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 _____	R 01/15/2026

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 01/15/2026, Surveyors completed a self-report investigation and 2 verification visits for Statement of Deficiency (SOD) QAVZ11 and SOD 46GJ11 for Heritage on Hampton. As a result, 10 of the previous deficiencies were corrected, 14 were recited and 11 new deficiencies identified. Therefore, a total of 25 deficiencies were identified. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 26	{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. The licensee did not comply with requirements and special orders outlined in a Notice and Order letter from the Department. As a result of the 2 verification visits, 24 deficiencies were identified. Fourteen of the 24 violations were repeat deficiencies related to resident medications, staff health screening, training, toxic substances, physical environment, and facility complies with laws. This is a repeat deficiency. See Statement of	{N 196}		

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

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{N 196}	Continued From page 1 Deficiency (SOD) QAVZ11, dated 11/17/2025. 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 01/12/2026, Surveyors reviewed Department records and identified the following: On 09/30/2025, Surveyors completed a standard survey and 2 complaint investigations. Twenty-three deficiencies were identified, and 2 complaints were substantiated. On 10/28/2025, Surveyors completed 2 complaint investigations. One deficiency was identified, 1 complaint was substantiated, and 1 complaint was unsubstantiated. On 11/17/2025, Statement of Deficiency (SOD) 46GJ11 and Notice and Order letter was sent via email. The following deficiency was identified: N0388 83.35(3)(c) Implement, Follow Service Plan On 11/17/2025, Statement of Deficiency (SOD) QAVZ11 and Notice and Order letter was sent via email. The following deficiencies were identified: N0196 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0205 83.14(2)(j) Not Permit a Condition of Substantial Risk	{N 196}		

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{N 196}	Continued From page 2 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 The Notice and Order letter included the following: Special Orders: " ...CONSULTANT REQUIRED	{N 196}		

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{N 196}	Continued From page 3 2. Pursuant to Wis. Stat. § 50.03(5g)(b)6., EFFECTIVE IMMEDIATELY, the licensee shall ensure the provision of services to meet residents' physical and mental health needs. The licensee will correct identified deficiencies in consultation with a Registered Nurse, not currently affiliated with the licensee, at the licensee's expense. The consultant will have knowledge of assisted living regulations (e.g., Wis. Admin. Code ch. 83, Wis. Stat. ch. 50) and knowledge of the client groups served by Heritage on Hampton Assisted Living Facility. WITHIN 45 DAYS of receipt of this notice, in collaboration with the RN consultant, the licensee will, at a minimum, develop (or review/revise) procedures to address: Medication Management and Administration -Including how the facility will: (a) document medication orders, medication administration, and missed/refused doses; (b) administer medications to ensure residents receive medications at the intervals and dosages prescribed; (c) prevent medication errors; (d) respond to medication errors if they occur; (e) monitor for adverse side effects; (f) ensure medications are securely stored; g) monitor for adverse side effects; (h) discontinue and dispose of medications; and (i) document and maintain proof of use record for schedule II drugs. Refer to: https://www.dhs.wisconsin.gov/regulations/assisted-living/mmi.htm Assessment and Service Plan -All required written resident assessments will be	{N 196}		

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{N 196}	Continued From page 4 retained in resident records, in accordance with Wis. Admin. Code § DHS 83.35(1)(d). -All staff responsible for assisting in resident assessment will be trained on assessment procedures. - The timely development, completion and revision of individualized services plans. The ISP review process shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or legal representative shall sign the ISP acknowledging their involvement in, understanding of and agreement with the ISP. - All staff responsible for providing services to residents will review the resident's individualized service plan and will provide services in accordance with the plan. Homelike Environment - All potential health or safety hazards will be addressed immediately. Fixtures, furnishings, and trim boards that cannot be properly cleaned or repaired will be replaced. - Timely repairs and scheduled maintenance of the facility; and Scheduled and 'as needed' housekeeping to maintain a safe, clean, homelike environment. - Safe food handling, including proper food storage, cleaning, and sanitizing the kitchen and appliances. The licensee will provide the RN with a copy of the SOD QAVZ11, along with this Notice and Order letter prior to providing consultation services. The licensee shall obtain a signed and dated statement from the RN to verify participation in the development (or review) of the facility's written procedures required by Order #2.	{N 196}		

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{N 196}	Continued From page 5 WITHIN 21 DAYS of receipt of this notice, the licensee shall hold a separate care conference for Resident 1, Resident 3, and Resident 5; with their legal representative, and case manager (if any), for the purpose of discussing the resident's mobility needs and the resident's access to the facility and within the facility. Additionally: - All managers and service providers (as appropriate) will receive in-service training regarding the facility's written procedures required by Order #2. - Training will be documented in employee files and will include the date/duration of training, the signature/qualifications of the instructor, and an outline of course content. - A copy of the written procedures and all documentation as evidence of meeting the requirements in Order #2 will be made available to department representatives upon request. -Consultation activities will be documented and will include the dates of consultation, and the resulting recommendations in writing, signed and dated by the consultant. Records will be maintained at the facility and will be made available to department representatives upon request." On 01/13/2026, Surveyors conducted 2 verification visits for SOD QAVZ11 and SOD 46GJ11. The following deficiencies were identified: N0196 83.14(2)(a) Licensee Ensures Facility Complies with Laws (repeat deficiency) N0203 83.14(2)(h) Posting: License, Deficiencies, Revocations	{N 196}		

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{N 196}	Continued From page 6 N0205 83.14(2)(j) Not Permit A Condition of Substantial Risk (repeat deficiency) N0220 83.17(2)(a) Employees Screened For Communicable Diseases (repeat deficiency) N0230 83.19 Orientation (repeat deficiency) N0352 83.32(3)(h) Rights of Residents- Receive Medication (repeat deficiency) N0362 83.33(1)(d) Grievance Procedure Written Summary N0381 83.35(1)(a) Pre-Admission and Ongoing Assessments (repeat deficiency) N0386 83.35(3)(a) Comprehensive Individualized Service Plan (repeat deficiency) N0388 83.35(3)(c) Implement, Follow Service Plan (repeat deficiency) N0394 83.35(5)(b) Annual Evaluation of Evacuation Limitations N0415 83.37(2)(d) Documentation of Medication Administration (repeat deficiency) N0427 83.38(1)(c) Leisure Time Activities N0428 83.38(1)(d) Community Activities N0450 83.41(2)(a) Nutrition: Menus (repeat deficiency) N0481 83.41(1) Environment Safe, Clean, and Comfortable N0496 83.45(1)(e) Electrical, Mechanical, Water Supply N0499 83.45(3) Toxic Substances (repeat deficiency) N0503 83.46(1)(b) Portable Space Heaters Prohibited N0507 83.46(1)(f) Combustibles (repeat deficiency) N0535 83.48(1)(b) Smoke and Heat Detectors Per Nfpa 72 N0540 83.48(3)(c) Smoke and Heat Detectors Exposure to Fire N0617 83.55(6)(b) Bath and Toilet Areas: Water Temperature (repeat deficiency) Z3235 50.09(1)(f) Privacy	{N 196}		

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{N 196}	Continued From page 7 50.09(1)(L) Care (repeat deficiency) On 01/13/2026, at approximately 10:15 AM, Licensee A showed Surveyors an email from Nurse Consultant P. The email was dated 12/23/2025 from Nurse Consultant P. The email contained information regarding s/he received the SOD and [Plan of Correction] (POC). Nurse Consultant P made recommendations to the physical environment of the facility. There was no indication of a review or creation of policies as ordered by the department, or training to be conducted as order for corrections for SOD QAVZ11. Licensee A confirmed s/he did not have any further consultant logs from Nurse Consultant P. On 01/13/2026, at 4:30 PM, Surveyors interviewed Licensee A and Registered Nurse (RN) C. RN C reported Resident 1's ISP was not reviewed within 21 days as ordered. RN C reported s/he did send the ISP to Resident 1's managed care team (MCO), but confirmed a care conference did not take place. RN C confirmed staff training was not completed, nor were policies updated as ordered. Earlier during the survey, Licensee A reported s/he thought they had until March to make the corrections. Licensee A confirmed s/he did receive the Notice and Order Letter. Licensee A and RN C reported they would continue to make corrections. On 01/15/2026, at 10:00 AM, Surveyors interviewed Licensee A and RN C. Licensee A reported s/he was aware Resident 2 was on the second floor and smoked in her/his room. Licensee A reported this was due to the elevator being inoperable. Licensee A reported s/he was unaware of Resident 4 extinguishing her/his cigarettes in a plastic bottle. Licensee A reported	{N 196}		

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{N 196}	Continued From page 8 the intervention for Resident 13 since the fire was to remove her/his bedroom door handle. Licensee A reported the door handle was going to be replace with a door handle without a locking mechanism. On 1/28/2026, the Department determined Heritage on Hampton will not be issued a regular license due to continued non-compliance with all laws governing the CBRF.	{N 196}		
N 203	83.14(2)(h) Posting: license, deficiencies, revocations The licensee shall post the CBRF license, any statement of deficiency, notice of revocation and any other notice of enforcement action in a public area that is visually and physically available. A statement of deficiency shall remain posted for 90 days following receipt. Notices of revocation and other notices of enforcement action shall remain posted until a final determination is made. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the statement of deficiency (SOD), and notice of enforcement action was posted in a public area that was visually and physically available for 90 days following receipt or until a final determination was made for notices of enforcement action. Findings include: On 01/13/2026, at 9:50 AM, Surveyor observed a black binder on a table outside of the administrator's office. Surveyor opened the binder and observed outdated SODs located in the binder. Surveyor did not observe SOD QAVZ11 or	N 203		

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N 203	Continued From page 9 the Notice and Order letter which was issued with SOD QAVZ11. Surveyor did not observe SOD 46GJ11 or the Notice and Order letter which was issued with SOD 46GJ11. SOD QAVZ11 and SOD 46GJ11 and Notice and Order letters were issued to the provider on 11/17/2025. Surveyor continued to tour the facility and did not observe SOD QAVZ11 and SOD 46GJ11 and Notice and Order letters posted in the facility. On 01/15/2026, at 10:00 AM, Surveyor interviewed Licensee A and Registered Nurse (RN) C. RN C reported the SODs were placed in a binder in the lobby. Surveyor relayed the SODs were from previous years and not the SODs issued 11/17/2025. RN C reported s/he reviewed both SODs and corrections with Front Desk Attendant R and Manager Q and requested them to place the SODs in the binder.	N 203		
{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 observation, record review and interview, the provider did not prohibit the existence of a condition which may create substantial risk to the welfare of residents. Resident 13 was smoking in her/his room and started a fire in the facility. This had the potential to affect 26 of 26 residents.	{N 205}		

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{N 205}	Continued From page 10 This is a repeat deficiency. See Statement of Deficiency (SOD) QAVZ11, dated 11/17/2025. Findings include: "Cigarette and smoking related fires are among the top causes of fire related fatalities. These fires often involve the ignition of mattresses, bedding, upholstered furniture or trash by improperly discarded cigarettes, ashes or matches. ...Several factors contribute to the high fatality rates of cigarette and smoking fires. Smoking materials are often in close proximity to people. In fact, a leading cause of smoking fire fatalities involves the person falling asleep or passing out with a lit cigarette. The lit cigarette ignites the mattress, couch or upholstered furniture where the person is sleeping and because the fire is so close to the person upon igniting, it is difficult to escape harm. Top factors contributing to the lethality of smoking fires are: People are often slowed by alcohol or medication when a cigarette fire starts. Materials in upholstered furniture ignite quickly, consume a great deal of oxygen and release toxins. People are often asleep when the fire ignites. ...the following steps can help prevent cigarette and smoking related fires in your home: Never smoke in bed, when you're tired, or when taking medication that may make you drowsy. Never smoke in a house after consuming alcohol. Use large, heavy, non-tip ashtrays and always place them on flat stable services; never	{N 205}		

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{N 205}	Continued From page 11	{N 205}		

use your lap or a couch cushion.
Use child resistant lighters and matches and keep them out of the reach of children.
Douse smoking materials with water when you're done smoking.

(Source: The Hartford Junior Fire Marshal Program: Smoking Fire https://www.thehartford.com/about-us/junior-fire-marshal/smoking-fires (retrieval date - January 27, 2026).)

Observations

On 01/13/2026, at 9:30 AM, Surveyors toured the facility and observed the following:

- A smoking policy was located on the west wall on the first floor near the lobby. The policy was dated 02/27/2025 which indicated, "Purpose: To ensure the health, safety, and well-being of residents, staff, and visitors by establishing clear guidelines regarding smoking within the facility. 1. designated smoking areas: smoking is permitted only in designated outdoor areas that are clearly marked and away from entrances, windows, and common areas to minimize exposure to secondhand smoke. Residents who smoke must use these designated areas and adhere to any posted rules. Two period prohibited areas: smoking is strictly prohibited inside the facility, including: resident rooms, common areas, bathrooms, administrative offices, staff areas. 3. Support for residents: CBRF is committed to providing support for residents who wish to quit smoking. This may include access to counselling, smoking cessation programs, and informational resources. Staff will encourage and assist residents in seeking help to quit smoking as needed. 4. Compliance: all residents and staff

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{N 205}	Continued From page 12 must comply with this policy. Failure to adhere to the smoking policy may result in disciplinary action and other consequences, including potential eviction for residents who violate this policy ..." - Resident 2 had smoking materials in her/his bedroom on a table. - Resident 4 had a pack of cigarettes, a lighter, and a bottle of burnt cigarette butts next to her/his bed. - Resident 13's door did not contain a doorknob. Record Review On 01/12/2026, in the Department e-file for the facility, Surveyor reviewed a "Health Care Facility Fire Report", dated 12/15/2025, which reported a fire occurred on 12/12/2025, in room 125. The type of fire with narrative description reported, "Resident was smoking in [her/his] bedroom while in bed what seems to be illegal drugs, specifically crack cocaine as crack pipes were found in room. Resident fell asleep while smoking crack and dropped the lit pipe in [her/his] bed ..." A self-report, dated 12/15/2025, indicated Resident 13 suffered "superficial burns on her/his lower extremities, one arm and buttocks." On 01/13/2026, at 11:30 AM, Surveyors reviewed resident records and identified the following: - Resident 13 was admitted on 03/25/2025 with diagnoses including schizophrenia and bipolar disease. Resident 13's record contained an individual service plan (ISP) dated 01/05/2026, indicated the following:	{N 205}		

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{N 205}	Continued From page 13 Self- Abusive Behavior - history of polysubstance abuse, cocaine, alcohol, smokes cigarettes while in bed. Service Provided - Offer rehab services, emphasize house rules and smoking policy and enforce risk agreements. Destructive of Property or self, physically or mentally abusive - history of causing damage to property regarding smoking inside facility. Service Provided - Ensure resident is not smoking inside facility. Report any indoor smoking to manager. Remind resident of smoking policy and house rules when attempting to smoke indoors. Resident 13's previous ISP, dated 09/16/2025, did not indicate any behaviors in self-abusive behaviors or property damage. A "Risk Agreement for Smoking in Resident Rooms" dated 01/02/2026, was signed by Resident 13 and Licensee A. The risk agreement indicated the following: " ...4. Condition of smoking in rooms - designated Areas: Smoking is only permitted in designated areas as outlined by facility management ...Compliance: Residents must comply with all fire safety regulations and facility policies regarding smoking ...5. Responsibilities of Residents - Safety: Residents must ensure that smoking materials are kept secure and away from flammable items. Cleanliness: Residents are responsible for maintaining cleanliness in their rooms and disposing of smoking materials properly ...." Surveyors did not review an assessment of Resident 13's ability to practice safe smoking practices prior to the fire or after the fire. Surveyors did not review Resident 13's admission	{N 205}		

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	0020768	A. BUILDING: _____ B. WING _____	R 01/15/2026

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HERITAGE ON HAMPTON ASSISTED LIVING F/	4615 W HAMPTON AVE MILWAUKEE, WI 53218

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{N 205}	Continued From page 14 paperwork in her/his file. Resident 2 was admitted on 08/19/2024 with diagnoses including seizures. Resident 2's record did not contain an assessment of Resident 2's ability to practice safe smoking practices. Resident 2's ISP, dated 01/12/2026, did not indicate Resident 2's ability in practicing safe smoking. Resident 4 was admitted on 05/13/2025 with diagnoses including paraplegia. Resident 4's record did not contain an assessment of Resident 4's ability to practice safe smoking practices. Interviews On 01/13/2026, at 2:30 PM, Surveyor interviewed Caregiver F. Caregiver F reported s/he had observed Resident 13 smoke cigarettes in her/his room and had found crack pipes in her/his room. Caregiver F reported s/he would throw away the pipes and report finding them to Administrator B. On 01/13/2026, at 2:49 PM, Surveyor interviewed Resident 2. Resident 2 reported s/he had pressed his/her button over 1 hour ago and no caregiver came to his/her room to assist him/her. Resident 2 reported s/he was paralyzed on his/her right side and was unsteady on his/her feet. S/he required staff assistance to use the stairs. Resident 2 reported s/he used to be independent with getting to the first-floor patio to smoke, but since the elevator broke several months ago, s/he has been unable to go outside. Resident 2 reported since staff never answer his/her call button when s/he wants to smoke, s/he smokes his/her cigarettes in his/her room, which was multiple times per day.	{N 205}		

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{N 205}	Continued From page 15 On 01/13/2026, at 4:30 PM, Licensee A and Registered Nurse (RN) C. Licensee A and RN C confirmed residents were not to be smoking inside the building and were to be smoking outside. RN C and Licensee A relayed concerns regarding resident rights. RN C confirmed no assessment was documented and no effective interventions for the behavior of smoking inside were implemented. On 01/15/2026, at 10:00 AM, Surveyor interviewed Licensee A and Registered Nurse (RN) C. Licensee A reported s/he encouraged the residents to go outside to smoke. Licensee A reported Resident 13's doorknob was removed as an intervention to her/his smoking in her/his room. Licensee A reported with the elevator being broke, it made it difficult for the residents on the second floor to go outside to smoke. Licensee A reported they moved some residents down to the first floor. Licensee A confirmed s/he was aware Resident 2 was on the second floor and smoked in her/his room.	{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	{N 220}		

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{N 220}	Continued From page 16 screening documentation for verification purposes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis (TB), within 90 days before the start of employment for 2 of 2 (Caregiver N and Housekeeper O) staff members reviewed. This is a repeat deficiency. See Statement of Deficiency (SOD) QAVZ11, dated 11/17/2025. Findings include: On 01/13/2026, at 3:00PM, Surveyors reviewed staff files and identified the following: Caregiver N was hired on 01/01/2026. Caregiver N's record did not contain any evidence of a communicable disease screening or a TB test. Housekeeper O was hired on 01/02/2026. Housekeeper O's record did not contain any evidence of a communicable disease screening or a TB test. On 01/13/2026 at 2:00 PM, Surveyors interviewed Licensee A and Registered Nurse (RN) C. RN C reported s/he was aware of the code requirement. RN C reported s/he was in the process of updating resident and staff files. RN C confirmed Caregiver N and Housekeeper O were not screened for TB or communicable diseases.	{N 220}		

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{N 230}	Continued From page 17	{N 230}		
{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 2 of 2 staff (Caregiver N and Housekeeper O) 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 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) Community Based Residential Facility (CBRF) policies and procedures, (6) Recognizing and responding to resident changes of condition. This is a repeat deficiency. See Statement of Deficiency (SOD) QAVZ11, dated 11/17/2025. Findings include:	{N 230}		

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{N 230}	Continued From page 18 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. The following definition of Wis. Admin. Code § DHS 83.02 is as follows: Wis. Admin. Code § DHS 83.02(22) "Employee" means any person who works for a CBRF or for an entity that is affiliated with the CBRF or that is under contract to the CBRF, who is under direct control of the CBRF or corporation affiliated with the CBRF and who receives compensation subject to state and federal employee withholding taxes. On 01/13/2026, at 3:00PM, Surveyors reviewed staff files and identified the following: Caregiver N was hired on 01/01/2026. Caregiver N'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. Housekeeper O was hired on 01/02/2026. Housekeeper O's record did not contain evidence of orientation training in prevention and reporting of resident abuse, neglect, and misappropriation	{N 230}		

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{N 230}	Continued From page 19 of resident property; emergency and disaster plan and evacuation procedures under DHS 83.47(2); CBRF policies and procedures. On 01/13/2026 at 2:00 PM, Surveyors interviewed Licensee A and Registered Nurse (RN) C. RN C reported s/he was aware of the code requirement. RN C reported s/he was in the process of updating resident and staff files and did not update staff files. RN C confirmed the staff were working on the floor. RN C confirmed Caregiver N and Housekeeper O did not complete the required orientation training prior to performing job duties.	{N 230}		
{N 352}	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the 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 3 of 3 residents (Resident 2, Resident 13, and Resident 17) reviewed received prescribed medications in the dosage and at intervals prescribed by the practitioner. Resident 2 did not receive 19 doses of his/her Eliquis and 8 doses of her/his donepezil. Resident 13 did not receive 2 doses of vitamin D2 and 4 doses of aspirin.	{N 352}		

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{N 352}	Continued From page 20 Resident 17 did not receive 7 doses of furosemide, 1 dose of haloperidol, and 11 doses of metoprolol succinate This is a repeat deficiency. See Statement of Deficiency (SOD) QAVZ11, dated 11/17/2025. Findings include: Observations On 01/13/2026, at 8:00 AM, Surveyor observed Caregiver F conduct the morning medication pass. Surveyor observed Caregiver F unable to find medications in the medication cart to administer all resident's prescribed medications. On 01/13/2026, at 9:08 AM, Surveyors observed a paper cup in Resident 2's room located on a bedside table. The cup contained 4 medications: 1 vitamin D3 50 micrograms (mcg) capsule, 1 gabapentin 300 milligram (mg) capsule, 1 loratadine 10 mg tablet, and 1 levetiracetam 500 mg tablet. Resident 2 confirmed the medications were her/his morning medications for 01/13/2026. Surveyors did not observe Resident 2's Eliquis in her/his morning medication cup. On 01/13/2026, at 12:45 PM, Surveyors reviewed the medication cart. Surveyors did not observe any evidence of medication cards/containers of Resident 2's Eliquis or donepezil. Record Review On 01/13/2026, at 11:25 AM, Surveyors reviewed resident records and identified the following: Resident 2 was admitted on 08/19/2024, with	{N 352}		

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{N 352}	Continued From page 21 diagnoses including cerebral infarction and hemi spasticity of right side. Resident 2's medication administration record (MAR) for January 2026 indicated Resident 2 was prescribed Eliquis 5 mg tablet: Take 1 tablet by mouth twice daily, Vitamin D3 50 micrograms (mcg) capsule: take 1 capsule by mouth daily, Gabapentin 300 mg: Take 1 capsule by mouth 3 times daily, Loratadine 10 mg tablet: take 1 tablet by mouth daily, levetiracetam 500 mg tablet: take 1 tablet by mouth every 12 hours, and donepezil 5 mg tablet: take 1 tablet by mouth every night at bedtime. Resident 2's MAR Indicated the following: Eliquis 5 mg tablet 01/01/2026 AM - No documentation 01/01/2026 PM - Circled initials 01/02/2026 AM - Circled initials 01/02/2026 PM - Circled initials 01/03/2026 AM - Circled initials 01/03/2026 PM - Circled initials 01/04/2026 AM - Circled initials 01/04/2026 PM - Circled initials 01/05/2026 PM - Circled initials 01/06/2026 AM - Circled initials 01/06/2026 PM - Circled initials 01/07/2026 AM - Circled initials 01/07/2026 PM - Circled initials 01/08/2026 AM - Circled initials 01/08/2026 PM - Circled initials 01/09/2026 PM - No documentation 01/12/2026 AM - Circled initials 01/12/2026 PM - Circled initials 01/13/2026 AM - Circled initials donepezil 5 mg tablet 01/06/2026 PM - Circled initials	{N 352}		

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{N 352}	Continued From page 22 01/07/2026 PM - Circled initials 01/07/2026 PM - Circled initials 01/08/2026 PM - Circled initials 01/09/2026 PM - Circled initials 01/10/2026 PM - Circled initials 01/11/2026 PM - Circled initials 01/12/2026 PM - No documentation Resident 13 was admitted on 03/25/2025 with diagnoses including schizophrenia, bipolar disease and hypertension. Resident 13's MAR for January 2026 indicated Resident 13 was prescribed amlodipine 5mg 1 tablet once a day, mirtazapine 7.5 mg tablet at bedtime, vitamin D2 1250 mg capsule once a week on Tuesdays, and Aspirin 8 1mg tablet once a day. Resident 13's MAR indicated the following: Vitamin D2 01/06/2026 AM - Circled initials 01/13/2026 AM - Circled initials Aspirin 81 mg 01/10/2026 AM - Circled initials 01/11/2026 AM - Circled initials 01/12/2026 AM - Circled initials 01/13/2026 AM - Circled initials Resident 17 was admitted on 11/07/2025 with diagnoses including high cholesterol, emphysema and hyperthyroidism. Resident 17's MAR for January 2026 indicated Resident 17 was prescribed furosemide 20 mg once a day, haloperidol 2 mg tablet in the morning, haloperidol 2 mg take 2 tablets (4 mg) at bedtime, metoprolol succinate 50 mg tablet once a day, quetiapine 25 mg take half tablet once a day, Symbicort inhaler 2 puff twice a day,	{N 352}		

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{N 352}	Continued From page 23 latanoprost 0.005% eyedrops at night, Alphagan 0.15% eye drops twice a day, brimonidine 0.15% eye drops three times a day, and dorzolamide 2% eye drops 3 times a day. Resident 17's MAR indicated the following: Furosemide 20 mg 01/03/2026 AM - Circled initials 01/04/2026 AM - Circled initials 01/06/2026 AM - Circled initials 01/10/2026 AM - Circled initials 01/11/2026 AM - Circled initials 01/12/2026 AM - Circled initials 01/13/2026 AM - Circled initials Haloperidol 2 mg 01/13/2026 AM - Circled initials Metoprolol succinate 50 mg 01/03/2026 AM - Circled initials 01/04/2026 AM - Circled initials 01/05/2026 AM - Circled initials 01/06/2026 AM - Circled initials 01/07/2026 AM - Circled initials 01/08/2026 AM - Circled initials 01/09/2026 AM - Circled initials 01/10/2026 AM - Circled initials 01/11/2026 AM - Circled initials 01/12/2026 AM - Circled initials 01/13/2026 AM - Circled initials Interview On 01/13/2026, at 8:00 AM, Surveyor interviewed Caregiver F. Caregiver F explained the process of medication administration to Surveyor. Caregiver F reported when s/he was unable to locate a medication in the cart, s/he normally had a pad of paper to write down the medication	{N 352}		

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{N 352}	Continued From page 24 which was missing. Caregiver F reported s/he would give the paper to Registered Nurse (RN) C. Caregiver F reported when a medication was missing, they initial the MAR, then circle their initials to indicate the medication was not passed. Caregiver F reported they were then to write in the back of the MAR the reason the medication was not administered. Surveyor inquired about all the circled initials but not every circled initial had corresponding note in the back of the MAR, Caregiver F stated, "Well we are supposed to write in the back, not everyone does." On 01/13/2026, at 9:00 AM, Surveyors interviewed Resident 2. Resident 2 reported s/he did not receive her/his prescribed Eliquis. Resident 2 reported s/he did not receive her/his "memory medication". On 01/13/2026, at 2:30 PM, Surveyors interviewed RN C. RN C reported Eliquis was requested on 01/06/2026. RN C reported the medication was unable to be refilled until 01/22/2026. RN reported the medication was not in the facility because of a pharmacy error. On 01/13/2026, at 3:32 PM, Surveyors interviewed RN C. RN C reported s/he located Resident 2's Eliquis in the administrator's office. RN C confirmed the medication was delivered to the facility on 12/30/2025. On 01/13/2026, at 3:31 PM, Surveyors interviewed RN C. RN C reported s/he found Resident 2's Eliquis in the office. RN C confirmed the medication was delivered on 12/30/2025 by pharmacy. RN C stated, "It was in the office the whole time, somebody just didn't open a bag. We need to tighten up our system."	{N 352}		

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{N 352}	Continued From page 25 On 01/15/2026, at 10:00 AM, Surveyors interviewed Licensee A and RN C. RN C reported Resident 2's medications were later located in the facility, and s/he received her prescribed medications. RN C reported s/he would review medication documentation with staff. Cross Reference N0415 DHS 83.37(2)(d) Documentation of Medication Administration	{N 352}		
N 362	83.33(1)(d) Grievance procedure: written summary The CBRF shall provide a written summary of the grievance, the findings and the conclusions and any action taken to the resident or the resident ' s legal representative and the resident ' s case manager. The CBRF shall maintain a copy of the investigation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide a written summary of the grievance, the findings, and the conclusions and any action taken to the resident, resident's legal representative, and case managers, potentially affecting 26 of 26 residents in the facility. Findings include: On 01/13/2026, Surveyor reviewed the facility's record of grievances. The following was identified: -Resident 4's grievance, dated 09/27/2025, identified Resident 4 complained of being left in	N 362		

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N 362	Continued From page 26	N 362		

his/her chair on second shift and third shift. S/He reported s/he was not being rotated on third shift and staff were sleeping. S/He reported s/he was not being served properly during mealtimes. The elevator was down and had been down for months. S/He reported s/he was not able to leave the building, and s/he was missing appointments. The follow up listed stated, "Resident was offered a room downstairs. Resident stated [s/he] didn't want to share a bathroom." There was no other follow up for any of the concerns Resident 4 reported. There was no resolution on the form. Administrator B signed the form.

-Resident 2's grievance, dated 10/08/2025, identified Resident 2 complained of laundry not being finished, quality of food was not good, food was being served without being covered, and their room was not being cleaned. The follow up listed was, "Laundry found and returned. Making sure food is covered." There was no resolution. Administrator B signed the form.

-Resident 18's grievance, dated 10/11/2025, identified Resident 18 complained s/he did not receive any assistance on second shift, laundry was not being completed timely, food was cold, and portions of food were small. There was no resolution or follow up completed. Administrator B signed the form.

-Resident 10's grievance, dated 10/12/2025, identified Resident 10 reported several pairs of shoes were missing. There was no follow up or resolution identified. Administrator B signed the form.

-There was no additional grievance records dated after 10/12/2025.

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N 362	Continued From page 27 On 01/13/2026, Surveyor reviewed the facility's grievance procedure. The procedure, not dated, identified, "...4. CBRF (community based residential facility) shall provide a written summary of the grievance, the findings and the conclusions, and any action taken by the resident or the resident's legal representative and the resident's case manager. The CBRF shall maintain a copy of the investigation...8. Filling [sic] a grievance: Residents and staff may file a grievance verbally or in writing...9. Investigation Process Upon receiving grievance, the Grievance Officer will conduct a thorough and timely investigation..." The procedure identified the grievance officer as Licensee A. On 01/13/2026, at approximately 9:15 AM, Surveyor interviewed Resident 2. Resident 2 reported s/he was not able to leave the facility due to not having a working elevator in the building. Resident 2 reported s/he was uneasy with navigating the stairs, even with caregiver assistance. Resident 2 reported s/he uses his/her call button, but no one ever comes to assist him/her. Resident 2 reported s/he complains to staff all the time about not getting his/her medication s/he needs. Resident 2 reported s/he has not received Eliquis and has told staff daily s/he was not getting all his/her medication. Resident 2 reported no one told him/her why s/he did not get the medication and reported it was important due to his/her history of strokes. Resident 2 reported no one follows up with him/her about his/her service complaints. On 01/13/2026, at approximately 4:00 PM, Surveyor interviewed Registered Nurse (RN) C regarding the grievance procedure. RN C reported Administrator B was responsible for completing the grievance investigations and	N 362		

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N 362	Continued From page 28 resolution prior to November 2025. In the beginning of November 2025, another person became responsible for following up on grievances. RN C reported there were posters around the facility with the grievance phone number for residents and staff to call with their grievances. RN C reported there were no grievances received by the identified grievance officer from November 2026 to 01/11/2026, when the grievance officer changed to Manager Q. Manager Q had the phone beginning 01/12/2026. The process was for staff or residents to call the hotline number, and the grievance officer would fill out the forms, investigate the grievances, and complete the resolution. RN C reported there may have been a communication issue when they updated the procedure to using the phone system and the compliance officer changed to someone who was not regularly in the building. On 01/13/2026, at approximately 4:30 PM, Surveyor interviewed Caregiver G. Caregiver G reported s/he had been employed at the facility since the summer of 2025, and had been working full time for over 6 months. Caregiver G reported s/he did not know what to do if a resident had a grievance other than fix the problem in the moment if s/he could. Caregiver G reported s/he did not know about a number to call to report grievances to. On 01/13/2026, at approximately 4:45 PM, Surveyor interviewed Caregiver F. Caregiver F reported s/he did not know about a phone number for residents and staff to call to report grievances to.	N 362		
{N 381}	83.35(1)(a) Pre-admission and ongoing assessments.	{N 381}		

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{N 381}	Continued From page 29 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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each resident's abilities were assessed as required for 1 of 1 resident (Resident 13). Resident 13 was not assessed for her/his ability to practice safe smoking activities and started a fire inside her/his bedroom in the facility. This is a repeat deficiency. See Statement of Deficiency (SOD) QAVZ11, dated 11/17/2025. Findings include: On 01/13/2026, at 6:30 AM, Surveyor reviewed a self-report, dated 12/17/2025. The self-report indicated on 12/12/2025 "at approximately 5:00 PM, heat and smoke detector alarms were triggered .... The fire department [sic] called by monitoring system. Caregivers and licensee rushed to the heat and smoke source (room 125). Licensee and caregivers observed resident in bed with smoking materials still in his hands. Licensee and caregivers observed smoke in room. Only	{N 381}		

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{N 381}	Continued From page 30	{N 381}		

one sprinkler [sic] triggered. The fire had already been extinguished by sprinklers ..."

On 01/13/2026, at 3:30 PM, Surveyors reviewed Resident 13's record. Resident 13 was admitted on 03/25/2025 with diagnoses including schizophrenia and bipolar disease. Resident 13's record contained an individual service plan (ISP) dated 01/05/2026, indicated the following:

- Self- Abusive Behavior - history of polysubstance abuse, cocaine, alcohol, smokes cigarettes while in bed.
Service Provided - Offer rehab services, emphasize house rules and smoking policy and enforce risk agreements.

- Destructive of Property or self, physically or mentally abusive - history of causing damage to property regarding smoking inside facility.
Service Provided - Ensure resident is not smoking inside facility. Report any indoor smoking to manager. Remind resident of smoking policy and house rules when attempting to smoke indoors.

Resident 13's previous ISP, dated 09/16/2025, did not indicate any behaviors in self-abusive behaviors or property damage.

Surveyors did not review an assessment of Resident 13's ability to practice safe smoking practices prior to the fire or after the fire.

On 01/13/2026, at 4:30 PM, Surveyors interviewed Licensee A and Registered Nurse (RN) C. RN C reported Resident 13's ISP was updated, and a risk agreement was completed, but an assessment was not completed. RN C reported s/he was unsure if an assessment was

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{N 381}	Continued From page 31 completed on Resident 13's smoking abilities prior to the fire.	{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 specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 2 residents (Resident 14) had a comprehensive individual service plan (ISP) completed in 30 days which 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. This is a repeat deficiency. See Statement of Deficiency (SOD) QAVZ11, dated 11/17/2025. Findings include: On 01/13/2026, at 9:45 AM, Surveyors reviewed	{N 386}		

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{N 386}	Continued From page 32 a resident roster. The roster indicated Resident 14 was admitted to the facility on 11/15/2025. On 01/13/2026, at 1:00 PM, Surveyor requested Resident SH's record. Registered Nurse (RN) C emailed Surveyor a Member Centered Plan (MCP), dated 07/28/2025, from Resident 14's Managed Care Organization (MCO). The MCP indicated Resident 14's diagnoses were schizophrenia, type 2 diabetes, lower limb amputation, chronic kidney disease, depression, anxiety and chronic pain. Surveyor was unable to review an ISP for Resident 14. On 01/13/2026, at 3:05 PM, Surveyor interviewed RN C. RN C reported s/he had not completed Resident 14's file and was still working on it. RN C confirmed there was not an ISP for Resident 14. On 01/15/2026, at 10:00 AM, Surveyor interviewed Licensee A and RN C. RN C reported Resident 14 required total assistance with cares and transfers due to her/his physical disabilities. Licensee A and RN C reported Resident 14 was non-compliant with personal cares, medical appointments and medications.	{N 386}		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure each resident's Individual Service Plan (ISP) was implemented for 1 of 1 (Resident 2) resident.	N 388		

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Resident 2 had a history of chronic pain and was prescribed pain medication. Resident 2 did not receive medications as outlined in her/his ISP.

This is a repeat deficiency. See Statement of Deficiency (SOD) 46GJ11, dated 11/17/2025.

Findings include:

Observations

On 01/13/2026, at approximately 11:30 AM, Surveyors observed Resident 2 in her/his room. Resident 2 reported to Registered Nurse (RN) C her/his right knee leg pain was a 6/10 pain. RN C informed Resident 2 s/he would receive her/his as needed (PRN) medication for her/his pain.

Record Review

On 01/13/2026, at 11:25 AM, Surveyors reviewed Resident 2's record. Resident 2 was admitted on 08/19/2024, with diagnoses including chronic pain. Resident 2's ISP dated, 01/12/2026 indicated:

"... General Health

- Current Status - asthma, [history] (Hx) [cerebrovascular accident] CVA, chronic pain, constipation, [hypertension] (HTN), obesity, depression, seizures, poor coordination, right hand contracture, disorder of lymphatic system, anxiety, speech aphasia

- Frequency of Service and Service Provided - Ensure resident attends all MD appointments. Ensure resident takes all meds [sic] as ordered. [blood pressure] (BP) monitoring monthly. Notify nurse for [systolic blood pressure] SBP >180.

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Report any seizure activity to nurse. Perform [range of motion] ROM on each shift. Report any [shortness of breath] (SOB) to nurse/ Provide [sic] nonpharmalogical [sic] pain interventions between analgesics (massage, warm/cold compress, distraction meditation. Report any sign of depression-tearfulness, withdrawal, no interest in activities previously enjoyed. Invite to group activities.

- Goal/Outcome - Pain will be tolerable at 3 or less on pain scale. Will be free of seizure activity. SOB will be treated promptly, BP will remain [within normal limit]. Will have no sign of depression.

- Service Provider Responsible - Care staff, Nursing, Activity Staff..."

Surveyors reviewed Resident 2's medication administration record (MAR) for the month of January 2026 which included the following medications:

- Oxycodone immediate release (IR) 5 milligram (mg) tablet (tab): Take 1 tablet by mouth daily as needed for severe pain.

- Acetaminophen 500 mg tab: Take 2 tablets (1000mg) by mouth every six hours as needed for mild pain, headache or fever.

- Tizanidine 2 mg tablet: Take 1 tablet by mouth every 6 hours as needed.

Interview

On 01/13/2026, at 2:49 PM, Surveyor interviewed Resident 2. Resident 2 reported s/he had pressed his/her call button approximately 1 hour ago

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because s/he had not received his/her pain medication s/he requested earlier in the day. Resident 2 reported s/he felt his/her pain was getting "out of control" and was at an 8 on a scale of 1-10, with 10 being the highest.

On 01/13/2026, at approximately 3:50 PM, Surveyors interviewed Resident 2. Resident 2 reported Administrator B informed her/him s/he did not have any prescribed pain medication in the medication cart. Resident 2 reported s/he then asked Administrator B if s/he could receive her/his muscle relaxer. Resident 2 reported s/he was administered a "muscle relaxer" for her/his pain by Administrator B approximately "15 or 20 minutes ago" at approximately 3:30 PM, approximately 4 hours after reporting a 6/10 pain.

On 01/13/2026, at approximately 4:00 PM, Surveyors interviewed RN C. Surveyors inquired when RN C notified staff of Resident 2's request for PRN pain medication. RN C reported s/he informed Administrator B of Resident 2's request immediately after leaving Resident 2's room. Surveyors informed RN C Resident 2 did not receive pain medication and received her/his tizanidine approximately 4 hours after her/his request. RN C called Administrator B, Administrator B confirmed s/he did not give Resident 2 her/his acetaminophen because s/he could not locate the medication.

On 01/13/2026, at 4:15 PM, Surveyors interviewed RN C. RN C reported s/he administered Resident 2 her/his 1000 mg PRN acetaminophen.

On 01/13/2026, at 4:30 PM, Surveyors interviewed Licensee A and RN C regarding resident 2's prescribed pain medications. RN C

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N 388	Continued From page 36 confirmed Resident 2's medications should be given when requested because of her/his chronic pain.	N 388		
N 394	83.35(5)(b) Annual evaluation of evacuation limits Evaluation update. The CBRF shall evaluate each resident ' s mental or physical capability to respond to a fire alarm at least annually or when there is a change in the resident ' s mental or physical capability to respond to a fire alarm. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not evaluate each resident's mental or physical capability to respond to a fire alarm at least annually for 1 of 1 resident (Resident 2). Resident 2 was not reevaluated in August 2025 after the elevator in the facility was no longer working because of flood damage which occurred around 08/10/2025. Findings include: Observations On 01/13/2026 at 8:15 AM, Surveyors toured the facility. The elevator was not operable during the time of the survey. Record Review On 01/13/2026, at 11:25 AM, Surveyors reviewed Resident 2's record. Resident 2 was admitted on 08/19/2024, with diagnoses including chronic pain, cerebral infarction, and hemi spasticity of right side (Dominate side). Resident 2's record contained an evacuation evaluation assessment dated 03/07/2025. Resident 2's evacuation	N 394		

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N 394	Continued From page 37 assessment indicated: "... Impaired Mobility ... Yes - 3. Needs limited assistance means that the resident may require some initial or brief intermittent assistance but can accomplish most of the evacuation without assistance. Total time required for staff to assist the resident, and for the resident to evacuate the facility should not exceed the required evacuation time for the facility..." Resident 2's ISP dated 01/12/2026 indicated: "... Physical Disabilities - Current Status - Nees assist of 1. Uses walker. Electric wheelchair for long distance. May pivot with assist of 1. - Frequency of Service and Service Provided - Support weak right side for pivot transfers. Remind client to ask for more help on weak days. - Goal/Outcome - Will be free of falls or injury for 6 month [sic]..." Interview On 01/13/2026, at 9:00 AM, Surveyors interviewed Resident 2. Resident 2 reported s/he utilized the elevator to go the first floor when it was in service. Surveyors inquired how Resident 2 is transported to the second floor. Resident two reported s/he is required to walk down the stairs. Surveyors inquired how Resident 2 would take to ambulate down the stairs. Resident to reported "10 to 15 minutes".	N 394		

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N 394	Continued From page 38 On 01/13/2026, at 4:30 PM, Surveyors interviewed Licensee A and RN C. Surveyors inquired if Resident 2's ability to evacuate the facility in the required time was reevaluated after the elevator was no longer in service. RN C confirmed Resident 2's ability to evacuate from the facility in the event of an emergency changed since elevator broke.	N 394		
{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 1 of 4 residents (Resident 2). Staff did not accurately document when Resident 2 was or was not administered prescribed medications. This is a repeat deficiency. See Statement of Deficiency (SOD) QAVZ11, dated 11/17/2025.	{N 415}		

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{N 415}	Continued From page 39 Findings include: On 01/13/2026, at 11:25 AM, Surveyors reviewed resident records and identified the following: Resident 2 was admitted on 08/19/2024, with diagnoses including: chronic pain, cerebral infarction and hemi spasticity of right side. Resident 2's medication administration record (MAR) for January 2026 indicated Resident 2 was prescribed Eliquis 5 milligram (mg) tablet: Take 1 tablet by mouth twice daily, Vitamin D3 50 micrograms (mcg) capsule: take 1 capsule by mouth daily, Gabapentin 300 mg: Take 1 capsule by mouth 3 times daily, loratadine 10 mg tablet: take 1 tablet by mouth daily, levetiracetam 500 mg tablet: take 1 tablet by mouth every 12 hours, donepezil 5 mg tablet: take 1 tablet by mouth every night at bedtime, pantoprazole delayed release (DR) 40 mg tablet: take 1 tablet by mouth daily before breakfast at 6 AM, and tizanidine 2 mg: take 1 tablet by mouth every 6 hours as needed. Resident 2's MAR Indicated the following: Surveyors reviewed Resident 2's MARs for the month of January 2026 and identified the following dates did not contain staff initials indicating if the following medications were or were not administered to Resident 1: Eliquis 5 mg tablet at 8:00 AM - 01/01/2026 Eliquis 5 mg tablet at 9:00 PM - 01/09/2026 vitamin D3 50 mcg capsule at 8:00 AM - 01/01/2026 gabapentin 300 mg at 8:00 AM - 01/01/2026	{N 415}		

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	0020768	A. BUILDING: _____ B. WING _____	R 01/15/2026

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{N 415}	Continued From page 40 loratadine 10 mg tablet at 8:00 AM - 01/01/2026 levetiracetam 500 mg tablet at 8:00 AM - 01/01/2026 donepezil 5 mg tablet at 9:00 PM - 01/12/2026 pantoprazole DR 40 mg tablet at 6:00 AM - 01/01/2026, 01/04/2026 - 01/13/2026 tizanidine 2 mg PRN - 01/13/2026 Allopurinol 200 mg at 8:00 AM - 01/05/2025, 01/17/2025, 01/24/2025 Surveyor did not review any notes indicating if the medications were or were not administered to Resident 2. On 01/13/2026, at approximately 3:50 PM, Surveyors interviewed Resident 2. Resident 2 reported Administrator B informed her/him s/he did not have any prescribed pain medication in the medication cart. Resident 2 reported s/he then asked Administrator B if s/he could receive her/his muscle relaxer. Resident 2 reported s/he was administered a "muscle relaxer" for her/his pain by Administrator B approximately "15 or 20 minutes ago" approximately 3:30: approximately 4 hours after reporting a 6/10 pain. On 01/13/2026, at approximately 4:00 PM, Surveyors interviewed RN C. Surveyors inquired when RN C notified staff of Resident 2's request for PRN pain medication. RN C reported s/he informed Administrator B of Resident 2's request immediately after leaving Resident 2's room. Surveyors informed RN C Resident 2 did not receive pain medication, but s/he received her/his	{N 415}		

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{N 415}	Continued From page 41 tizanidine approximately 4 hours after her/his request. RN C called Administrator B, Administrator B confirmed s/he did not give Resident 2 her/his acetaminophen because s/he could not locate the medication. Surveyors reviewed Resident 2's MAR with RN C. RN C confirmed Administrator B did not document the administration of tizanidine given to Resident 2 at approximately 3:30 PM. On 01/15/2026, at 10:00 AM, Surveyors interviewed Licensee A and RN C. RN C reported Resident 2's medications were located in the facility, and s/he received her/his prescribed medications. RN C reported s/he would review medication documentation with staff. Cross-Reference N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medications	{N 415}		
N 427	83.38(1)(c) Leisure time activities. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Leisure time activities. The CBRF shall provide a daily activity program to meet the interests and capabilities of the residents. Employees shall encourage and promote resident participation in the activity program. The CBRF shall develop and post the activity schedule in an area available to residents.	N 427		

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N 427	Continued From page 42 This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a daily activity program to meet the interest and capabilities of 26 of 26 residents was provided. Findings include: Observations On 01/13/2026, at 8:00 AM, Surveyors entered the facility. Upon entering, Surveyors observed caregivers assisting residents with cares and medications. At 9:40 AM, Surveyors observed breakfast served. Surveyors observed a white board which indicated the activities for the week were as follows: 10:00 AM - social time with relaxing music 11:30 AM - snacks any choice 1:00 PM - lunch 3:00 PM - 5:00 PM - activity time 5:00 PM - 5:30 PM - dinner Throughout the survey, Surveyors did not observe any activities conducted in the facility. Surveyors observed residents seated out in the front lobby area and in their rooms. Surveyors left the facility at 5:00 PM. Interviews On 01/13/2026, at 9:00 AM, Surveyors interviewed Resident 2. Resident 2 reported the facility does not offer activities in the community for residents to attend. Resident 2 reported the facility does not hold organized leisure activities	N 427		

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N 427	Continued From page 43 during the day for residents On 01/13/2026, at 2:00 PM, Surveyors interviewed Resident 4. Resident 4 reported the facility does conduct organized leisure time activities for residents. Resident 4 reported s/he has not been offered any community activities outside of the facility since her/his admittance in May 2025. On 01/13/2026, at 12:45 PM, Surveyors interviewed Manager Q and Caregiver F. Manager Q reported they had an activity coordinator, but they were off today. Manager Q reported the activity coordinator was responsible for completing the activity calendar and offering activities. Manager Q confirmed on the day of the survey there were no organized leisure activities offered.	N 427		
N 428	83.38(1)(d) Community activities. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Community activities. The CBRF shall provide information and assistance to facilitate participation in personal and community activities. The CBRF shall develop, update and make available to all residents, monthly schedules and notices of community activities, including costs. This Rule is not met as evidenced by:	N 428		

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N 428	Continued From page 44 Based on observation and interview, the provider did not provide monthly schedules of community events and assist with arranging services for 26 of 26 residents. Findings include: On 01/13/2026, at 8:15 AM, Surveyors toured the facility. Surveyors did not observe any posted Activity Schedule. On 01/13/2026, at 9:00 AM, Surveyors interviewed Resident 2. Resident 2 reported the facility does not offer activities in the community for residents to attend. Resident 2 reported the facility does not hold organized leisure activities for residents and has not done so since his/her admittance over a year ago. On 01/13/2026, at 2:00 PM, Surveyors interviewed Resident 4. Resident 4 reported the facility does conduct organized leisure time activities for residents. Resident 4 reported s/he has not been offered any community activities outside of the facility since her/his admittance. On 08/13/2021, at 11:28 AM, Surveyor interviewed Resident 4. Resident 4 confirmed s/he didn't get opportunities to go in the community. Resident 4 reported s/he wanted to go shopping and hasn't been able to go shopping since s/he moved in a year and a half ago. On 01/13/2026, at 12:45 PM, Surveyors interviewed Manager Q and Caregiver F. Manager Q reported they had an activity coordinator, but they were off today. Manager Q reported the activity coordinator was responsible for completing the activity calendar and offering	N 428		

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N 428	Continued From page 45 activities. Manager Q confirmed there were no community activities offered. Manager Q was unaware of the requirement to provide opportunities for community activities. On 01/13/2026, at approximately 4:30 PM, Surveyors interviewed Licensee A and Registered Nurse (RN) C. RN C reported they were working on getting all systems in place.	N 428		
{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 observation, record review and interview, the provider did not make menus available to 26 of 26 residents. This is a repeat deficiency. See Statement of Deficiency (SOD) QAVZ11, dated 11/17/2025. Findings include: Observations On 01/13/2026, at 8:45 AM, Surveyors toured the facility. Surveyors did not observe a menu posted for residents. Surveyors toured the facility's kitchen. Cook M was preparing breakfast which consisted of oatmeal, scrambled eggs and toast.	{N 450}		

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{N 450}	Continued From page 46 Surveyors did not observe any drink served with breakfast. At 12:50 PM, Surveyors observed lunch. Lunch consisted of chicken tossed with different sauces, tater tots and a side salad. Surveyors did not observe any drink served with lunch. Record Review On 01/13/2026, at 9:35 AM, Cook M gave Surveyors a menu. The menu was undated and contained a handwritten note at the top, "This week". The menu indicated the following was to be served during the survey: Breakfast: scrambled egg, smothered potato, sausage link, fresh fruit Lunch: tuna casserole, soup, salad, fresh fruit At the bottom of the menu, was written, "All meals will be served with a choice of milk, juice, and water." On 01/13/2026, at 4:30 PM, Surveyors interviewed Registered Nurse (RN) C. RN C confirmed the menus were to be posted. RN C reported Licensee A was responsible for shopping and creating the menus and was unsure why the food purchased for meals did not match the menus.	{N 450}		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas	N 481		

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N 481	Continued From page 47 shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a living environment which was safe, clean, comfortable, and homelike for 26 of 26 residents. A light fixture in a closet emitted sparks and flames, standing water in a common tub, broken ceiling tiles, light switches were not in working order, resident bathrooms contained accumulation of what resembled dust on the exhaust fans, and walls contained holes. Findings include: The facility is a class CNA non-ambulatory community based residential facility licensed to serve up to 36 residents in the areas of advanced age, irreversible dementia/ Alzheimer's, alcohol/ drug dependent, traumatic brain injury, terminally ill, correctional clients, developmentally disabled, emotionally disturbed/ mental illness, and physically disabled. On 01/13/2026 at 8:15 AM, Surveyors toured the facility and observed the following: 1st Floor Janitor Closet Surveyor turned on the light switch, which caused the light fixture to start sparking and emitted flames from the top of the light fixture. When Surveyor turned off the light switch, the odor in the janitor closet was an acrid chemical odor similar to burnt plastic or rubber. 1st Floor Shower Room: Standing brown water in base of the tub	N 481		

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N 481	Continued From page 48 Broken wall tiles, incorrect bases over light switches with exposed metal Toilet tank cover appeared too small to top tank which caused a gap between the toilet tank and cover 1st Floor Hallway: Water stains on ceiling tiles Broken ceiling tiles 1st Floor Bedroom #125 Missing door handle 1st Floor Bathroom #116 Paper towel dispenser taken off wall and on placed on top of toilet, no paper towels Missing towel rack, brackets still on the wall Bathroom had a strong urine odor 1st Floor Bedroom #122 Light switch did not work which caused Resident 19 to sit in her/his room in the dark. Second Floor Resident Bathrooms: Ceiling and exhaust fans in the bathrooms were coated with a substance consistent with dust approximately 1/8 inch thick and contained rust. Bathrooms contained broken ceiling tiles and holes in the ceiling and walls On 01/13/2026, at 9:10 AM, Surveyors interviewed Licensee A. Surveyor reported the concern regarding the janitor closet. Licensee A reported s/he would let maintenance know immediately. On 01/15/2026, at 10:00 AM, Surveyors interviewed Licensee A and Registered Nurse (RN) C. Licensee A reported the facility was in the process of making repairs in the buildings.	N 481		

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N 481	Continued From page 49 Licensee A reported s/he was unaware of the standing water in the first-floor tub room. Licensee A reported s/he believed staff used the tub for used mop water.	N 481		
N 496	83.45(1)(e) Electrical, mechanical, water supply Systems. The CBRF shall maintain all electrical, mechanical, water supply, plumbing, fire protection and sewage disposal systems in a safe and functioning condition. This Rule is not met as evidenced by: Based on record review, observation and interview, the provider did not maintain the 1 of 1 elevator in working condition. Findings include: On 01/12/2026, Surveyor reviewed the facility file. On 12/15/2025, Licensee A submitted documentation to Surveyor regarding the facility's elevator repair. The documentation indicated the following: On 10/15/2025, an insurance claim denial letter was issued to Licensee A in regard to the flooding and loss of property which occurred on 08/09/2025. Repair Invoice, dated 10/17/2025, "[Licensee A] called on 8/10/2025 at 2:45 PM reporting passenger elevator was shut down. When we arrived on 8/11/2025 at 3:12 AM [sic] the unit was at the floor with the doors open. We checked the operation of the hydraulic jack unit. Upon leaving at 3:45 AM [sic] we left the elevator out of service. Additional resources required. This was the result of water damage a propposal [sic] sent to [sic]	N 496		

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N 496	Continued From page 50 customer." Repair Invoice, dated 10/31/2025 "[Elevator Company] recommends the following repairs. On 8/12/25, [Elevator Company] found the elevator shut down due to water intrusion into the elevator pit. The traveling cable was exposed to water which has caused the elevator to be shut down until it can be replaced. The traveling cable which travels with the car of the elevator, has been damaged beyond repair and should be replaced. Failure to correct this condition may lead to serious personal injury, death, or property damage." A contract from the Elevator Company was signed by Licensee A on 11/19/2025. Repair Invoice, dated 11/21/2025, " ...[Elevator Company] will remove existing fire panel and replace with a new Electrodyn fire service like for like panel re-placement [sic]. We will pull a permit and schedule the inspection with the inspector from the authority having jurisdiction ..." On 12/08/2025 at 8:49 AM, Licensee A emailed the Elevator Company to indicate the invoice had been paid. At 9:02 AM, Elevator Representative U emailed back s/he would pass it along to schedule once all the parts were in. On 01/13/2025, at 8:00 AM, Surveyors toured the facility. 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. Surveyors observed the elevator was not operable during the time of the survey.	N 496		

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N 496	Continued From page 51 At 9:40 AM, Surveyors observed breakfast served. Breakfast was brought up on trays and served to all residents in their rooms. At 12:50 PM, Surveyors observed lunch served. Lunch was brought up on trays and served to all residents in their rooms. On 01/13/2026, at 2:49 PM, Surveyor interviewed Resident 2. Resident 2 reported s/he required staff assistance to utilize the stairs due to her/his disability. Resident 2 reported s/he was more independent with her/his mobility when the elevator was working. On 01/13/2026, at approximately 2:00 PM, Surveyor interviewed Licensee A. Licensee A reported s/he was working with a company to fix the elevator. Licensee A reported the company was waiting for parts and still needed to pull the permit for the work. Licensee A reported they did move some residents down to the first floor. Licensee A acknowledged some residents were not able to access areas due to the elevator being not being operational.	N 496		
{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 3 of 3 areas.	{N 499}		

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{N 499}	Continued From page 52 This is a repeat deficiency. See Statement of Deficiency (SOD) QAVZ11, dated 11/17/2025. 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, traumatic brain injury, physically disabled, terminally ill, and developmentally disabled residents. On 01/13/2026, at 9:00 AM, Surveyors toured the facility and observed the following: - A janitor room on west side of the 1st floor was unsecured. The door had a locking mechanism which was not engaged. The door had a sign which stated, "Door must stay locked.". The room contained a bottle of Fabuloso multi-purpose cleaner, a bottle of Zep floor stripper, a bottle of Easy-Off concentrated glass cleaner, a bottle of Lysol heavy duty bathroom cleaner, a bottle of Lysol I.C. Quaternary disinfectant cleaner, and a bottle of HDX germicidal bleach. - A storage room on the ground floor 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. -The laundry room on the ground floor contained a shelf with a gallon of bleach. The room was unlocked. Surveyor observed residents moving freely throughout the facility.	{N 499}		

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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 499}	Continued From page 53 On 01/13/2026, at 4:30 PM, Surveyors interviewed Licensee A and Registered Nurse (RN) C. Administrator B and RN C confirmed the code requirement. RN C reported they would ensure all chemicals were securely stored.	{N 499}		
N 503	83.46(1)(b) Portable space heaters prohibited. The use of portable space heaters is prohibited except for Underwriters Laboratories listed electric heating equipment that is listed for permanent attachment to the wall. Portable space heaters shall have an automatic thermostatic control and shall be physically attached to a wall. This Rule is not met as evidenced by: Based on observation and interview, the provider did not prevent the use of a portable space heater in 1 of 1 resident rooms. Resident 15 had a portable space heater in her/his room plugged in to the electrical outlet. Findings include: On 01/13/2026, at 12:15 PM, Surveyors interviewed Resident 15. Resident 15 reported concerns with the heat on the second floor. Resident 15 reported s/he would sleep in her/his leather coat to keep warm. Resident 15 reported s/he was given a space heater by management to assist with keeping warm. On 01/13/2026, at 12:50 PM, Surveyor went with Resident 15 to her/his room. Surveyor observed a space heater on top of Resident 15's dresser. The space heater was plugged into an electrical outlet. When Surveyor turned on the space heater, there was heat emitted from the unit.	N 503		

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N 503	Continued From page 54 On 01/15/2026, at 10:00 AM, Surveyor interviewed Licensee A and Registered Nurse (RN) C. Licensee A reported the space heaters were utilized for the residents who were extremely cold. Licensee A reported they were more like fans which circulated heat. Licensee A reported the space heaters would turn off if they were tilted. Licensee A reported s/he would have them mounted to the walls.	N 503		
{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 the facility boilers and water heaters. This had the potential to affect 26 of 26 residents. There was a box on top of a boiler and shop vacuums and dehumidifiers within 3 feet of the boilers. There were work gloves and a wooden ladder within 3 feet of the water heaters. This is a repeat deficiency. See Statement of Deficiency (SOD) QAVZ11, dated 11/17/2025. Findings include: On 01/13/2026, at 2:28 PM Surveyors toured the basement. Surveyors observed the boiler room and observed the following: Boilers - 1 box was placed on top of the 1st boiler	{N 507}		

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{N 507}	Continued From page 55 - A dehumidifier was placed approximately 13 inches from the first boiler - A shop vacuum was placed approximately 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 - a wooden ladder was placed approximately 5.5 inches from the 1st water heater closest to the door. On 01/13/2026, at 4:30 PM, Surveyors interviewed Licensee A and Registered Nurse (RN) C. Licensee A confirmed the code requirement. Licensee A reported the items would remove from around the boilers and water heaters.	{N 507}		
N 535	83.48(1)(b) Smoke and heat detectors per NFPA 72. Smoke and heat detectors shall be installed and maintained in accordance with NFPA 72 National Fire Alarm Code and the manufacturer ' s recommendation. Smoke detectors powered by the CBRF ' s electrical system shall be tested by CBRF personnel according to manufacturer ' s recommendation, but not less than once every other month. CBRFs shall maintain documentation of tests and maintenance of the detection system. This Rule is not met as evidenced by:	N 535		

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N 535	Continued From page 56 Based on observation and interview, the provider did not ensure each bedroom had a smoke detector maintained in operable condition in 1 of 1 resident bedroom. Resident 13's bedroom's smoke detector was covered. Findings include: On 01/13/2026, at 9:24 AM, Surveyor observed Resident 13's bedroom. In the middle of the ceiling was what appeared to be a brown plastic bag, similar to a plastic disposable shopping bag. The bag appeared to be tied around an object on the ceiling. Surveyor observed a metal pipe which ran along the ceiling from the area of the plastic bag to the north wall near the door which contained a sprinkler head. On 01/14/2026 at 1:46 PM, Surveyor interviewed Fire Detection Technician S. Technician S reported if a smoke detector was covered with any type of covering, the smoke detector would not function as the covering would not allow the detector to detect smoke. On 01/15/2026, at 10:00 AM, Surveyor interviewed Licensee A and Registered Nurse (RN) C. Licensee A reported s/he put the bag over the smoke detector and forgot to remove it. Licensee A reported when they were spraying chemicals during the remodeling of the bedroom after the fire, the smoke detector activated, so s/he placed a bag over the smoke detector so it would not go off due to the chemicals.	N 535		
N 540	83.48(3)(c) Smoke and heat detectors exposure to fire All smoke and heat detectors suspected of	N 540		

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N 540	Continued From page 57 exposure to a fire condition shall be inspected, cleaned and tested by a certified or trained and qualified person within 5 days after each exposure in accordance with the specifications in NFPA 72 and the manufacturer ' s specifications and procedures. Each detector shall operate within the manufacturer ' s intended response or it shall be replaced within 10 days after exposure to a fire condition. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure smoke detectors suspected of exposure to a fire condition were inspected, cleaned and tested by a certified or trained and qualified person within 5 days after exposure in 1 of 1 instance. Smoke detectors were not inspected after the facility experienced a fire. Findings include: Observations On 01/13/2026, at 9:24 AM, Surveyor observed Resident 13's bedroom. In the middle of the ceiling was what appeared to be a brown plastic bag, similar to a plastic disposable shopping bag. The bag appeared to be tied around an object on the ceiling. Surveyor observed a metal pipe which ran along the ceiling from the area of the plastic bag to the north wall near the door which contained a sprinkler head. Record Review On 01/12/2026, Surveyor reviewed Department records at a self-report, dated 12/17/2025. The self-report indicated on 12/12/2025 "at approximately 5:00 PM, heat and smoke detector	N 540		

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N 540	Continued From page 58	N 540		

alarms were triggered .... The fire department [sic] called by monitoring system. Caregivers and licensee rushed to the heat and smoke source (room 125). Licensee and caregivers observed resident in bed with smoking materials still in [her/his] hands. Licensee and caregivers observed smoke in room. Only one sprinkler [sic] triggered. The fire had already been extinguished by sprinklers ..."

On 01/13/2026, at 2:00 PM, Surveyor reviewed the facilities safety files. The fire detection system was last serviced on 03/07/2025. Surveyor did not review any evidence the fire detection was inspected after the fire.

On 01/14/2026, at 1:25 PM, Licensee A sent Surveyor an email, which contained a report regarding the sprinkler repair. The document was dated 12/12/2025 which stated the following, "Sprinkler head activated due to fire in senior room. Piping determined to be in good condition ...New sprinkler head installed, used from head box. System put back in service."

Interviews

On 01/13/2026, at approximately 1:45 PM, Surveyor interviewed Licensee A. Licensee A reported they had the sprinkler replaced after the fire. Licensee A reported they did not have the smoke detectors reinspected after the fire. Licensee A reported the inspection from March was the last time the smoke detectors were inspected.

On 01/14/2026, at 1:46 PM, Surveyor interviewed Fire Detection (FD) Technician Q. Technician Q confirmed smoke detectors should be inspected after exposure to a fire to ensure they work

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N 540	Continued From page 59 properly. On 01/15/2026, at 10:00 AM, Surveyors interviewed Licensee A and Registered Nurse (RN) C. Licensee A reported s/he thought the technician who fixed the sprinkler head inspected the complete system. Licensee A reported when the technician put the system back in service, s/he thought it meant the sprinklers and smoke detectors. RN C reported s/he thought the fire department ensured the smoke detectors were working prior to leaving the facility the night of the fire. Surveyors requested a report regarding the smoke detector inspection, Licensee A reported s/he would contact the technician for the report and send it to Surveyor. Surveyors requested the report by 01/15/2026 at 3:00 PM. As of 01/20/2026, at 8:10 AM, Surveyor did not receive the requested report.	N 540		
{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	{N 617}		

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{N 617}	Continued From page 60 degrees Fahrenheit (F) in 3 of 3 bathrooms. Bathroom water temperatures measured between 122 degrees F and 127 degrees F. This is a repeat deficiency. See Statement of Deficiency (SOD) QAVZ11, dated 11/17/2025. Findings include: The facility is a class CNA non-ambulatory community based residential facility licensed to serve up to 36 residents in the areas of advanced age, irreversible dementia/ Alzheimer's, alcohol/ drug dependent, traumatic brain injury, terminally ill, correctional clients, developmentally disabled, emotionally disturbed/ mental illness, and physically disabled. On 01/13/2026, at 9:00 AM Surveyors toured the facility and observed the following: Room 221 Resident 2's bathroom water temperature was 127.6 degrees F. Room 125 Resident 13's bathroom water temperature was 122.2 degrees F. Room 116 Resident 16's bathroom water temperature was 124.9 degrees F. On 01/13/2026, at 4:30 PM, Surveyors interviewed Licensee A and Registered Nurse (RN) C. RN C confirmed the code requirement. RN C reported maintenance would adjust water temperature to the appropriate temperature.	{N 617}		
Y3235	50.09(1)(f) Privacy (1) RESIDENTS' RIGHTS. Every resident	Y3235		

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Y3235	Continued From page 61 in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to: (f) Physical and emotional privacy in treatment, living arrangements and in caring for personal needs, including, but not limited to: This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 1 of 1 resident (Resident 13) had the right to privacy. Resident 13's bedroom door did not contain a door handle. Findings include: On 01/13/2026, at 8:15 AM, Surveyor observed Caregiver F pass medications to Resident 13 in her/his bedroom. Resident 13 was in bed. Resident 13's bedroom door was open during the medication pass. At 9:24 AM, Surveyor toured Resident 13's bedroom. The bedroom door did not contain a door handle. When Surveyor closed the door, the door was unable to latch close. Surveyor	Y3235		

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Y3235	Continued From page 62 observed the door slowly swing open. Surveyor was able to see into Resident 13's room from the hallway. On 01/15/2026, at 10:00 AM, Surveyor interviewed Licensee A and Registered Nurse (RN) C. Licensee A reported s/he took the door handle off with permission from Resident 13 due to safety concerns with the fire. Licensee A reported Resident 13 enjoys going into her/his room. Licensee A reported the plan was to replace the door handle with a door handle which did not have a lock because Licensee A stated, "I have an extreme concern."	Y3235		
{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:	{Y3244}		

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{Y3244}	Continued From page 63	{Y3244}		

Based on interviews, observations and record review, the provider did not ensure residents received adequate and appropriate services that were within the provider's capacity. This had the potential to affect 26 of 26 residents. The facility's call light system did not work properly to inform caregivers of resident's who requested assistance. The provider did not ensure staff were available on the second floor to assist residents who needed assistance.

This is a repeat deficiency. See Statement of Deficiency (SOD) QAVZ11, dated 11/17/2025.

Findings include:

Observations

On 01/13/2026, at 11:40 AM, Surveyors observed no caregiver on the second floor. There were 3 residents who required assistance with ambulation on the second floor during the observation. At 2:27 PM, Caregiver Q returned to the second floor. The floor was unattended by caregiver staff for approximately 2.5 hours.

On 01/13/2025, at approximately 9:00 AM, Surveyor observed Resident 2 get up from his/her recliner and ambulate in an unsteady manner, dragging his/her right leg and foot behind him/her while moving forward with his/her left leg to go to the bathroom. Resident 2 informed Surveyors s/he required assistance of staff to transfer, but staff never came to his/her aid, so s/he had to get up on his/her own to use the bathroom.

Interviews

On 01/13/2026, at approximately 9:05 AM, Surveyors interviewed Caregiver T. Caregiver T

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{Y3244}	Continued From page 64	{Y3244}		

confirmed Resident 2 required assistance of staff to transfer and went to Resident 2's room after Surveyors informed him/her s/he ambulated to the bathroom on his/her own.

On 01/13/2026, at approximately 11:40 AM, Surveyors interviewed Resident 2. Resident 2 reported staff were nowhere to be found. Resident 2 reported the call button was never answered when s/he pushed it for staff assistance.

On 01/13/2026, at 2:49 PM, Surveyor interviewed Resident 2. Resident 2 reported s/he had pressed his/her button over 1 hour ago and no caregiver came to his/her room to assist him/her. Resident 2 reported s/he was paralyzed on his/her right side and was unsteady on his/her feet. S/he required staff assistance to use the stairs. Resident 2 reported s/he used to be independent with getting to the first-floor patio to smoke, but since the elevator broke several months ago, s/he has been unable to go outside. Resident 2 reported since staff never answer his/her call button when s/he wants to smoke, s/he smokes his/her cigarettes in his/her room, which was multiple times per day. Staff did not respond to his/her call light when s/he pressed the button. S/He reported s/he was supposed to have assistance with getting into the bathroom, but s/he can never wait for staff to help.

On 01/13/2026, at approximately 11:45 AM, Surveyor interviewed Administrator B. Administrator B reported Caregiver T, who was previously assigned to the second floor, was a companion for a resident who went to an appointment. Administrator B confirmed there was no caregiver assigned to the second floor while Caregiver T was away, but Manager Q and

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{Y3244}	Continued From page 65 Caregiver F, who were on the first floor, could assist with any of the residents' needs. On 01/13/2026, at 12:45 PM, Surveyor interviewed Manager Q and Caregiver F. Surveyor asked about the system for coverage when the second-floor caregiver was not in the facility. Manager Q and Caregiver F reported if the caregiver assigned to cover the second floor had to step out, one of the caregivers from the first floor would go upstairs and cover the second floor. Surveyor asked why there was no caregiver upstairs while Caregiver T was with a resident at an appointment. Caregiver F and Manager Q asked each other if they knew Caregiver T was out. Caregiver F and Manager Q confirmed no one informed them Caregiver T was gone, and the second floor was unattended. Manager Q reported there were 2 caregivers covering the first floor and 1 caregiver scheduled for the day to cover the second floor. On 01/13/2026, at approximately 3:05 PM, Surveyor interviewed Front Desk Attendant R. Attendant R was in the office next to the front desk. The front desk was unattended. Attendant R reported the call light system worked, but the device at the front desk no longer emitted a sound to alert staff someone needed to respond to them. Attendant R reported staff would need to look at the device to see if someone was needed. If there was no attendant sitting directly at the desk, it would take awhile for a caregiver to respond to someone's call light. Record Reviews On 01/13/2026, at 9:45 AM, Surveyors reviewed a resident roster which indicated 11 residents resided on the second floor.	{Y3244}		

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{Y3244}	Continued From page 66 On 01/13/2026, at 11:25 AM, Surveyors reviewed Resident 2's record. Resident 2 was admitted on 08/19/2024, with diagnoses including hemi spasticity, depression, anxiety, dysphasia, dizziness, chronic pain, asthma and hypertension. Resident 2's individual service plan (ISP), dated 01/12/2026, indicated Resident 2 required the following assistance: Supervision - [Blank] Capacity for Self-Care - [Blank] Eating - Staff to monitor resident at mealtime to prevent any episodes of choking General Health - Pain will be tolerable at 3 or less on pain scale. Will be free of seizure activity. Shortness of breath will be treated promptly. Report any seizure activity or shortness of breath to the nurse. Physical Disability - Needs assist of 1, support weak right side for pivot transfers.	{Y3244}		