temporary ISP did not indicate what Resident 1 required assistance with, desired outcomes, goals, methods for delivering care, who was responsible or the frequency of needed care. Resident 2 was admitted on 08/19/2024, with diagnoses including hemi spasticity, depression, anxiety, dysphasia, dizziness, chronic pain and hypertension. Resident 2's ISP, dated 05/06/2025, indicated the following: - Presence and Intensity of Pain: Current Status: Member has chronic pain Frequency of Service and Service Provided: Staff will monitor [her/him] for signs of pain Desired Outcome: To maintain [her/his] current level of pain Service Provider Responsible: Staff to monitor daily for any signs of change in condition. - Physical Disabilities Current Status: The member uses a wheelchair and is partial weight bearing. Frequency of Service and Service Provided: Daily and as needed	N 386		

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N 386	Continued From page 29 Desired Outcome: To continue walking and ambulating with the assistance of [her/his] walker Service Provider Responsible: Staff to continue to encourage the member to use [her/his] walker. - Toileting Current Status: The member is incontinent of bowel and bladder. The member has to be toileted every 2 hours and assisted with peri care 3 times a day (AM, PM, [as needed]) Frequency of Service and Service Provided: Daily and as needed Desired Outcome: To efficiently and clearly execute proper toileting Service Provider Responsible: To assist the member with toileting as needed. - Wandering/Elopement Current Status: The member has a history of wandering. Frequency of Service and Service Provided: To monitor daily and as needed for any episodes of wandering with frequent checks to prevent wandering. Desired Outcome: The member will remain free of wandering Service Provider Responsible: To maintain the present level of care and to be free of wandering. - Destructive or Property or Self, Physically or Mentally Abusive Current Status: The member has a history of self-harm and verbal abusive. The member can be verbally abusive and argumentative with staff. Frequency of Service and Service Provided: To monitory daily for any episodes of verbal abuse or self-harm. Desired Outcome: To remain free from self-harm and verbal abuse. Service Provider Responsible: Staff will continue	N 386		

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to monitor any changes in condition and notify the family, case manager, and Dr. of all changes.

Surveyor reviewed Resident 2's after visit summaries (AVS) which indicated the following:

01/15/2025 - Breakthrough Seizures
05/06/2025 - Botox injections with physical therapy and occupational therapy orders
06/11/2025 - Admitted to hospital with shortness of breath, chest tightness, altered mental status.
07/23/2025, 07/30/2025, 08/05/2025 - Occupational Therapy
07/30/2025, 08/05/2025, 08/11/2025, 08/12/2025, 08/18/2025 - Physical Therapy

Resident 2's physician orders for 08/01/2025 - 08/31/2025 indicated Resident 2 was prescribed the following as needed medications:
Acetaminophen 500 milligrams (mg) take 2 tablets every 6 hours as needed for mild pain
Lidocaine 4% cream apply topically to affected area every hour as needed for numbing
Oxycodone 5 mg take 1 tablet daily as needed for severe pain
Tizanidine 2 mg take 1 tablet every 6 hours

Resident 2's ISP did not accurately describe the services staff were to provide to Resident 2, or goals of attainment. Resident 2's ISP did not indicate Resident 2's health issues, new services by outside agencies, how to assist Resident 2 with pain symptoms or describe behaviors and what staff were to do when a behavior occurred.

Resident 4 was admitted on 05/13/2025 with diagnoses including paraplegia, and neurogenic bladder. Resident 4's ISP, undated, indicated the following:
- Dressing

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N 386	Continued From page 31 Current Status: Able to dress upper body independently. Requires total assist for dressing lower body. Frequency of Service and Service Provided: Allow Client to dress upper body. Assist with lower body. Allow client to choose [her/his] daily clothing. Goal/Outcome: To be dressed age, gender, and weather appropriate daily. Service Provider Responsible: To continue to assist resident with verbal cues when applying on [sic] clothing. - Bathing Current Status: Able to participate in bathing process. Requires assistance with lower body ....falls in bathroom. Bed bath daily in am. Frequency of Service and Service Provided: Provide daily bed bath ...provide total assist with bathing of lower body. Desired Outcome: Maintain cleanliness and proper body image ...maintain skin integrity, will remain free of body odor, kin will remain clean, dry and intact Service Provider Responsible: To provide assistance with bathing and providing all necessary items to complete bathing. -Toileting Current Status: Incontinent of bowel and bladder. Self straight cath [sic] every 8 hours. Frequency of Service and Service Provided: Assist client with toileting per bed pan for [bowel movements] as tolerated. Do not leave client on bedpan longer than 15 [minutes]. Allow client to straight cath [sic] [herself/himself] every 8 hours. Provide assistance as requested by client ... Desired Outcome: Will be free of constipation ...will be free of urinary retention Service Provider Responsible: Staff to monitor	N 386		

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N 386	Continued From page 32 and report any complaints to [Registered Nurse] promptly - General Health Current Status: Poor Frequency of Service and Service Provided: Keep all scheduled doctor's appointments and dialysis appointments Desired Outcome: To receive constant supervision and care from staff with all general health practices and to accompany resident to all doctors' appointments Service Provider Responsible: Staff to monitor for any signs or symptoms of any changes in condition - Physical Disabilities Current Status: Paraplegic [related to] [gunshot wound]. Transfer with 2 and mechanical lift Frequency of Service and Service Provided: Reposition [every] 2 hours. Use moisture barrier creams with peri care [sic]. Provide prompt peri care [sic] after each incontinent episode. Desired Outcome: will be free of falls and injury until next ISP update. Will have improved skin and reduced breakdown. Service Provider Responsible: [blank] Resident 4's ISP did not accurately describe the services staff were to provide to Resident 4, or goals of attainment. Resident 4's ISP did not indicate Resident 4's correct toileting schedule, bathing schedule, health issues, or physical disabilities. Resident 5 was admitted on 06/11/2025. Resident 5's record did not contain an ISP. Resident 5's file contained a form titled "Pre- Admission Questionnaire", dated 06/11/2025 which indicated s/he had a history of alcohol use/ abuse, s/he	N 386		

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was verbally abusive when intoxicated, s/he was restricted from alcohol, and indicated "yes" for aggressive and combative behaviors. Surveyors reviewed the Pre-Screening and Assessment for Admission form for Resident 5 which indicated the following:

Behavioral/Mental Condition
- Socially Inappropriate /Disruptive Behavior - "Yes"

Resident 5's file contained incident reports with a summary and dates listed below:

-6/18/2025 Resident was intoxicated and called 911.
-7/07/2025 Resident was intoxicated, drinking in the facility, went to liquor store, grabbed male care giver in genital area, yelled at staff and residents
-7/11/2025 Resident was drinking, urinated on hallway floor, yelled at residents, and blocked doorway to residents' rooms refusing to let them in.
-8/25/2025 Resident attempted to kiss caregiver and made inappropriate sexual comments.
-9/01/2025 Resident pulled fire alarm.

Surveyors did not review evidence of a temporary service plan or ISP which informed staff of Resident 5's specific behaviors/patterns or how to redirect Resident 5's behaviors.

Interviews

On 09/03/2025, at 09:30 AM, Surveyors interviewed Resident 1. Resident 1 reported her/his medications were administered by staff.

On 09/03/2025, at 12:00 PM, Surveyors

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N 386	Continued From page 34 interviewed Resident 4. Resident 4 reported s/he performed self-catheterization on herself/himself every 6 hours. Resident 4 reported s/he needed assistance with her/his bed baths as s/he was supposed to receive one daily. Resident 4 reported there was only 1 staff s/he could count on to ensure s/he received a bed bath. Resident 4 reported s/he needed assistance with dressing and cares. Resident 4 reported s/he stayed in bed to ensure s/he would not soil herself/himself due to concerns with not having staff around to assist with cares. On 09/04/2025 at 11:45 AM, Surveyors interviewed Caregiver I. Caregiver I reported Resident 4 did not use a mechanical lift for transfers. Caregiver I reported all the lifts were on 1st floor and unable to come up to 2nd floor due to the broken elevator. Caregiver I reported Resident 4 utilized 1 staff and a slide board for transfers. Caregiver I reported s/he would go downstairs to "help out because 2nd floor was more independent." On 09/04/2025 at 2:00 PM, Surveyors interviewed Administrator B and Registered Nurse (RN) Consultant C. Administrator B reported Licensee A hired nurse consultants to complete resident ISPs. RN Consultant C reported s/he was going to be taking over completing the resident ISPs. RN Consultant C and Administrator B confirmed resident ISP's need to be updated to identify the residents' needs, desired outcomes, measurable goals, methods for delivering care, who was responsible for delivering the care and the frequency for the needed care.	N 386		
N 393	83.35(5)(a) Initial evaluation of evacuation limitations.	N 393		

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N 393	Continued From page 35 Initial evaluation. The CBRF shall evaluate each resident within 3 days of the resident ' s admission to determine whether the resident is able to evacuate the CBRF within 2 minutes in an unsprinklered CBRF and 4 minutes in a sprinklered CBRF without any help or verbal or physical prompting, and what type of limitations that resident may have that prevent the resident from evacuating the CBRF within the applicable period of time. A form provided by the department shall be used for the evaluation. The resident ' s evaluation shall be retained in the resident ' s record. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure 4 of 4 residents (Resident 1, Resident 3, Resident 4 and Resident 5) were evaluated, using the form provided by the department, within 3 days of the resident's admission to determine whether the resident was able to evacuate the community based residential facility (CBRF) within 2 minutes. Findings include: On 09/03/2025, at 9:30 AM, Surveyors toured the facility and observed the following: The facility consisted of 3 floors, the basement or ground floor where the dining room, kitchen, activity room and laundry were located. The 1st floor and 2nd floor consisted of resident rooms. There was 1 elevator to reach the other floors. The elevator was not operable during the time of the survey. Surveyors observed 2 sets of stairs to reach the 2nd floor. Surveyors went to the 2nd floor and observed Resident 1 utilized a power	N 393		

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N 393	Continued From page 36 wheelchair, Resident 3 utilized a manual wheelchair, Resident 4 utilized a wheelchair and Resident 5 utilized a wheelchair. During the survey, Surveyors witnessed Resident 1, Resident 3 and Resident 5 utilize the stairs with staff assistance. On 09/04/2025, 10:00 AM, Surveyors reviewed resident records and identified the following: Resident 1 was admitted on 07/02/2025. Resident 1's record did not contain evidence of a completed resident evacuation assessment. Resident 3 was admitted on 08/07/2025. Resident 3's record did not contain evidence of a completed resident evacuation assessment. Resident 4 was admitted on 05/13/2025 with diagnoses including paraplegia. Resident 4's record did not contain evidence of a completed resident evacuation assessment. Resident 5 was admitted on 06/11/2025. Resident 5's record did not contain evidence of a completed resident evacuation assessment. On 09/04/2025 at 2:00 PM, Surveyors interviewed Administrator B and Registered Nurse (RN) Consultant C. Administrator B reported s/he was responsible for completing evacuation assessments for residents. Administrator B reported s/he was unaware of the code requirements for initial evacuation assessment to be completed within 3 days.	N 393		
N 401	83.37(1)(b) Medication label permanently attached.	N 401		

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N 401	Continued From page 37 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, record review, and interview, the provider did not ensure medications were labeled to ensure proper and safe usage for 2 of 2 residents (Resident 7 and Resident 8). Findings include: On 09/03/2025, at 11:09 AM, Surveyors observed resident medications. Resident medications were stored in a locked filing cabinet. Each resident had their medications separated by dividers. Surveyors observed a medication card which contained 8 red, white, and blue colored capsules. The medication card contained Resident 8's name and room number, "Tylenol extra strength 500 [milligrams] (mg) and [as needed] (PRN)" written in black marker. The handwritten label did not indicate the route or frequency of the order for the medication. The over-the-counter medication which was not maintained in the manufacturer's container was not labeled by a pharmacist as indicated by the code requirement. Surveyors observed a second medication card which contained 32 white colored tablets. The medication card contained Resident 7's name and room number, "Take 1 tab (tablet) by mouth	N 401		

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N 401	Continued From page 38 every day if needed PRN Ramelton [sic] 8mg" written in black marker. On 09/04/2025, at 10:00 AM, Surveyors reviewed Resident 8's MAR. Resident 8 was admitted on 07/31/2025 Surveyors reviewed Resident 8's March and September 2025 MARs. Surveyors did not review any evidence of Tylenol extra strength 500 mg on Resident 8's March or September MARs. On 09/30/2025, at 1:20 PM, Surveyors reviewed Resident 8's October MAR. The MAR indicated: Tylenol Extra Strength 500 mg. The MAR did not indicate the route or frequency of the order for Resident 8. On 09/30/2025, at 10:45 AM. Surveyors reviewed Resident 7's MAR. Resident 7 was admitted on 08/01/2025. Surveyors reviewed Resident 7's September 2025 MARs. Resident 7's MAR indicated s/he was prescribed Ramelteon 8 mg tablet; take 1 tablet by mouth every night as need for sleep [prescription] (RX) 0311663 with an expiration date of 08/25/2026, which was not what was indicated on the medication card observed. Surveyors requested physician orders for Resident 7 and Resident 8. Administrator B was unable to locate physician orders. On 09/04/2025 at 2:00 PM, Surveyors interviewed Administrator B and Registered Nurse (RN) Consultant C. Administrator B reported s/he repackaged the medications at the facility. Administrator B reported s/he was not delegated to perform the task by an RN. Administrator B reported s/he was aware of labeling requirements for repackaged medications. RN Consultant C	N 401		

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N 401	Continued From page 39 and Administrator B acknowledged concerns.	N 401		
N 406	83.37(1)(g) Disposition of medications. Disposition of medications. 1. When a resident is discharged, the resident ' s medications shall be sent with the resident. 2. If a resident ' s medication has been changed or discontinued, the CBRF may retain a resident ' s medication for no more than 30 days unless an order by a physician or a request by a pharmacist is written every 30 days to retain the medication. 3. The CBRF shall develop and implement a policy for disposing unused, discontinued, outdated, or recalled medications in compliance with federal, state and local standards or laws. The CBRF shall arrange for the stored medications to be destroyed in compliance with standard practices. Medications that cannot be returned to the pharmacy shall be separated from other medication in current use in the facility and stored in a locked area, with access limited to the administrator or designee. The administrator or designee and one other employee shall witness, sign, and date the record of destruction. The record shall include the medication name, strength and amount. This Rule is not met as evidenced by: Based on observation and interview, the provider did not establish an effective procedure for proper destruction and disposal of expired medications. Expired medications were observed stored with resident's non-expired medications in 1 of 1 medication cart. Findings include:	N 406		

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N 406	Continued From page 40 On 09/03/2025, at 11:09 AM, Surveyors observed resident medication cart. Surveyors observed the following expired medications: -Resident 2 Oxycodone 5 mg (milligram) tablet (Tab) with a use by date of 07/23/2025 -Resident 9 Olanzapine 5 mg ODT Tab #15 with a use by date of 02/26/2025 Risperidone 0.25 mg Tab with a use by date of 08/16/2025 -Resident 10 Midodrine 5 mg Tab with a use by date of 01/20/2025 Midodrine 5 mg Tab with a use by date of 03/09/2025 Polyvinyl alcohol (AL) 1.4% ophthalmic (OP) Solution (SOL) with a use by date of 01/20/2025 -Resident 11 Hydralazine 25 mg Tab with an end date of 08/09/2025 Latanoprost 0.005% SOL with a use by date of 10/21/2024 On 09/04/2025 at 2:00 PM, Surveyors interviewed Administrator B and Registered Nurse (RN) Consultant C. Administrator B confirmed the code requirement. Administrator B reported s/he was responsible for review of the medications to ensure expired medication were disposed of. Administrator B reported s/he checked medication carts once weekly for expired or discontinued medications. Administrator B did not provide any information for why expired medications were still on the medication cart.	N 406		

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N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As 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 ensure each resident's medication administration record (MAR) was accurately maintained for 3 of 3 resident (Resident 1, Resident 5 and Resident 12) reviewed. Staff did not accurately document when Resident 1, Resident 5 and Resident 12 was or was not administered prescribed medications. Findings include: On 09/04/2025, at 9:30 AM, Surveyors reviewed resident records and identified the following: - Resident 1 was admitted on 07/02/2025, with diagnoses including acute and chronic respiratory failure with hypercapnia, chronic kidney disease, chronic obstructive pulmonary disease (COPD), congestive heart failure systolic chronic, epilepsy, obesity and stroke. Surveyor reviewed Resident 1's MARs for the	N 415		

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N 415	Continued From page 42 month of August 2025 and identified the following dates did not contain staff initials indicating if the following medications were or were not administered to Resident 1: Allopurinol 200 milligrams (mg) at 8:00 AM - 08/05/2025, 08/17/2025, 08/24/2025 Ellipt inhaler at 8:00 AM - 08/05/2025, 08/17/2025, 08/24/2025, 08/31/2025 Atorvastatin 80 mg at 9:00 PM - 08/02/2025, 08/08/2025, 08/10/2025, 08/11/2025, 08/13/2025, 08/17/2025, 08/20/2025, 08/23/2025, 08/29/2025 Baclofen 10 mg at 8:00 AM - 08/05/2025, 08/17/2025, 08/24/2025 Baclofen 10 mg at 5:00 PM - 08/08/2025, 08/11/2025, 08/17/2025, 08/31/2025 Baclofen 10 mg at 8:00 PM - 08/08/2025, 08/10/2025, 08/11/2025, 08/13/2025, 08/17/2025, 08/23/2025 Bumetanide 2mg at 8:00 AM - 08/05/2025, 08/17/2025, 08/24/2025 Bumetanide 2 mg at 2:00 PM - 08/03/2025, 08/05/2025, 08/14/2025, 08/15/2025, 08/17/2025 - 08/22/2025, 08/23/2025, 08/24/2025, 08/28/2025, 08/30/2025, 08/31/2025 Eliquis 5 mg at 8:00 AM - 08/05/2025, 08/17/2025, 08/24/2025 Eliquis 5 mg at 9:00 PM - 08/08/2025, 08/10/2025, 08/11/2025, 08/13/2025, 08/17/2025, 08/19/2025, 08/24/2025	N 415		

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Ferrous Sulfur 325 mg at 8:00 AM - 08/05/2025, 08/17/2025, 08/24/2025

Gabapentin 500 mg at 8:00 AM - 08/05/2025, 08/17/2025, 08/24/2025

Gabapentin 500 mg at 5:00 PM - 08/08/2025, 08/11/2025, 08/17/2025, 08/27/2025, 08/31/2025

Gabapentin 500 mg at 9:00 PM - 08/08/2025, 08/10/2025, 08/11/2025, 08/13/2025, 08/17/2025, 08/23/2025

Hydroxyzine 25 mg at 9:00 PM - 08/01/2025, 08/02/2025, 08/03/2025, 08/08/2025, 08/10/2025, 08/11/2025, 08/13/2025, 08/17/2025, 08/19/2025, 08/20/2025, 08/23/2025

Loratadine 10 mg at 8:00 AM - 08/05/2025, 08/17/2025, 08/24/2025

Metolazone 2.5 mg at 10:00 AM - 08/05/2025, 08/12/2025

Metoprolol Succinate 25 mg at 8:00 AM - 08/05/2025, 08/17/2025, 08/24/2025

Trazodone 50 mg at 9:00 PM - 08/08/2025, 08/10/2025, 08/11/2025, 08/13/2025, 08/15/2025, 08/16/2025, 08/17/2025, 08/19/2025, 08/23/2025

Surveyor did not review any notes indicating if the medications were or were not administered to Resident 1.

- Resident 5 was admitted on 06/11/2025 with diagnoses including post-traumatic stress disorder, high blood pressure, alcohol use, anemia, anxiety and low back pain. Surveyor reviewed Resident 5's MARs for the month of

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N 415	Continued From page 44 August 2025 and identified the following dates did not contain staff initials indicating if the following medications were or were not administered to Resident 5: Duloxetine 60 mg at 8:00 AM - 08/05/2025, 08/08/2025, 08/12/2025, 08/14/2025, 08/15/2025, 08/16/2025, 08/17/2025, 08/21/2025 Amlodipine 10 mg at 8:00 AM - 08/05/2025, 08/08/2025, 08/12/2025, 08/14/2025, 08/15/2025, 08/16/2025, 08/17/2025, 08/21/2025, 08/24/2025, 08/25/2025 Gabapentin 600 mg at 8:00 AM - 08/05/2025, 08/08/2025, 08/12/2025, 08/14/2025, 08/15/2025, 08/16/2025, 08/17/2025, 08/21/2025, 08/24/2025, 08/25/2025 Gabapentin 600 mg at 2:00 PM - 08/03/2025, 08/10/2025, 08/11/2025, 08/12/2025, 08/14/2025, 08/15/2025, 08/16/2025, 08/17/2025, 08/21/2025, 08/22/2025, 08/23/2025, 08/24/2025, 08/25/2025, 08/28/2025, 08/31/2025 Gabapentin 600 mg at 9:00 PM - 08/03/2025, 08/05/2025, 08/11/2025, 08/12/2025, 08/14/2025, 08/15/2025, 08/16/2025, 08/17/2025, 08/22/2025, 08/27/2025 Ramelteon 8 mg at 9:00 PM - 08/03/2025, 08/10/2025, 08/11/2025, 08/13/2025 - 08/23/2025, 08/25/2025, 08/26/2025, 08/27/2025, 08/29/2025 Surveyor did not review any notes indicating if the medications were or were not administered to Resident 5. - Resident 12 was admitted on 08/07/2025 with	N 415		

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N 415	Continued From page 45 diagnoses including major depressive disorder, hypertension, alcohol abuse and moderate protein-calorie malnutrition. Surveyor reviewed Resident 12's MARs for the month of September 2025 and identified the following dates did not contain staff initials indicating if the following medications were or were not administered to Resident 12: Lacosamide 150 mg at 9:00 PM - 09/10/2025 Latanoprost 0.005% at 9:00 PM - 09/03/2025, 09/06/2025, 09/10/2025 Levetiracetam 1500 mg at 9:00 PM - 09/10/2025 Surveyor did not review any notes indicating if the medications were or were not administered to Resident 12. On 09/04/2025, at 2:00 PM, Surveyors interviewed Administrator B and RN Consultant C. Administrator B reported s/he was performing checks throughout the month on the MARs to ensure they were filled out. Administrator B did not offer an explanation. RN Consultant C reported s/he would be overseeing medications. Cross-Reference N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medications	N 415		
N 447	83.41(1)(c) Dishwashing Dishwashing. 1. Whether washed by hand or mechanical means, all equipment and utensils shall be cleaned using separate steps for pre-washing, washing, rinsing and sanitizing. Residential dishwashers may be used in kitchens serving 20 or fewer residents. Kitchens serving	N 447		

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N 447	Continued From page 46 21 or more residents shall have a commercial type dishwasher for washing and sanitizing equipment and utensils in accordance with standard practices described in the Wisconsin food code. 2. A 3-compartment sink for washing, rinsing and sanitizing utensils, with drain boards at each end is required for all large facilities with a central kitchen. Washing, rinsing and sanitizing procedures shall be in accordance with standard practices described in the Wisconsin food code. In addition, a single compartment sink or overhead spray wash located adjacent to the soiled drain board is required for pre-washing. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all equipment and utensils were cleaned using separate steps for pre-washing, washing, rinsing, and sanitizing. This had the potential to affect 32 of 32 residents residing in the facility. Findings include: On 09/03/2025, at 10:00 AM, Surveyors observed Licensee A pre-wash dishes by hand in a 2-compartment sink. Licensee A reported the commercial dishwasher was broken. Surveyors observed dishes on a drying rack next to the 2-compartment sink. Surveyors did not observe a compartment for sanitizing of dishes. Surveyors did not observe Licensee A sanitize dishes. On 09/04/2025, at 2:00 PM, Surveyors interviewed Administrator B and Registered Nurse (RN) Consultant C. Administrator B was unaware of the code requirement. Administrator B reported the dishwasher was broken.	N 447		

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N 448	83.41(2)(a) Nutrition: diet. Diets. 1. The CBRF shall provide each resident with palatable food that meets the recommended dietary allowance based on current dietary guidelines for Americans and any special dietary needs of each resident. 2. The CBRF shall provide a therapeutic diet as ordered by a resident ' s physician. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 32 of 32 residents were provided with palatable food. Residents reported the food served at the facility was unappetizing and insufficient. Residents reported they did not receive additional food when they asked for more at mealtimes. Findings include: On 09/19/2025, the Department received a complaint with concerns regarding food in the facility. The provider is licensed to provide services up to 36 residents within the client groups of irreversible dementia/Alzheimer's, traumatic brain injury, advanced age, physically disabled, developmentally disabled, terminally ill, correctional clients, alcohol/drug dependent, and emotionally disturbed/mental illness. Observations On 09/03/2025, at approximately 9:20 AM, Surveyors observed breakfast served. Breakfast	N 448		

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consisted of a McDonald's breakfast burrito, a banana and a doughnut. The menu indicated breakfast served should have been oatmeal, sausage patties, berries, and grape juice.

On 09/03/2025, at approximately 1:35 PM, Surveyors observed the lunch meal. Surveyors observed what appeared to be a type of flour tortilla with a baked cheese on top, a fried chicken drumstick. Some plates had rice with mushrooms, a green vegetable and a meat mixed together, and other plates had noodles with orange and red chunks with a type of sauce mixed in. The menu indicated lunch served should have been casserole, sweet peas, slice of bread, raspberry juice, and a donut.

On 09/04/2025, at 8:25 AM, Surveyor observed breakfast served. Breakfast consisted of a doughnut, a hardboiled egg and a type of breakfast sandwich with pancakes, egg, cheese and sausage. The menu indicated breakfast served should have been pancakes, bacon, cheese eggs, strawberries, and lemonade.

On 09/04/2025 at 12:31 PM Surveyors observed lunch served. Lunch consisted of egg noodles, meatballs, green beans and a piece of buttered bread. The menu indicated lunch served should have been red beans and rice, pancakes, grapes, and sweet tea.

Interviews

On 09/03/2025, at approximately 9:40 AM, Surveyors interviewed Licensee A. Licensee A reported s/he was cooking. Licensee A reported s/he was making tamales and rice for lunch.

On 09/03/2025, at 11:45 AM, Surveyors

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interviewed Resident 2 and Resident 3. Resident 2 and Resident 3 both reported the food at the facility was often served late and was "not very good". Resident 2 reported s/he purchased food of her/his own if s/he wanted extra food.

On 09/03/2025, at 12:00 PM, Surveyors interviewed Resident 4. Resident 4 reported there was not enough food served. Resident 4 reported the food comes up from the basement and was "cold and lazy ". Surveyors inquired what Resident 4 meant when s/he referred to food as lazy. Resident 4 reported s/he did not believe any effort was put into meals, food was premade and had no nutritional value. Resident 4 reported the alternative meal is a grilled cheese. Resident 4 reported meals were not served on time, lunch would be as late as 2:00 PM and supper would be served at 8:00 PM. Resident 4 reported s/he buys her/his own meals or had someone bring her/him in food.

On 09/03/2025, at 1:35 PM Surveyors inquired to Caregiver I, who was serving lunch, what was being served for lunch, s/he replied, "I don't know, we are trying to figure that out."

On 09/04/2025, at 12:50 PM, Surveyors interviewed Cook J. Cook J reported Administrator B makes the monthly menus and Licensee A purchases the groceries. Cook J reported s/he provided input on groceries and menus. Surveyors inquired when the 09/04/2025 lunch menu was determined. Cook J reported s/he told Licensee A the morning of 09/04/2025 what s/he would cook for lunch, then Licensee A purchased the items.

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N 450	Continued From page 50	N 450		
N 450	83.41(2)(c) Nutrition: menus. Menus. 1. The CBRF shall make reasonable adjustments to the menu for individual resident ' s food likes, habits, customs, conditions and appetites. 2. The CBRF shall prepare weekly written menus and shall make menus available to residents. Deviations from the planned menu shall be documented on the menu. This Rule is not met as evidenced by: Based on record review, observation, and interview, the provider did not make menus available to 32 of 32 residents. Findings include: On 09/03/2025, at 9:30 AM, Surveyors toured the facility. Surveyors did not observe any menus throughout the facility. At 9:45 AM, Surveyors requested 3 months of menus from Administrator B. At 12:40 PM, Administrator B gave Surveyors a menu for one week. On 09/03/2025, at 11:45 AM, Surveyors interviewed Resident 2 and Resident 3. Resident 2 and Resident 3 reported they were not aware of any menus being available to residents. Resident 3 reported s/he had not seen a posted menu in the facility. On 09/04/2025 at 2:00 PM, Surveyors interviewed Administrator B and Registered Nurse (RN) Consultant C. Administrator B reported s/he was responsible for creating the menus. Administrator	N 450		

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N 450	Continued From page 51 B confirmed the menu s/he gave Surveyors was the menu for the week. Administrator B reported s/he created the menus week by week or sometimes a month at a time. Surveyors inquired if the menus were posted and available to residents. Administrator B confirmed the menus were posted. Surveyors inquired where the menus were posted. Administrator B did not offer an answer, but repeated the menus were posted.	N 450		
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 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. Raw meats were stored in containers with ready to eat foods, as well as stored above raw	N 452		

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N 452	Continued From page 52 vegetables. Moldy food was found in areas of the kitchen and prepared food was not labeled with a date of preparation. Findings include: On 09/03/2025, at 10:00 AM, Surveyors toured the facility kitchen and observed the following: Refrigerators - a bag of raw shrimp was on the same shelf as a head of lettuce. Under the shelf was a produce drawer, which had a head of cabbage and lunch meat. - a metal cooking pan which contained 4 Cornish hens in wrappers, a block of cheddar cheese in a wrapper, a green pepper, and a package of sliced cheese. - 2 heads of cabbage covered in black spots, similar to mold - a head of cauliflower covered in black spots, similar to mold - a container labeled "macaroni salad" which was dated 08/13/2025. - 2 bags of what appeared to be cooked brats, not labeled with a date. - a bag of celery which was brownish and soft. - The bottom of a refrigerator had yellow liquid under the produce drawer. - a gallon of 2% milk exposed to air due to no cover on the jug - a bottle of hoisin sauce, dated 03/20/2024 - a bottle of tandoori marinade, dated 08/22/2024 The kitchen had a box of assorted buns and bagels. Surveyors observed buns and bagels with bluish green areas, similar to mold. The freezers contained ice buildup on the walls.	N 452		

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N 452	Continued From page 53 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) Arrange by proper food storage order. Although it may not seem like it would matter, the wrong order of food on shelves could potentially promote the growth of pathogens, increasing the risk of foodborne illness. Shelves should be ordered from lowest cooking temperature to highest, going down. This is done to prevent juices or other liquids from higher temperature cooking foods from contaminating foods that won't reach that temperature ...Top Shelf: Ready-to-Eat The top shelf should be reserved for ready-to-eat foods. These are foods that will be served without being cooked first. Second Shelf: 135°F (57°C) This category includes foods that will be hot-held that are not included in other categories. Third Shelf: 145°F (63°C) Foods that should be cooked to 145°F include whole seafood; whole cuts of beef, pork, veal, lamb; roasts; and eggs that will be served immediately. Fourth Shelf: 155°F (68°C) It is important that meat that has been ground, injected, or tenderized be kept on a lower shelf. This category also includes eggs that will	N 452		

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N 452	Continued From page 54 be hot held. Bottom Shelf: 165°F (74°C) The bottom shelf should hold foods with the highest cooking temperatures. This includes all poultry (turkey, duck, chicken, or fowl); stuffing that contains foods that require temperature control; dishes with previously cooked foods, such as casseroles. (State Food Safety, https://www.statefoodsafety.com/Resources/Posters/fridge-storage-for-food-safety, retrieval date 09/20/2025) On 09/04/2025 at 2:00 PM, Surveyors interviewed Administrator B and Registered Nurse (RN) Consultant C. Administrator B reported the kitchen staff for the day were responsible for food safety and the removal of expired food. Administrator B reported s/he did not know the systems in the kitchen. Administrator B and RN Consultant C acknowledged Surveyors concerns.	N 452		
N 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure cleaning compounds and toxic substances were securely stored in 4 of 4 areas. Findings include: The facility is licensed as a Class CNA (non-ambulatory) Community Based Residential Facility which may serve up to 36 advanced aged, emotionally disturbed/mentally ill, dementia,	N 499		

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N 499	Continued From page 55 traumatic brain injury, physically disabled, terminally ill, and developmentally disabled residents. On 09/03/2025, at 9:30 AM, Surveyors toured the facility and observed the following: - The tub room on the 1st floor had 2 bottles of Whirlout jetted bath cleaner. The door had a locking mechanism which was not engaged. On 09/04/2025, at 12:30 PM, Surveyors toured the facility and observed the following: - A storage room in the basement contained 23 one-gallon cans of paint, 2 cans of wood stain, 4 five-gallon pails of paint, 8 cans of spray paint. The door contained a locking mechanism which was not engaged. - A linen closet on the 1st floor had a bottle of Pledge - The tub room on the 1st floor had a housekeeping cart stored inside. There was a bottle of Murphy soap, can of Pledge, can of Great Value air freshener and a bottle of glass cleaner. The door had a locking mechanism which was not engaged. Surveyor observed residents moving freely throughout the facility. On 09/04/2025 at 2:00 PM, Surveyors interviewed Administrator B and Registered Nurse (RN) Consultant C. Administrator B and RN Consultant C confirmed the code requirement. RN Consultant reported they would ensure all chemicals were securely stored.	N 499		

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N 507	Continued From page 56	N 507		
N 507	83.46(1)(f) Combustibles. Combustible materials shall not be placed within 3 feet of any furnace, boiler, water heater, fireplace or other similar equipment. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure combustible materials were not placed within 3 feet of 3 of 3 boilers and 3 of 3 water heaters. There were boxes, Styrofoam, shop vacuums, within 15 inches of the boilers. There were work gloves 10 inches from the water heaters. Findings include: On 09/03/2025, at 10:00 AM Surveyors toured the basement. Surveyors observed the boiler room and observed the following: Boilers - 2 boxes were placed right next to the 1st boiler - 2 pieces of Styrofoam sheets 5 inches from the 1st boiler - 2 boxes were 15 inches from the 1st boiler - There were papers placed on top of the 1st boiler - A shop vacuum was placed 10 inches from the 2nd and 3rd boiler Water Heaters - There was a type of wire spring drain cleaner placed next to the water heaters. On top of the wire spring drain cleaner was a set of cloth work gloves and a rubber hose, 5 inches from the 2nd and 3rd water heaters, and 18 inches from the 1st water heater.	N 507		

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N 507	Continued From page 57 On 09/04/2025 at 2:00 PM, Surveyors interviewed Administrator B and Registered Nurse (RN) Consultant C. Administrator B and RN Consultant C reported it was Licensee A's responsibility to ensure the area was safe. Administrator B and RN Consultant C reported they were unaware why items were stored in the boiler room. RN Consultant C reported s/he would speak with Licensee A about moving the debris from the room.	N 507		
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 2 of 3 bathrooms. Bathroom water temperatures measured between 124 degrees F and 126 degrees F. Findings include: The facility is licensed as a Class CNA (non-ambulatory) Community Based Residential Facility which may serve up to 36 advanced aged, emotionally disturbed/mentally ill, irreversible	N 617		

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N 617	Continued From page 58 dementia/Alzheimer's, traumatic brain injury, physically disabled, terminally ill, alcohol/drug dependent, correctional clients, and developmentally disabled residents. On 09/03/2025, at 9:30 AM Surveyors toured the facility and observed the following: Resident 1's bathroom water temperature was 126.1 degrees F. Resident 4's bathroom water temperature was 124.5 degrees F. On 09/04/2025 at 2:00 PM, Surveyors interviewed Administrator B and Registered Nurse (RN) Consultant C. Administrator B reported s/he was aware of the code requirement. Administrator B reported Licensee A was responsible for testing the water temperature monthly. Administrator B reported Licensee A tested water temperatures in the basement.	N 617		
Z 012	50.065(2)(bm) OUT OF STATE BACKGROUND CHECKS If the person who is the subject of the search under par. (am) or (b) is not a resident of this state or if at any time within the 3 years preceding the date of the search that person has not been a resident of this state, or if the department or entity determines that the person's employment, licensing, or state court records provide a reasonable basis for further investigation, the department or the entity shall make a good faith effort to obtain from any state or other United States jurisdiction in which the person is a resident or was a resident within the 3 years	Z 012		

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Z 012	Continued From page 59	Z 012		

preceding the date of the search information that is equivalent to the information specified in par. (am) 1. or (b) 1.

The department or entity may require the person to be fingerprinted on 2 fingerprint cards, each bearing a complete set of the person's fingerprints. The department of justice may provide for the submission of the fingerprint cards to the federal bureau of investigation for the purposes of verifying the identity of the person fingerprinted and obtaining the records of his or her criminal arrests and convictions.

This Rule is not met as evidenced by:
Based on interview and record review, the provider did not ensure 2 of 6 staffs' (Caregiver D and Caregiver H) out of state background checks, for staff living out of state within the last three years, were completed.

Findings Include:

On 09/03/2025, at 12:27 PM, Surveyors reviewed employee records and identified the following:

- Caregiver D was hired on 08/11/2025. Caregiver D's background information disclosure form (BID) indicated Caregiver D lived in Miami, Florida within the last 3 years (2017 to 2022). Caregiver D's BID did not indicate specific dates of when s/he lived in Florida. No evidence of an out of state background check was identified in her/his file.

- Caregiver H was hired on 08/03/2025. Caregiver H's BID indicated Caregiver H lived out of state

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Z 012	Continued From page 60 within the past 3 years. Caregiver H's BID did not indicate what state s/he lived within the past 3 years. No evidence of an out of state background check was identified in her/his file. On 09/04/2025 at 2:00 PM, Surveyors interviewed Administrator B and Registered Nurse (RN) Consultant C. Administrator B reported s/he was unaware of the code requirement and confirmed there were no out of state background checks for staff who previously lived out of state.	Z 012		
Y3244	50.09(1)(L) Care (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to (l) Receive adequate and appropriate care within the capacity of the facility. This Rule is not met as evidenced by: Based on interviews, observations and record review, the provider did not ensure residents received adequate and appropriate services that	Y3244		

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Y3244	Continued From page 61 were within the provider's capacity. This had the potential to affect 32 of 32 residents. Findings include: On 09/19/2025, the Department received a complaint alleging there was not adequate staff to meet resident needs. Interviews On 09/03/2025, at approximately 11:40 AM, Surveyors interviewed Resident 2 and Resident 3. Resident 2 and Resident 3 reported staff were nowhere to be found. Resident 3 reported the call button was never answered when s/he pushed it for staff assistance. On 09/03/2025, at 12:00 PM, Surveyors interviewed Resident 4. Resident 4 stated, "When I pull the call light, no one comes ....they take care of the first floor but not the second floor." Resident 4 reported s/he stays in bed to ensure s/he does not have an accident because "there's no one here to help me." Resident 4 reported s/he had raised concerns regarding staff multiple times with management, but nothing changed. On 09/04/2025, at 11:45 AM, Surveyors interviewed Caregiver I. Caregiver I reported there were supposed to be 2 staff working upstairs and 2 staff working downstairs. Caregiver I reported they were short on companions, so the 2nd staff who was scheduled for upstairs went on an appointment. Caregiver I reported s/he would go downstairs to "help out because 2nd floor was more independent." Record Reviews	Y3244		

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Y3244	Continued From page 62 On 09/03/2025, at 10:30 AM, Surveyors reviewed a resident roster which indicated 12 residents resided on the second floor. On 09/04/2025, at 10:00 AM, Surveyors reviewed resident records and identified the following: Resident 2 was admitted on 08/19/2024, with diagnoses including hemi spasticity, depression, anxiety, dysphasia, dizziness, chronic pain and hypertension. Resident 2's individual service plan (ISP), dated 05/06/2025, indicated Resident 2 required assistance with supervision, self-direction, self-care, dressing, grooming, bathing, toileting every 2 hours, and behaviors such as wandering and self-harm. Resident 3 was admitted on 08/07/2025 with diagnoses including spinal stenosis, chronic obstructive pulmonary disease (COPD), hepatitis C, iron deficiency and hyperlipidemia. Resident 3's record contained physical therapy notes, dated 07/29/2025, which indicated Resident 3 was a fall risk due to left sided weakness and limited range of motion. Resident 3's therapy notes indicated Resident 3 required supervision or touching assistance for ambulation with a walker and all transfers. Resident 4 was admitted on 05/13/2025 with diagnoses including paraplegia, and neurogenic bladder. Resident 4's ISP, undated, indicated Resident 4 required assistance with dressing and bathing her/his lower body, medication administration, monitoring at mealtimes to prevent choking, assistance of 1-2 staff for evacuation drills, repositioning every 2 hours, and all housekeeping tasks. Observations	Y3244		

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Y3244	Continued From page 63 On 09/03/2025, at 12:45 PM, Surveyors observed Resident 3 and Caregiver K engage in a conversation at the front desk. Resident 3 reported her/his call button did not work. Caregiver K pushed the call button, and Surveyors heard a faint bell sound when the button was pushed. Caregiver K reported to Resident 3 the call button did work, and Resident 3 inquired why staff did not answer the call button if it worked. Surveyors observed Caregiver K turn up the volume on the receiver and push the call button again. Surveyors heard a louder bell sound from the receiver. On 09/04/2025, at 8:30 AM, Surveyors observed Caregiver I on the 2nd floor. Throughout the survey, Surveyors observed Caregiver I go down to 1st floor to assist with cares, which left 2nd floor unsupervised and no staff available for resident assistance. On 09/04/2025, at 11:45 AM, Surveyors observed Resident 5 at the top of the staircase. Resident 5 was in a wheelchair and was yelling for staff.	Y3244		