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N 000	Initial Comments On 04/20/2026 with additional information gathered through 05/04/2026, Surveyors conducted a standard survey and three (3) complaint investigations. As a result 22 deficiencies were identified and five (5) of the twenty-two (22) deficiencies were repeat deficiencies. Three of (3) complaints were substantiated. Census: 7	N 000		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation. This Rule is not met as evidenced by: Based on record review and interview, the	N 158		

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

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provider did not take immediate steps to ensure the safety of residents or conduct and document an investigation after receiving allegations of neglect and abuse.

On 11/18/2025, 12/21/2025, 12/30/2025 and 04/08/2026, Administrator D received allegations that Caregiver C was sleeping during third shift and not providing resident care.

On 03/22/2026, Administrator D received allegations that Caregiver B caused injury to Resident 6 and that Caregiver C may have inappropriately administered psychotropic medication as a form of restraint.

Administrator D did not take immediate steps to protect residents or conduct and document investigations into any of the allegations.

Findings include:

The Department received a complaint alleging residents were left soaked in urine.

EXAMPLE 1:

On 04/20/2026 at 10:15 AM, Surveyors interviewed Caregiver B and Caregiver A.

--Caregiver B volunteered frustrations that third shift staff are sleeping and not providing resident care. Caregiver B showed Surveyor a photo s/he took of a caregiver sleeping on the facility love seat on 01/24/2026. Caregiver B said the concerns have been reported to Administrator D.

--Caregiver A echoed there are persistent problems with third shift caregivers sleeping and typically there is only one staff scheduled with a

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float staff used between the sister facility. S/he said Administrator D is aware of it and says s/he will take care of it, "but the issues keep happening." Caregiver A said s/he no longer reports the concern because Administrator D doesn't do anything to fix it.

On 04/20/2026 at 12:20 PM, Surveyor interviewed Resident 1 regarding care and treatment at the facility. Resident 1 stated, "The night shift staff sleep a lot when they work" and s/he has to wake them when s/he needs assistance. Resident 1 also said, "When [Caregiver C] works [s/he] locks [her/himself] in the office and doesn't answer the door."

On 04/20/2026 at 10:45 AM, Surveyor conducted a tour of the facility with Caregiver B and observed Resident 4's mattress did not have sheets or blankets on it. Caregiver B said s/he was incontinent overnight and the bedding was being washed.

On 04/20/2026 at 3:31 PM, Surveyor reviewed portions of Resident 4's record to include observation notes and the individual service plan (ISP) current as of 04/20/2026. The ISP identified the need for staff to "take resident to the bathroom every 2 hrs."

Surveyor noted the following timeline when reviewing Resident 4's observation notes and messages exchanged between Caregiver A and Administrator D (received 04/21/2026) utilizing text messages and the "Home Base" messaging application.

11/18/2025 text string starting at 8:10 AM:
-Caregiver A wrote, So [third shift] worker was sleeping when I came in no lights on in the

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building and work wasn't done/completed and a resident soaked in urine...this is getting ridiculous." The text included a photo of a resident lying in bed wearing gray sweatpants that were wet (darker color) from his/her entire abdominal area down to just above his/her knees.
-Administrator D replied, asking who the staff was and Caregiver A replied it was Caregiver C.

12/21/2025 text string starting at 7:42 AM:
-Caregiver A wrote, "It was reported to me that [Caregiver C] was sleeping last night by a residents [sic] family member..."
-Administrator D replied, "Wth (what the heck)" and asked who the family member was.
Caregiver A provided the information.
Administrator D replied, "Okay."
-Caregiver A replied, "I'm sorry but I think I'm gonna turn [him/her] into the state [Resident 2] was soaked this morning to the point shower needed [sic] and [Resident 4] was also wet and dirty...I'm done telling [Caregiver C]."
-Administrator D replied, "I will take care of [Caregiver C.]"

12/30/2025 8:40 AM text string:
-"So this morning [Resident 4] was soaked again all the way up [his/her] back along with [his/her] bed...how hard is it to have someone use the bathroom and clean them up this is really ridiculous...a non stop [sic] thing for when [s/he]'s here (alone)..."
-Administrator D replied that it could be because Resident 4 doesn't like Caregiver C and "maybe [s/he] won't get up for [him/her]. Not making excuses."
-Caregiver A replied with skepticism.
-Administrator D replied, "I am just wondering. I am not making excuses I am just asking. But I understand and I will talk with [him/her] again."

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N 158	Continued From page 4 Observation notes authored by Caregiver A: 01/06/2026: "...bedding washed due to resident being wet in urine when first shift came on." 01/20/2026: "when staff came on staff found resident soaked in urine up [his/her] back down to...back of knee caps with [his/her] bed also soaking wet..." 02/04/2026: "When first shift came in staff found resident laying in bed soaked in urine...bedding taken off and washed. Resident also showered." 02/18/2026: "When staff came into shift resident was found laying in urine in [his/her] bed...changed and showered...bedding and laundry taken to be washed." 04/08/2026 "Home Base" messages (quoted as written): --Caregiver A wrote a message in the group chat addressed to Caregiver C, "Let's use this morning for example I came in and [Resident 4] was soaked in urine up to [his/her] neck I said something to you and what did you do tell me how you took [Resident 2]'s trash out cause it was full of dirty briefs instead of taking care of [Resident4]...[Resident 4] should not have been wet to begin with [s/he] is not a supper soaker..." Caregiver A s/he was "wondering why [Resident 4]'s so wet how long [s/he] had been wet." Caregiver A went on to express concern Resident 4 could have behaviors due to being left wet, s/he could get urinary tract infections or s/he could develop wounds. S/he also wrote that Resident 4 was "cold and smelly...it's the same thing over and over again." --The Home Base app indicated Administrator D read the message. Surveyor interviewed Caregiver C on 04/22/2026	N 158		

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N 158	Continued From page 5 at 7:34 AM. Caregiver C confirmed s/he works third shift and typically works alone with occasional assistance from a float staff in the sister facility. Caregiver C described Resident 4 as waking frequently during the night, needing toileting assistance every 2 hours and exit seeking during the overnight hours. S/he said Resident 6 is also an elopement risk. Caregiver C admitted there are times s/he falls asleep during third shift due to working long hours and sometimes at the start of first shift because it's hard for him/her to stay awake in the morning. Caregiver C denied that resident care lacks when s/he works. Caregiver C reviewed his/her scheduled and confirmed s/he worked the following: --02/17/2026: 6:00 PM to 2:00 PM --02/03/2026: 6:00 PM to 2:00 PM, had a 4 hour break and then worked 6:00 PM to 6:00 AM --04/19/2026: 6:00 PM to 6:00 AM --Surveyor note: these shifts all preceded dates when 1st shift found Resident 4 heavily incontinent. Caregiver C said s/he is aware other staff have complained about him/her sleeping but felt that wasn't fair because the staff that complained do the same thing. Caregiver C said s/he has not been interviewed by Administrator D about the allegations. On 04/21/2026, Surveyor sent Administrator D an email and requested documentation of all abuse or neglect investigation s/he has conducted since 11/01/2025. Administrator D replied with one unrelated investigation. Administrator D did not provide documentation of an investigation into the allegations Caregiver C was sleeping during 3rd shift and neglecting to provide resident care.	N 158		

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N 158	Continued From page 6 During the exit conference on 05/01/2026 at 8:30 AM, Surveyor reviewed the aforementioned concerns with Administrator D and Licensee F. They did not offer additional information or evidence of an investigation. EXAMPLE 2: On 04/20/2026 at 3:40 PM, Surveyor interviewed Resident 6 who stated, "I hate this place. I just want to get out of here." Resident 6 said Caregiver B is "Abrupt. [S/he] will say, 'You're taking a shower right now'...you don't have any choice with [him/her]...[S/he] is rude." Later in the interview Resident 6 reiterated, "I hate it here, I really do." Surveyor interviewed Caregiver A on 04/20/2026 at 12:29 PM and s/he said Caregiver B has a "history of antagonizing [Resident 6.]" Caregiver A stated this has been reported to Administrator D but "nothing gets done about it" and so s/he has stopped complaining to Administrator D about it. On 04/20/2026 at 10:52 AM, Surveyor reviewed portions of Resident 6's record including observation notes. --01/16/2026: Caregiver B authored a note that read, "Resident continues to be very obnoxious throughout the day and night time." --03/19/2026: Resident 6 told Caregiver A s/he wasn't feeling good, but s/he wasn't sick. S/he then said, "something happened last night" but s/he "did not want to talk about it and wants to go to sleep." --03/23/2026: While Caregiver A was giving Resident 6 a shower, Caregiver A observed "a bruise on [his/her] lower leg and a sore on [his/her] knee...Bruise and sore was reported to	N 158		

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N 158	Continued From page 7 [Administrator D]." Surveyor reviewed text messages dated 03/23/2026 between Caregiver A and Administrator D (received 04/21 and 04/22/2026.) Surveyor noted Administrator D received allegations regarding Caregiver B and Caregiver C: --Caregiver A sent 2 photos of Resident 6's left leg to Administrator D and noted, "This is on [Resident 6]." One photo showed a deep purple quarter size bruise and a red scrape approximately 2" long. The other showed an open, red sore about the size of a nickel. --Administrator D replied, "Did [s/he] burn [him/herself] or fall" (Surveyor note: Resident 6 smokes cigarettes) --Caregiver A replied "[S/he] said the red one did it to [him/her]...That's what [s/he] calls [Caregiver B.]" --Administrator D replied and asked if Resident 6 said when it happened. --Caregiver A replied, "[S/he] said [Caregiver B] was pushing into [his/her] room. Did u [sic] know [Caregiver C] gave [him/her] 2 (lorazepam) last night" --Administrator D replied, "Oh my, why 2 lorazepam" --Caregiver A replied, "[S/he] said the first one didn't do anything ...and [s/he] wouldn't stop taking stuff that didnt [sic] belong to [him/her] and wouldn't stay in room [sic]." --Administrator D replied, "we cant [sic] use medication. [sic] For a restraint" --Caregiver A replied, "I don't know what to tell you to be honest I don't do that stuff" --Administrator D replied, "I don't know, either" --Caregiver A replied, "[Caregiver B] and I both asked [Caregiver C] if [s/he] wrote [Resident 6]'s	N 158		

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N 158	Continued From page 8 behaviors in an obs (observation note) [s/he] said yes and guess what there is nothing wrote up in obs that I seen. [sic]" --Administrator D replied, "Omg" Surveyor note: The observation notes and MARs did not contain documentation of the behaviors or the administration and no incident reports were created. When responding to the aforementioned request for documentation of all abuse or neglect investigations conducted since 11/01/2025, Administrator D did not provide evidence of investigations into allegations Caregiver B caused Resident 6's injuries or the allegation Caregiver C inappropriately administered psychotropic medications. During the exit conference on 05/01/2026 at 8:30 AM, with Administrator D and Licensee F, Surveyor reviewed the aforementioned concerns. They did not offer additional information or evidence of an investigation. Cross Reference: N0161 DHS 83.12(3)(a) Investigate Injuries of Unknown Source N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations N0389 DHS 83.35(3)(d) Service Plans Updated Annually or On Change N0433 DHS 83.38(1)(i) Behavior Management	N 158		
N 161	83.12(3)(a) Investigate injuries of unknown source. Investigating injuries of unknown source. A CBRF shall investigate any of the following: 1. An injury	N 161		

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that was not observed by any person. 2. The source of an injury to a resident that cannot be adequately explained by the resident. 3. An injury to a resident that appears suspicious because of the extent of the injury or the location of the injury on the resident.

This Rule is not met as evidenced by:
Based on interview and record review, the provider did not investigate injuries of unknown source.

On 02/18/2026, Resident 2 was found with bruises to her/his right outer and upper thigh. In addition, on 02/22/2026, Resident 2 was found with severe bruising and swelling to both hands. The injuries were significant, unwitnessed and Resident 2 was unable to provide a clear explanation for how they occurred. The facility did not thoroughly investigate Resident 2's injuries of unknown source in attempt to ensure mistreatment, neglect, or abuse had not occurred or prevent further injuries from occurring.

Findings include:

On 04/20/2026, Surveyor reviewed the record of Resident 2. The record indicated Resident 2 had a guardian and was admitted to the facility on 05/18/2022 with diagnoses to include paranoid schizophrenia and depression. Resident 2's ISP (Individualized Service Plan) signed and dated 11/11/2025, documented the resident utilized a four wheeled walker and required assistance from staff for bathing, dressing, and toileting. The ISP also indicated Resident 2 did not display any suicidal behaviors or tendencies, destructive/abusive behaviors, or self-abusive behaviors. Additionally, Resident 2's ISP stated, "[Resident 2] is very cooperate with cares.

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Document if [s/he] refuses care. [S/he] thinks [s/he] has 140 children, and [s/he] needs to go see them...Can speak and sound out words. Speaks in broken words...Encourage and assist in communicating needs or ideas as [s/he] is unable to make needs known...Do body checks with every shower, dressing etc. due to [her/him] complaints of falls and does have some bruises but no falls documented. When you ask resident [s/he] denies falls. [S/he] states [s/he] doesn't know where bruises are coming from."

On 04/20/2026, Surveyor reviewed Resident 2's observations notes from 01/01/2026 through 04/20/2026 and the following was documented:
~02/18/2026 at 12:15 PM- Caregiver A wrote, "When writer went to toilet resident and clean [her/him] up...Writer noticed resident has new bruises on [her/his] right outer thigh and upper top right thigh. Writer asked resident what happened, resident stated [s/he] fell last night. Writer and [Administrator D] are not aware of any fall resident had. [Resident 2] states it does not hurt. Writer asked staff that showered [her/his] this morning if [s/he] knew about the resident's bruises and [s/he] stated yes [s/he] seen them when [s/he] showered [her/him]. Writer asked [her/him] if [s/he] reported to [Administrator D] and [s/he] stated no so writer reported the bruises to [Administrator D] and also sent [Administrator D] photos of the bruises."
~02/22/2026 at 7:45 PM- Caregiver C wrote, "Incident report: Event Notes: Severe bruising and swelling like goose eggs.
~02/22/2026 at 7:45 PM- Caregiver C wrote, "Writer went into give meds to resident...Noticed residents hands. Asked what happened, [s/he] stated [s/he] was trying to get [her/his] baby doll out from the wall in between [her/his] bed. The second story is [s/he] injured them while using the

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wheelchair or trying to get the wheelchair. All [s/he] said was wheelchair. They are severely bruised and swollen like goose eggs on both hands."

Resident 2's record did not include additional documentation regarding further evaluation of Resident 2's bruising.

On 04/20/2026 at 5 PM, Surveyor attempted to interview Resident 2 privately in the resident's bedroom regarding the care and treatment s/he receives at the facility. Surveyor could not make out what Resident 2 was saying as the resident's words were garbled and unintelligible.

On 04/21/2026 at 3:25 PM, Surveyor interviewed Caregiver A regarding the above observation note on 02/18/2026. Caregiver A confirmed Resident 2 had bruises to her/his right upper and outer thigh area and stated, "Both bruises were large and a good size." Caregiver A indicated the bruising could have occurred from Resident 2 trying to get in or out of her/his bed, but Caregiver A was unsure as s/he did not witness anything. Surveyor asked Caregiver A what Resident 2 explained to Caregiver A as the source of the bruises. Caregiver A stated, "When I asked [Resident 2], [s/he] said [s/he] fell, but there were no falls documented. [Resident 2] is disoriented, [her/his] memory is not the best and [s/he] can't explain things." Caregiver A verified the above bruises and photos were reported and sent to Administrator D. Caregiver A commented s/he did not complete a witness statement after discovery of the bruises on Resident 2's right thigh. Caregiver A stated, "[Administrator D] never checked back with me or asked me any follow up questions after I reported [Resident 2's] bruises." Surveyor then asked Caregiver A about

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the bruises discovered on Resident 2's hands on 02/22/2026. Caregiver A stated, "[Resident 2] had severe bruising on both hands...It wasn't just a spot on [Resident 2's] hands, the bruises were dark black and covered the entire top of [her/his] hands...There's no way a wheelchair or [her/his] trying to get a baby doll out between the wall and bed would've caused that significant bruising."

On 04/22/2026 at 4:20 PM, Surveyor interviewed Caregiver C regarding the above observation note on 02/22/2026. Caregiver C confirmed s/he observed severe swelling and bruising to both of Resident 2's hands. Caregiver C indicated, Resident 2's hands were significantly swollen, with pronounced dark bruising across the knuckles and surrounding areas. Caregiver C stated, "The bruises hit an alarm with me because it looked like [Resident 2] was in a fist fight." Caregiver C went on to say, "[Resident 2] told me two different stories, but I have no idea what happened or how it happened because I didn't witness anything...[Resident 2] has "good days and bad days" with memory and cognitive impairments. Caregiver C stated, "[Resident 2] can't give you reliable information. [Resident 2] will respond to questions that don't make sense." Caregiver C confirmed s/he reported the bruising to Resident 2's hands and sent pictures to [Administrator D] through the homebase app (an app designed for communication between employees). Caregiver A stated, "[Administrator D] asked me what happened through the homebase app, and I told [her/him] I didn't know." Caregiver C verified Administrator D did not follow up or ask Caregiver C any additional questions after the discovery of the severe bruising to Resident 2's hands.

On 04/21/2026, Surveyor sent Administrator D an

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N 161	Continued From page 13 email and requested documentation of all investigations regarding abuse, neglect, and injuries of unknown source conducted from 11/01/2025 through 04/20/2026. Administrator D provided one (1) investigation into an incident related to Resident 3. No other documented investigations were provided. On 05/01/2026 at 8:30 AM, during the exit conference with Administrator D, Surveyors questioned Administrator D if there was an investigation into the bruises found on Resident 2's right thigh on 02/18/2026 and hands on 02/22/2026. Administrator D verified the facility did not conduct an investigation and had no documented investigation into the above bruising found on Resident 2. Cross Reference N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse & Neglect N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations	N 161		
N 169	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition.	N 169		

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N 169	Continued From page 14 This Rule is not met as evidenced by: Based on record review and interview, the provider did not immediately notify the resident's legal representative and the resident's physician when residents were injured or experienced changes in condition. On 01/29/2026, Resident 1 experienced dizziness, nausea, a rapid heartbeat, numbness in her/his hands and arms and refused to eat supper due to being sick and numb all day. The provider did not immediately notify Resident 1's legal representative or physician regarding these changes for potential interventions. Four days later (02/02/2026), Resident 1 was sent to the ED (Emergency Department), diagnosed with a UTI, dental pain and right groin pain and prescribed two antibiotics. On 02/18/2026, Resident 2 was found with bruises to her/his right outer and upper thigh. On 02/22/2026, Resident 2 was found with severe bruising and swelling to both hands. The injuries were not reported to Resident 2's physician or his/her legal guardian and the injuries were not medically assessed. On 03/23/2026, Resident 3 experienced a mental health crisis during which s/he became physically aggressive with staff. During the incident Resident 3 experienced 2 falls and was witnessed kicking the door and punching the walls. Caregiver B acknowledged utilizing a "pressure point" technique to intervene, which involved putting pressure on Resident 3's shoulder. After the incident, Resident 3 developed bruises on his/her shoulder and foot. The injuries were not reported to Resident 3's PCP or his/her legal guardian and the injuries were not medically assessed.	N 169		

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N 169	Continued From page 15 Findings include: The Department received a complaint physicians were notified of changes in condition. Resident 1 On 04/20/2026, Surveyor reviewed Resident 1's record. Resident 1 had a guardian and was admitted to the facility on 09/06/2023 with diagnoses to include history of UTIs (urinary tract infection), diabetes and cutaneous abscess of groin. Resident 1's ISP dated 03/17/2025 and 04/20/2026 indicated Resident 1 was able to make her/his needs known and required assistance with bathing, dressing and toileting. Additionally, both ISPs indicated Resident 1 had no complaints of pain, and did not have any short term, chronic or recurring illnesses. On 04/20/2026, Surveyor reviewed observation notes from 01/01/2026 through 02/28/2026 for Resident 1 and the following was noted: ~01/29/2026 at 12:00 PM- "Resident is having complaints of not feeling well. Resident states [her/his] hands and arms are numb. Med tech took vitals...and BS for 12 PM medication pass was 355...Resident also states [s/he] is dizzy...Resident states [s/he] feels like [her/his] heart is racing and feeling like [s/he] is going to throw up..." ~01/29/2026 at 03:00 PM- "Resident is refusing to eat supper due to being sick and numb all day." ~02/04/2026 at 06:30 PM- "Resident is starting two antibiotics tonight."	N 169		

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N 169	Continued From page 16 An ED after visit summary dated 02/02/2026 for Resident 1 indicated, "You have been given two antibiotics...These will help treat your bladder infection and sore area in your groin...Diagnoses-UTI with hematuria, right inguinal pain, dental pain..." Resident 1's record did not include documentation Resident 1's physician or guardian were made aware of the resident's reported physical change on 01/29/2026. On 04/29/2026 at 3:50 PM, Surveyor interviewed Caregiver A regarding Resident 1. Caregiver A indicated Resident 1 at times will have complaints of not feeling well and verified s/he did not notify Resident 1's physician or guardian of Resident 1's reported physical change. Caregiver A stated, "I did call [Administrator D] and [s/he] told me [Resident 1's] symptoms were due to [her/his] diet." Caregiver A went on to say, "I didn't report [Resident 1's] complaints of a possible change in condition to the guardian or physician because [Administrator D] told staff we're not allowed to contact guardians or physicians. Everything has to go through [Administrator D] or we will get yelled at." On 04/30/2026 at 9:35 AM, Surveyor interviewed APNP (Advanced Prescriber Nurse Practitioner)-L regarding Resident 1. APNP-L indicated s/he was not made aware of Resident 1's report of a potential change of condition on 01/29/2026 and stated, "My history with [Resident 1] is [her/his] symptoms are valid, and [s/he] doesn't falsify symptoms." APNP-L indicated s/he would have wanted to be notified of Resident 1's reports of not feeling well, feeling nauseated, dizzy, and numbness in hands/arms on 01/29/2026 to	N 169		

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N 169	Continued From page 17 ensure s/he received appropriate medical care. On 04/29/2026 at 8:55 AM, Surveyor interviewed Resident 1's guardian. Guardian K indicated s/he was not notified of Resident 1's reports of not feeling well on 01/29/2026 and stated s/he would have wanted to be updated to help assist with care and treatment. On 05/01/2026 at 8:30 AM, during the exit conference, Surveyors shared the above information regarding Resident 1. Administrator D indicated s/he was notified of Resident 1's change of condition on 02/02/2026, the day Resident 1 was sent to the ED. Administrator D confirmed s/he was not notified of any reported changes prior to 02/02/2026. Administrator D verified Resident 1's record did not contain any evidence the facility immediately notified Resident 1's guardian or physician on 01/29/2026, when Resident 1 reported to staff a physical change in condition. Resident 2 On 04/20/2026, Surveyor reviewed the record of Resident 2. The record indicated Resident 2 had a guardian and was admitted to the facility on 05/18/2022 with diagnoses to include paranoid schizophrenia and depression. On 04/20/2026, Surveyor reviewed Resident 2's observations notes from 01/01/2026 through 04/20/2026 and the following was documented: ~02/18/2026 at 12:15 PM- Caregiver A wrote, "When writer went to toilet resident and clean [her/him] up...Writer noticed resident has new bruises on [her/his] right outer thigh and upper top right thigh ...Writer reported the bruises to	N 169		

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[Administrator D] and also sent [Administrator D] photos of the bruises."
~02/22/2026 at 7:45 PM- Caregiver C wrote, "Incident report: Event Notes: Severe bruising and swelling like goose eggs." The incident report completed by Caregiver C indicated s/he informed the administrator but did not notify the resident's physician or legal representative.
~02/22/2026 at 7:45 PM- Caregiver C wrote, "Writer went into give meds to resident...Noticed resident's hands ...They are severely bruised and swollen like goose eggs on both hands."

Resident 2's record did not include evidence the injuries/bruising noted on 02/18/2026 and 02/22/2026 were reported to the resident's physician or guardian. In addition, the record did not include documentation regarding further evaluation of Resident 2's injuries/bruising.

On 04/21/2026 at 3:25 PM, Surveyor interviewed Caregiver A regarding the above observation note on 02/18/2026. Caregiver A confirmed Resident 2 had bruises to her/his right upper and outer thigh area and stated, "Both bruises were large and a good size." Caregiver A verified the above bruises and photos were reported and sent to Administrator D. Caregiver A commented s/he did not notify Resident 2's physician or guardian and stated, "I let [Administrator D] know. I've been told to notify [Administrator D] with any concerns, and [s/he] will notify the resident's physician and guardian. If I call any family/guardian or physician I'll get yelled at."

On 04/22/2026 at 4:20 PM, Surveyor interviewed Caregiver C regarding the above observation note on 02/22/2026. Caregiver C confirmed s/he observed severe swelling and bruising to both of Resident 2's hands. Caregiver C indicated

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N 169	Continued From page 19 Resident 2's hands were significantly swollen, with pronounced dark bruising across the knuckles and surrounding areas. Caregiver C confirmed s/he reported the bruising to Resident 2's hands and sent pictures to [Administrator D] through the homebase app (an app designed for communication between employees). Caregiver C verified s/he did not notify Resident 2's physician or guardian of the swelling and bruising to the resident's hands on 02/22/2026. Caregiver C stated, "On 02/20/2026, [Administrator D] told staff through the homebase app, staff need to contact [her/him] with changes, and [Administrator D] will update the resident's physician and guardian." On 05/01/2026 at 8:30 AM, during the exit conference with Administrator D, Surveyors questioned Administrator D if the above injuries/bruising found on Resident 2 were immediately reported to the resident's physician and guardian. Administrator D was unable to provide any written evidence Resident 2's physician and legal representative were immediately notified of Resident 2's injuries/bruising on 02/18/2026 and 02/22/2026. Resident 3 On 04/20/2026 at 10:28 AM, Surveyor reviewed Resident 3's electronic record. Observation notes detailed an incident on 03/23/2026 when the resident experienced a significant mental health crisis that escalated to a physical altercation with Caregivers B and C. During the ensuing physical struggle with Caregivers B and C, the resident sustained falls and it was noted Caregiver B was "forcing pressure" on Resident 3's shoulder to release his/her grip on Caregiver C.	N 169		

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N 169	Continued From page 20 Administrator D provided a misconduct incident (MIR) report to Surveyor on 04/22/2026. The report included observation notes about the 03/23/2026 incident and a handwritten note from Administrator D that read, "A [self-report] was made to DQA due to bruise noted by shoulder unknown how or when this happened." The MIR did not include evidence of an investigation into the source of the injury. Administrator D also provided a self-report to Surveyor on 04/22/2026 and the report was silent to bruising or any other injuries Resident 3 may have sustained. Surveyor conducted an interview with Caregiver B on 04/20/2026 at 11:02 AM. S/he recalled the incident, confirmed Resident 3 experienced falls during it and said s/he used "pressure points" on Resident 3's shoulder blades. Caregiver C said s/he was not trained to use pressure points, s/he just heard it was something that could be done. "Pressure points...refer to areas on the human body that may produce significant pain or other effects when manipulated in a specific manner... it is undisputed that there are sensitive points on the human body where even comparatively weak pressure may induce significant pain or serious injury..." https://en.wikipedia.org/wiki/Pressure_point#:~:text=Pressure%20points%20derive%20from%20the%20supposed%20meridian,effects%20when%20manipulated%20in%20a%20specific%20manner. Surveyor conducted an interview with Caregiver C on 04/22/2026 at 7:34 AM. S/he recalled Resident 3 experienced 2 falls during the 03/23/2026 incident and was kicking the door and punching the wall. S/he described the physical altercation as very intense, and s/he was injured.	N 169		

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N 169	Continued From page 21 Caregiver C said s/he was transported by ambulance to the hospital, but to his/her knowledge Resident 3 was not medically assessed. On 04/20/2026, Surveyor reviewed a text message dated 03/24/2026. It was sent by Caregiver A to Administrator D at 11:36 AM and included photos of bruising on Resident 3. One photo documented a bruise approximately the size of a quarter at the base of his/her right big toe and yellow and purple bruising on his/her left shoulder covering an area of approximately 5 inches long by 3 inches wide. Administrator D replied: "Oh k" [sic] On 04/27/2026, Surveyor interviewed Guardian J. Guardian J said s/he received a text message from Administrator D on 03/24/2026 stating Resident 3 "had a meltdown last night...(we) did have to call police to settle [him/her] down. [S/he] did hurt a staff member. [Resident 3] is OK." Surveyor noted the text did not include information that Resident 3 fell twice during the incident. Guardian J said s/he did not receive any other notifications related to the incident and was not notified Resident 3 developed bruises. On 04/27/2026 at 3:40 PM, Surveyor interviewed APNP L. S/he said Administrator D did not inform him/her that Resident 3 sustained falls during the 03/23/2026 incident or that Resident 3 developed bruising. APNP L said as a result, Resident 3 was not medically assessed. Cross Reference N0161 83.12(3)(a) Investigate Injuries of Unknown Source N0214 83.15(3)(a) Administrator Shall Supervise Daily Operations	N 169		

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N 169	Continued From page 22 N0431 83.38 (1)(g) Health Monitoring N0433 83.38(1)(i) Behavior Management	N 169		
N 214	83.15(3)(a) Administrator shall supervise daily operation The administrator shall supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel, finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. This Rule is not met as evidenced by: Based on observation, interviews and record review, Administrator D did not supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel and physical plant. Administrator D did not provide the supervision necessary to ensure that the residents received proper care and treatment, that their health and safety were protected and promoted and that their rights were respected. Findings include: The Department received a complaint alleging concerns with administrator oversight. SURVEY FINDINGS During an onsite visit 04/20/2026 and with	N 214		

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N 214	Continued From page 23 information collected through 05/04/2026, Surveyors investigated 3 complaints and completed a standard survey. Surveyors made observations and conducted interviews with residents, facility staff, managed care organization (MCO) representatives, medical providers and legal representatives. Surveyors reviewed facility records, MCO records and medical records. Based on the evidence collected, 3 of 3 complaints were substantiated and 22 deficiencies were identified; including 5 repeat deficiencies. In summary: --Administrator D did not ensure investigations were conducted after receiving allegations of neglect or being informed of injuries of unknown origin. --Administrator D did not ensure staff were trained and competent in areas to include fire evacuation, first aid and choking or challenging behaviors. --Administrator D did not ensure caregivers appropriately managed Resident 3's behaviors. His/her ISP was not updated to include interventions identified by his/her medical provider, guardian or care team. On 03/23/2026, Resident 3 experienced a mental health crisis, caregivers did not utilize appropriate interventions and Resident 3's behaviors escalated resulting in injury to staff and police response. Resident 3 also sustained injuries which were not reported to the guardian or medical provider and were not medically assessed. --Administrator D did not ensure residents' rights to receive medication were protected or that medication administration was provided in a manner appropriate to meet the needs of the residents. This impacted Residents 1, 2 and 3.	N 214		

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N 214	Continued From page 24 --Administrator D did not ensure health monitoring for Resident 1 and 4. Resident 1 went for several months with broken teeth, poor dentation and associated pain without receiving assistance scheduling a dentist appointment. Resident 4 did not receive assistance scheduling medical appointments to address gastrointestinal symptoms. --Administrator D did not ensure Resident 1 and 6's individual services plans were updated to identify residents' needs and associated interventions. --Administrator D did not ensure residents received special diets. This impacted Residents 2, 4 and 6. --Administrator D did not ensure menus were current, that food supply matched the menu, that residents received variety in their food or that food was stored safely. --Administrator D did not ensure the environment was safe, comfortable and well maintained. Furniture, floors, walls and registers were in poor repair, toxic chemicals were not secured and the exterior area was not well maintained. One delayed egress exit door would not disengage and others were equipped with deadbolts. The common use bathroom did not have hygiene supplies and would not lock to ensure privacy. --Administrator D did not ensure fire safety measures were in place; there was no heat detection in the laundry room, drier venting was flexible and not cleaned of lint, and fire drills were not conducted. --Administrator D did not ensure activities were provided. During the exit interview with Administrator D and Licensee F on 05/01/2026 at 8:30 AM, Surveyors reviewed the deficient practices identified above. Administrator D acknowledged s/he has	N 214		

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responsibility for oversight of day to day operations at the facility but did not offer additional insight or information.

CAREGIVER AND RESIDENT CONCERNS

In addition to the aforementioned concerns, interviews consistently revealed Administrator D was not present at the facility and did not respond to concerns.

On 04/20/2026 at 10:15 AM, Surveyors interviewed Caregivers A and B and inquired about resident records including medication orders and physician rounding forms. Caregivers A and B both indicated the only records maintained at the facility are the electronic records in ECP and they do not have access to medication orders, rounding forms or signed/dated individual service plans. Surveyor noted ECP did not contain official documentation of legal representative status, advanced directives and other important documentation.

Both caregivers volunteered ongoing concerns regarding Administrator D.

--Caregiver A said Administrator D was typically not present in person at the facility and described most communication as occurring through text messages or the "Home Base" communication application.
--Caregiver B said "we barely ever see [him/her]."
--Both caregivers reported Administrator D insists all communication with legal decision makers, the managed care organizations and medical providers goes through Administrator D, but the staff said Administrator D does not follow up. Caregivers shared text and Home Base messages as examples of barriers to

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communication and lack of follow through by Administrator D in areas to include medication management, lack of supplies and care concerns. Examples include:

11/08/2025 text string beginning at 6:47 AM:
--Caregiver A wrote, "I'm done doing meds in the building after today I'm sick of coming in having dirty needles and strips" (Photo of plastic bin with insulin pens and test strips.)
--Administrator D replied, "Who did that"
--Caregiver D replied it was Caregiver C and "same issues going on not being changed"

11/09/2025 text string beginning at 9:00 AM:
--Caregiver A wrote, "So noc (third shift) worker was sleeping when I came in no lights on in the building and work wasn't done/completed...meds inside cart in cups...I said something and [the caregiver] left without completing it." Included was a photo of the medication drawer open with two med cups full of pills with no identification which residents they belong to.
--Administrator D replied, "Who was doing meds"
--Caregiver A replied it was Caregiver C

Dec 2025 text string (immediately preceding a text dated 12/07/2025):
--Caregiver A wrote, "[Resident 2] is out of briefs and test strips"
--Administrator D replied, "[S/he] should have more briefs they were sent to [him/her] less than a month ago. Was here's [sic] strips ordered. Use [Resident 1]'s strips for now. I will call [pharmacy] in the am"
--Caregiver A wrote, "[Caregiver B] texted u [sic] about [his/her] strips days ago also [Resident 2] has had 2 utis [sic] so more accidents causes more use of briefs."
--Administrator D replied, "If [s/he] texted me then

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N 214	Continued From page 27 i [sic] ordered them. [S/he] couldn't have gone thru [sic] a whole case in 1 month." Undated text message: --Caregiver A sent a photo of a handwritten note authored by Caregiver C, addressed to Caregiver S that read in part, "Just so you know I reported you to management because you didn't do a full narc count with me..." --Administrator D replied, "Omg throw it out." --Caregiver a wrote, "No, I will not throw it out. Maybe some of the problems should be resolved in this building and people should be held accountable for what they're doing." Caregiver A also wrote s/he is not comfortable administering medications anymore because the medications counts are always off. --Administrator D replied, "It can also be a ecp issue too..." 02/20/2026 Home Base message authored by Administrator D (quoted as written): --"No caregiver is to be calling Md's, talking with guardians unless I have asked you to. you are to be updating me with changes and I will update md, mco's, guardians. No one should be giving out information unless you have talked to me first. There is a big mess right now that I have to fix cause someone has been talking to people and we are under fire right now with the mcos's ...You all need to work as a team no one is above anyone else down in ripon. So if someone thinks they are better than you co workers you better be checking your self and stay in your lane ans get off that soap box now before your knocked off by a big wind." Resident interviews also identified concerns: On 04/20/2026 at 11:20 AM, Surveyor interviewed	N 214		

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Resident 3 who said s/he does not know who Administrator D is. Surveyor asked who s/he would go to if s/he had an unresolved problem and s/he replied, "I don't know who to talk to."

On 04/20/2026 at 3:49 PM, Surveyor interviewed Resident 6. Resident 6 expressed feeling very unhappy with the care and treatment s/he receives at the facility. Resident 6 said s/he knew who Administrate D was, but said s/he does not see him/her at the facility.

RESIDENT 3 EXAMPLE

During the aforementioned interview with Resident 3, s/he volunteered s/he needs a new walker. Surveyor observed the 2 wheeled walker had a bent frame and the front wheels were not properly positioned or aligned. Surveyors subsequently observed Resident 3 ambulate using the walker; the wheels did not turn freely and it made a loud screeching sound.

On 04/20/2026 At 3:49 PM, Surveyor was interviewing Resident 6 in his/her room with the door shut and Surveyor heard a loud sound consistent with the sound of Resident 3's walker. Surveyor asked Resident 6 if s/he knew what it was and s/he said it was Resident 3's walker. S/he said it "bugs" him/her because it is "unbelievably loud."

Surveyor interviewed Caregiver A on 04/20/2026 at 12:29 PM. S/he said Resident 3 is at risk for falls and said s/he had experienced a fall in the past month while using the walker. Surveyor asked what interventions Resident 3 needs to prevent falls and s/he replied, "[S/he] needs a walker that [s/he]'s not going to trip over ...it's all bent ...the wheels aren't spinning like they

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should." Caregiver A said the walker had been in that condition since at least 3/23/2026 when Resident 3 threw it during a behavioral episode.

Surveyor interviewed Caregiver C on 04/22/2026 at 7:34 AM. S/he confirmed the walker was bent during a recent behavioral episode and did not know of plans to replace it. S/he commented, "Why? [S/he] will just break it again."

Surveyor reviewed Resident 3's electronic record and there was an observation noted on 04/04/2026 which read, "Resident was coming into the kitchen in a hurry kind of like normally [sic] and resident tripped over [his/her] walker and fell to the ground, hit the right side of [his/her] face with the walker. Resident 4 is all right."

Surveyor interviewed Resident 3's Guardian on 04/23/2026 at 8:56 AM. Guardian J said s/he was unaware Resident 3's walker was in need of repair or replacement.

Surveyor interviewed MCO Care Manager M on 04/27/2026 at 10:00 AM. S/he stated during a recent facility visit on 04/10/2026, s/he also observed the concerns with the walker and s/he informed facility staff they just needed to call the medical supply company to get it fixed or replaced and the MCO would cover the cost.

On 05/01/2026 at 8:30 AM, Surveyor shared the aforementioned concerns about Resident 3's walker with Administrator D and Licensee F. Surveyor summarized Resident 3's walker was in poor repair since 03/23/2026 and s/he experienced a fall while ambulating with the walker on 04/04/2026. The MCO became aware of the concern during a visit on 04/10/2026 and authorized payment to repair or replace it,

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N 214	Continued From page 30 however as of the date of the onsite visit on 04/20/2026, the walker had not been repaired or replaced. Administrator D did not offer additional information. Cross Reference N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse & Neglect N0161 DHS 83.12(3)(a) Investigate Injuries of Unknown Source N0169 DHS 83.12(5)(a) Notification: Incident/Injury/Change N0215 DHS 83.15(3)(b) Administrator Responsible for Staff Training N0287 DHS 83.27(2)(a) Admissions Compatible with the License Class N0352 DHS 83.32(3)(h) Right to Receive Medications N0389 DHS 83.35(3)(d) Service Plans Updated Annually or On Change N0427 DHS 83.38(1)(c) Leisure Time Activities N0431 DHS 83.38 (1)(g) Health Monitoring N0432 DHS 83.38 (1)(h) Med Administration Appropriate to Needs N0433 DHS 83.38(1)(i) Behavior Management N0448 DHS 83.41(2)(a) Nutrition: Diet N0450 DHS 83.41(2)(c) Nutrition: Menus N0452 DHS 83.41(3)(b) Food Safety N0481 DHS 83.43(1) Environment Safe, Clean and Comfortable N0488 DHS 83.44(1)(c) Clothes Dryers Vented N0492 DHS 83.45(1)(a) Exterior Area N0499 DHS 83.45(3) Toxic Substances N0525 DHS 83.47(2)(d) Fire Drills N0554 DHS 83.48(6)(e) Heat Detector in Laundry Room N0613 DHS 83.55(4)(a) Bath & Toilet Areas: Privacy	N 214		

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N 215	Continued From page 31	N 215		
N 215	83.15(3)(b) Administrator responsible for staff training The administrator shall be responsible for the training and competency of all employees. This Rule is not met as evidenced by: Based on record review and interview, Administrator D did not ensure the training and competency of all employees. Caregivers A, B and C were not adequately trained or competent in areas to include challenging behaviors and fire evacuation. In addition, interviews with the caregivers and an interview with Registered Nurse Q, indicated training was not provided in all areas that were documented in the training records. Findings include: Caregiver A Surveyor interviewed Caregiver A on 04/20/2026 at 12:29 PM. S/he stated s/he was never trained in how to evacuate residents in the event of a fire. Caregiver A stated s/he recently asked Administrator D for education on the topic and showed Surveyor a message in the "Home Base" communication application used by staff and Administrator D. The message read, "... [Administrator D] can (you) assist with telling us what our...fire escape plans are." Administrator D replied, "We will go over it Weds (Wednesday)." Caregiver A said Administrator D and Registered Nurse (RN) Q were onsite Wednesday 03/11/2026 for a staff meeting and training. S/he indicated it was the first time in a long time s/he	N 215		

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had seen them and the topic of fire evacuation was not covered.

Surveyor reviewed training documentation provided by Administrator D on 04/24/2026. There was documentation of training in 8 topics on 03/11/2026. The list of topics did not include the fire evacuation plan. On 05/01/2026 Administrator D provided Surveyor with documentation of the 03/11/2026 staff meeting, and topics did not include emergency evacuation procedures.

Caregiver B

Caregiver B's record indicated s/he was hired in November 2025. Surveyor reviewed training records provided by Administrator D on 04/24/2026 which documented the "Content of Training," hours and instructor.

--Orientation training: 11/14/2025, 20 minutes, "Evacuation policy and procedure" with instructor Administrator D
--Orientation training: 11/14/2025, 20 minutes, "Challenging Behaviors" with instructor Administrator D.
--Continuing education: 12/21/2025, 45 minutes, "Fire Safety" with instructors Administrator D and RN Q.
--Continuing education: 01/10/2026, 1 hour, "Emergency Planning/Evacuation Policy" with instructors Administrator D and RN Q.
--Continuing education: 02/08/2026, 1 hour, "First Aid/Choking" with instructor RN Q.
--Continuing education: 03/05/2026, 1 hour, "Dementia Behaviors/Challenging Behaviors" with instructors Administrator D and RN Q.

Surveyor interviewed Caregiver B on 04/20/2026

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N 215	Continued From page 33 at 3:13 PM and 04/27/2026 at 10:00 AM. --Caregiver B said s/he was "very positive" that s/he met RN Q for the first time at a staff meeting in 03/11/2026, and the staff meeting was the only training s/he had received during 2026. --Caregiver B said upon hire, s/he "had no training" from Administrator D and initial training consisted of 2 days of working with another caregiver. --Caregiver B said s/he was never trained in how to safely evacuate residents in the event of a fire. Surveyor asked where the safe meeting place was and s/he replied, "I don't know, I was never told." Caregiver B said if there was a fire, s/he would first evacuate all 7 residents and then call 911. --Caregiver B said s/he was certain s/he never received training in challenging behaviors and s/he felt ill equipped to manage Resident 3's behaviors. Caregiver C Caregiver C's record indicated s/he was hired 12/12/2024. Surveyor reviewed training records provided by Administrator D on 04/24/2026. --Orientation training: 12/12/2024, 20 minutes, "Evacuation policy and procedure" with instructor Administrator D. --Orientation training: 12/12/2024, 40 minutes, "Client Group Specific and "Challenging Behaviors" with instructor Administrator D. --Continuing education: 02/08/2026, 45 minutes, "Fire Safety"" with instructors Administrator D and RN Q. --Continuing education: 03/05/2026, 1 hour, "Dementia Behaviors/Challenging Behaviors" with instructors Administrator D and RN Q.	N 215		

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N 215	Continued From page 34 Surveyor interviewed Caregiver C on 04/22/2026 at 7:34 AM. Surveyor asked if s/he received training in emergency evacuation procedures and s/he replied, "No, not at all." Surveyor also asked if s/he was trained in the client groups the provider is licensed to serve and s/he replied, "In previous employment, but not here...when I started working I had to fill out a big pile of papers, put my initials on the bottom of pages, that's the only information I received..." Caregiver C said since that time, s/he has not received training in challenging behaviors and s/he did not feel comfortable providing care to Resident 3 due to his/her aggressive behaviors. Interview with RN Q: Surveyor interviewed RN Q on 05/04/2026 at 8:32 AM. RN Q said s/he was onsite once during 2026, on 03/11/2026, to provide training in medications. RN Q said s/he may have provided other training at different locations also managed by Administrator D but did not recall if any of the Bethel Ripon North staff were in attendance. Surveyor asked RN Q if s/he provided fire safety training to Bethel Ripon North staff and s/he replied, "I have not done it. I didn't know I had to." Surveyor asked RN Q if s/he provided training in first aid and choking to Bethel Ripon North staff and s/he replied, "I don't know, you'd have to talk to [Administrator D] in regards to that." RN Q said if there was documentation indicating that s/he provided the aforementioned trainings, it would not be accurate. Interview with Administrator D:	N 215		

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N 215	Continued From page 35 During an interview with Administrator D on 05/01/2026 at 8:30 AM, Surveyor reviewed concerns that the training documentation was not consistent with caregiver interviews about training, and specifically caregivers indicated they did not receive training from RN Q prior to 03/11/2026. Administrator D did not provide additional information. Cross Reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations N0215 DHS 83.15(3)(b) Administrator Responsible for Staff Training N0433 DHS 83.38(1)(i) Behavior Management N0525 DHS 83.47(2)(d) Fire Drills	N 215		
N 287	83.27(2)(a) Admissions compatible with the license class A CBRF may not admit or retain any of the following persons: A person who has an ambulatory or cognitive status that is not compatible with the license classification under s. DHS 83.04(2). This Rule is not met as evidenced by: Based on observation, record review and interview, the provider retained Resident 6 who had an ambulatory status that is not compatible with the licensure classification. The facility is licensed as a semi-ambulatory. "Semi-ambulatory" means a person is able to walk with difficulty or only with the assistance of an aid such as crutches, cane or a walker. Resident 6 does not have a walker, is consistently	N 287		

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reliant on a wheelchair for mobility and is unable to ambulate safely without it.

Findings include:

On 04/20/2026 at 3:24 PM, Surveyor reviewed Resident 6's electronic record. Resident 6 was admitted on 10/30/2024. The individual service plan identified the use of a walker "and will scoot around in [his/her] wheelchair on [his/her] own."

Surveyor reviewed visit notes from the Managed Care Organization on 04/29/2026. Notes dated 02/13/2026 and 03/26/2026 documented observations of Resident 6 self-propelling in the facility using a wheelchair and a note dated 02/17/2026 documented Resident 6 experienced a fall from his/her wheelchair.

Throughout the onsite visit on 04/20/2026, and specifically at 11:13 AM and approximately 4:00 PM, Surveyor observed Resident 6 using only a wheelchair for mobility.

During an interview with Resident 6 at 3:49 PM in his/her room, Surveyor observed s/he was lying in bed with the wheelchair next to the bed. No walker was visible in the room. Resident 6 said s/he needs the wheelchair for mobility.

On 04/20/2026 at 12:29 PM, Surveyor interviewed Caregiver A who stated Resident 6 uses a wheelchair for mobility and s/he is unsafe to ambulate without an assistive device.

On 04/27/2026 at 7:34 AM, Surveyor interviewed Caregiver C. S/he confirmed resident 6 relies on the use of a wheelchair for mobility. S/he said Resident 6 does not have a walker and is "always in the wheelchair." Caregiver C said without use

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N 287	Continued From page 37 of the wheelchair, Resident 3 is at risk for falls. During the exit conference with Administrator D and Licensee F on 05/01/2026, Surveyor reviewed the concerns. Administrator D acknowledged Resident 6 used a wheelchair but also thought Resident 6 had a walker available to him/her. Cross Reference N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations	N 287		
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 observation, record review and interview, the provider did not ensure each resident to receive all prescribed medications in the dosage and at the intervals prescribed by their practitioner. Resident 1 did not receive his/her medicated Triad Wound Dressing Paste or Estradiol cream multiple times in April 2026 because the medications were not available to be given. In addition, Resident 1 did not receive her/his eight (8) AM dose of Lantus insulin on 01/22/2026 because there was none available. Also, on 02/05/2026, Resident 1's physician wrote an	N 352		

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order to increase Lantus from forty (40) units twice daily, to forty (40) units in the AM and forty-seven (47) units in the PM. The Lantus order was not transcribed onto the February 2026 eMAR until 02/20/2026, and Resident 1 continued receiving forty (40) units of Lantus twice daily, for a total of 14 days.

Resident 2 had a physician's order dated 03/21/2026 for Nitrofurantoin (Macrobid) twice daily for seven (7) days for an acute UTI (urinary tract infection). The pharmacy received the physician's order, filled the medication and delivered it to the facility on 03/21/2026 at 7:55 PM. Resident 2 did not start receiving the medication until 8 PM on 03/23/2026, two days later.

Resident 3 had a prescribers order for MiraLAX for the treatment of constipation. The Medication Administration Records (MARs) from 03/01/2026 - 04/22/2026 revealed that the medication was omitted during at least 45 of 53 scheduled opportunities, with the reason for non-administration documented only as "na" or "med na." Although the provider was aware that payment authorization from the Managed Care Organization (MCO) was required for the pharmacy to dispense the medication, there was no evidence of efforts to resolve this barrier with the MCO or to notify the prescribing physician. Resident 3 experienced increased constipation during this timeframe.

This is a repeat deficiency and is being cited for the third time. See Statement of Deficiency (SOD) R4XS11, dated 08/14/2023 and SOD R4XS12 dated, 06/24/2024.

Findings include:

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BETHEL RIPON NORTH	530 NORTH UNION STREET RIPON, WI 54971

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N 352	Continued From page 39 The Department received a complaint alleging concerns with medications. Resident 1's medicated paste/cream On 04/20/2026, Surveyor reviewed Resident 1's record which indicated the resident was admitted to the facility on 09/23/2023 with diagnosis to include diabetes, history of UTIs and cutaneous abscess of groin. Additionally, the facility managed and administered all of Resident 1's medication. Resident 1 had physician's orders for, "Triad wound dressing paste topical to perineal area twice daily and Estradiol 0.01% cream to genital area every Monday, Wednesday and Friday." On 04/20/2026 at 12:20 PM, Surveyor interviewed Resident 1. Resident 1 indicated s/he has an open sore to her/his right groin area that's painful and s/he experiences frequent UTIs. Resident 1 stated, "I have creams that I'm supposed to get for my groin area and [genital area] but staff don't give me my creams or offer it to me...It's been an ongoing issue." On 04/20/2026 at approximately 3:35 PM, Surveyor observed the medication cart with Caregiver A. Surveyor asked to see Resident 1's medicated Triad wound dressing paste and Estradiol cream. Caregiver A was unable to show Surveyor Resident 1's paste or cream and stated, "We don't have either...They're not in the med cart or available in the facility. I believe [Resident 1's] paste and cream were sent with family when [Resident 1] went to their home...I don't think it was ever brought back." Surveyor asked Caregiver A what staff do when a medicated paste/cream is not available. Caregiver A stated,	N 352		

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N 352	Continued From page 40 "We let [Administrator D] know." On 04/20/2026 at 3:35 PM, Surveyor reviewed Resident 1's April 2026 eMAR (electronic Medication Administration Record) with Caregiver A which revealed Resident 1's Triad wound dressing paste was documented as "No pass Reason: Other Problems" eighteen (18) times in April 2026, with no further explanation as to why the paste was not passed or what the "Other Problem" was. Additionally, the eMAR revealed Resident 1's Estradiol cream was documented as "No pass Reason: Other Problems" six (6) times out of eight (8) opportunities in April 2026, with no further explanation as to why the cream was not passed or what the "Other Problem" was. Caregiver A acknowledge the above documentation and stated, "I documented 'Other Problems' because [Resident 1's] paste and cream were not available for me to administer." On 05/01/2026 at 8:30 AM, during the exit conference, Surveyor shared Resident 1's medicated Triad paste, and Estradiol cream were not administered during the month of April 2026 due to the above observation and documented reason. Administrator D acknowledged Resident 1's April 2026 eMAR documentation and stated, "[Caregiver A] told me family did not send them back." Surveyor then asked what staff were expected to do if a medicated cream/paste was not available for staff to administer. Administrator D stated, "Staff should be calling me to get it fixed. I was not aware they didn't have [Resident 1's] paste/cream." Resident 1's Lantus medication Resident 1 had a physician's order for Lantus Solostar to inject thirty (37) units subcutaneously	N 352		

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N 352	Continued From page 41 in the morning. On 04/20/2026, Surveyor reviewed Resident 1's February 2026 eMAR. On 01/22/2026 at 8 AM, Resident 1's eMAR documented "No pass Reason: Other Problems" with no further explanation as to why the Lantus was not given. On 04/20/2026, Surveyor reviewed Resident 1's observation notes for January 2026. An observation written by Caregiver A on 01/22/2026 at 2:30 PM, indicated, "[Resident 1] is out of Lantus at this time. [Administrator D] stated [s/he] would contact pharmacy as they were supposed to drop it off last night and it's still not here as of 2 PM. Staff have not yet seen it get dropped off or heard back from [Administrator D] what the pharmacy is waiting on..." On 04/21/2026 at 3:25 PM, Surveyor interviewed Caregiver A regarding the above entry in Resident 1's observation notes. Caregiver A confirmed s/he wrote the note and did not administer any Lantus insulin to Resident 1 on 01/22/2026 at 8 AM, because the medication was not available. Caregiver A stated, "On 01/22/2026 at 6:11 AM, I texted [Administrator D] to let [her/him] know we had no Lantus insulin for [Resident 1], so [s/he's] not getting it." ***Note: Resident 1's BS level on 01/22/2026 at 6:29 AM was 190 mg/dl and spiked to 367 mg/dl by 11:00 AM. On 02/04/2026, Resident 1's physician wrote the following order: "Increase Lantus to forty (40) units injected subcutaneously twice daily." On 02/05/2026, Resident 1's physician changed Resident 1's Lantus order and wrote the following	N 352		

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order: "Lantus: Inject forty (40) units subcutaneously every morning and forty-seven (47) units subcutaneously at bedtime."

On 04/22/2026, Surveyor reviewed Resident 1's February 2026 eMAR and noted forty (40) units of Lantus insulin was being administered twice a day until 02/20/2026. The Lantus order written on 02/05/2026 was not transcribed or documented on the eMAR until 02/20/2026. There was no evidence Resident 1 received the prescribed forty-seven (47) units of the Lantus medication as ordered for 14 days.

On 04/30/2026 at 9:35 AM, Surveyor interviewed APNP (Advanced Prescriber Nurse Practitioner)-L regarding Resident 1. APNP-L stated, "My orders are not always processed promptly or followed through on...I fax my orders directly to the pharmacy and [Administrator D] the same day I write the order. The pharmacy will input my orders into [Resident 1's] eMAR the same day, but the order will sit in the 'queue' until [Administrator D] reviews and approves them. Once approved the order will show up on Resident 1's eMAR for staff to administer the medication. Staff have told me they're not allowed to accept/approve any medication orders in the 'queue' only [Administrator D] can, which has caused delays in residents receiving the correct medication timely."

On 05/01/2026 at 8:30 AM, during the exit conference, Surveyors discussed Resident 1 not receiving her/his Lantus insulin the morning of 01/22/2026 because the insulin was not available. Administrator D did not provide any additional information. Surveyors then asked about Resident 1's Lantus order written on 02/05/2026. Administrator D verified s/he receives APNP-L's

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faxes and orders the same day and confirmed s/he's responsible for reviewing and accepting all medication orders in ECP (Electronic Care Provider). Administrator D indicated medication orders in the ECP 'queue' need to be approved by her/him before the order will show on the eMAR. Surveyors asked Administrator D why Resident 1's Lantus order dated 02/05/2026 was not transcribed, approved/accepted onto Resident 1's February 2026 eMAR until 02/20/2026, Administrator D stated, "I don't know, I have no idea."

Resident 2's Macrobid medication

On 04/20/2026, Surveyor reviewed Resident 2's record which indicated the resident was admitted to the facility on 05/18/2022 with diagnosis to include paranoid schizophrenia, diabetes and depression Additionally, the facility managed and administered all of Resident 2's medication.

An ED (Emergency Department) after visit summary for Resident 2 dated 03/19/2026 indicated, "Diagnoses: Altered mental status and Acute cystitis without hematuria...Start taking sulfamethoxazole-trimethoprim (Bactrim-an antibiotic). The original order from the ED visit on 03/19/2026 was filled and delivered to the facility on 03/19/2026. However, there were concerns the medication could cause a potassium increase with taking the Bactrim medication and the resident's Lisinopril medication together. The pharmacy let the physician know and a new physician's order was received for Nitrofurantoin (Macrobid-an antibiotic) 100 mg capsule twice daily for seven (7) days on 03/21/2026. The new order indicated to stop taking the Bactrim and start taking Macrobid 100 mg capsule twice daily for seven (7) days to avoid the potential

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N 352	Continued From page 44 interaction. On 04/22/2026 at 2:30 PM, Surveyor spoke with Pharmacy Technician G regarding Resident 2's order from the ED visit on 03/19/2026. Pharmacy Technician G explained the original order from the ED visit on 03/19/2026 was for Bactrim which was filled and delivered to the facility on 03/19/2026. However, there was a possible potassium increase with taking the Bactrim medication and the resident's Lisinopril medication. The pharmacy let the prescribing physician know of the concern and a new prescription was received on 03/21/2026 for Nitrofurantoin (Macrobid) twice a day for seven days. Pharmacy Technician G confirmed on 03/21/2026, Resident 2's new prescription for the Macrobid medication was entered into the eMAR and placed in the 'queue' to be reviewed and approved by staff at the facility. Pharmacy Technician G further confirmed Resident 2's Macrobid medication was filled and delivered to the facility on 03/21/2026 at 7:55 PM and signed for by Caregiver H. On 04/22/2026, Surveyor reviewed Resident 2's March 2026 eMAR and noted the Macrobid 100 mg capsule twice a day was not administered until eight (8) PM on 03/23/2026. Resident 2 did not receive the new prescribed antibiotic medication as ordered for 2 days, when the medication was available. On 04/21/2026 at 3:25 PM, Surveyor interviewed Caregiver A regarding Resident 2. Caregiver A indicated, Resident 2 was sent to the hospital on 03/19/2026 due to unusual behaviors, diagnosed with a UTI and returned to the facility with a prescription for an antibiotic. Caregiver A confirmed Resident 2's antibiotic was changed	N 352		

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N 352	Continued From page 45 from Bactrim to Macrobid on 03/21/2026. Caregiver A further confirmed on 03/23/2026, s/he observed Resident 2's Marcobid medication sitting in the med cart not administered and called [Administrator D] to report her/his findings. Caregiver A then stated, "When I came to work on 03/23/2026, [Resident 2's] Marcobid antibiotic was sitting in the med cart and not given for two days and the medication wasn't on [Resident 2's] eMAR. The pharmacy entered [Resident 2's] Macrobid order into ECP the same day it was delivered, but we have to wait for [Administrator D] to go into the eMAR 'queue' to review and approve the medication for administration. [Administrator D] didn't approve the medication until 03/23/2026, so staff didn't administer [Resident 2's] Marcobid on 03/21/2026 or 03/22/2026, because the order didn't show up on [Resident 2's] eMAR until 03/23/2026." Caregiver A verified Administrator D is the only staff member who can access the 'queue' and approve medication orders. On 05/01/2026 at 8:30 AM, during the exit conference, Surveyors shared the above information regarding Resident 2's Macrobid medication. Administrator D indicated s/he had no idea why Resident 2's Macrobid medication was not administered until 8:00 PM on 03/23/2026. Administrator D stated, "If the medication was in the med cart and not in [Resident 2's] eMAR staff should be calling me and asking me what to do...I didn't receive a call." Surveyors then asked Administrator D how often s/he checks the ECP eMAR 'queue'. Administrator D indicated s/he checks the 'queue' daily. ***Surveyors noted this was contrary to what Caregiver A and Pharmacy Technician G reported.	N 352		

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N 352	Continued From page 46 Resident 3's MiraLAX On 04/20/2026, Surveyor reviewed Resident 3's electronic record including his/her individual service plan (ISP) and medication administration records (MARs.) The ISP indicated Resident 3 relied on staff assistance with medication management and administration. The MARs for March and April 2026, indicated Resident 3 was prescribed polyethylene glycol (MiraLAX powder) daily in the morning for constipation. The MARs prompted for administration daily at 8:00 AM, but according to the charting it was not administered 30 of 31 days in March and 15 of 22 days in April. The reason was listed as "other" with notations to include "na" or "med na." No medication orders were onsite for Surveyor to review. On 04/23/2026 at 8:23 AM, Surveyor conducted an interview with Pharmacist O. S/he said MiraLAX has been a standing order for Resident 3 for years, but it has never been filled by their pharmacy. Pharmacist O explained the provider has made refill requests but each time the pharmacy replied that payment authorization is needed from the MCO. On 04/23/2026, Pharmacist O sent Surveyor the following documentation: --06/20/2024 - refill request from the provider for MiraLAX. Pharmacy response: "This medication requires MCO authorization prior to dispensing. Please contact the pharmacy with any questions." --10/22/2024 - refill request from the provider for MiraLAX. Pharmacy response: "This medication requires MCO authorization prior to dispensing. Please contact the pharmacy with any questions."	N 352		

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N 352	Continued From page 47 --10/10/2025 - updated order from Resident 3's nurse practitioner: Polyethylene glycol (MiraLAX), daily in the morning for constipation. --10/13/2025 - refill request from the provider for MiraLAX. Pharmacy response: "This medication requires MCO authorization prior to dispensing. Please contact the pharmacy with any questions." --04/21/2026 - refill request from the provider for MiraLAX. Pharmacy response: "This medication requires MCO authorization prior to dispensing. Please contact the pharmacy with any questions." On 04/22/2026, Administrator D faxed Surveyor a copy of the 04/21/2026 refill request, the corresponding pharmacy response that MCO authorization was needed and a rounding note authored by Advanced Practice Nurse Practitioner (APNP) L on 03/04/2026 which noted Resident 3 complained of constipation. On 04/27/2026 at 10:00 AM, Surveyor conducted an interview with MCO Care Manager M. S/he said Resident 3 has a history of experiencing constipation, however s/he was unaware of any concerns related to administration of MiraLAX until a recent facility visit on 04/10/2026. At that time Care Manager M asked staff about the medication and they initially reported Resident 3 refuses due to the taste. Care Manager M noted Resident 3 is not prone to medication refusals and when s/he asked more questions, staff said it hasn't been available. Care Manager M said this is a medication they would authorize payment for, but until recently they were not aware of the need for authorization. On 04/27/2026 at 3:40 PM, Surveyor interviewed APNP L and asked if s/he was aware Resident 3 has not been receiving MiraLAX. APNP L replied, "I have not known that...for the last 2 months	N 352		

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N 352	Continued From page 48 [Resident 3] has been complaining of constipation and I've been making (other) medication adjustments...Just today when I saw [him/her] s/he had concerns with constipation. I was going to increase MiraLAX to twice a day. Staff asked me not to do that because [s/he] doesn't like to drink it with water and asked me to prescribe Senna (laxative in pill form) instead." APNP L indicated s/he would have considered other options had s/he been aware Resident 3 was not receiving the MiraLAX. During the exit conference with Administrator D on 05/01/2026, Surveyor reviewed the aforementioned concerns. Administrator D did not provide additional information or evidence of efforts to try to resolve the payment authorization issue with the MCO. Cross Reference N0169 DHS 83.12(5)(a) Notification: Incident/Injury/Change N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations N0432 DHS 83.38(1)(h) Medication Administration	N 352		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or	N 389		

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resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan.

This Rule is not met as evidenced by:
Based on interview and record review, the provider did not review or revise residents' Individual Service Plan (ISP) annually or when there was a change in resident's needs, abilities or physical or mental condition.

Resident 1 had type II diabetes and the ISP did include information regarding diabetes management.

Resident 6 exhibited increased confusion, forgetfulness, and safety risks associated with smoking cigarettes. Resident 6 also had a history of falls, exit seeking behavior and prescribed PRN psychotropic medication. Resident 6's ISP was not updated to identify the needs and associated interventions and did not identify the specific behaviors warranting use of the medication.

This is a repeat deficiency and is being cited for the second time. See Statement of Deficiency (SOD) R4XS11, dated 08/14/2023.

Findings include:

The Department received a complaint about diabetes management.

Resident 1

On 04/20/2026, Surveyor reviewed Resident 1's

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record. Resident 1 was admitted to the facility on 09/06/2023 with diagnoses to include Type II diabetes mellitus. The record indicated Resident 1 had physician's orders for oral diabetic medication, a scheduled dose of Lantus insulin (long acting) in the morning and at bedtime and Humalog insulin (fast-acting) sliding scale to be given according to the results of Resident 1's blood sugar level. The insulin orders directed staff to call the physician if Resident 1's blood sugar level was either to high or to low based on the parameters given by the physician.

Resident 1's ISPs dated 03/17/2025 and 04/20/2026 indicated Resident 1 required assistance with medications, bathing, dressing and toileting. Additionally, the ISPs indicated staff managed and administered all of the resident's medications and included a section titled "Diabetes Management" which read, "Not Applicable."

The ISPs:
--Did not include any information regarding diabetes management.
--Did not include information about the physician orders or parameters to identify Resident 1's individualized needs, preferences and interventions in this area.
--Did not include information on how often blood sugars are checked
--Did not include the resident's signs and symptoms of hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar) or a treatment plan to manage the high or low blood sugar incidents.

On 05/01/2026 at 8:30 AM, during the exit conference, Administrator D confirmed the ISPs dated 03/17/2025 and 04/20/2026 provided to

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N 389	Continued From page 51 Surveyors for Resident 1 were the most current and up-to-date ISPs. Following the Surveyors review of the above ISPs, Administrator D acknowledged the ISPs for Resident 1 did not include information regarding diabetes management. Resident 6 On 04/20/2026, Surveyor reviewed Resident 6's electronic record including the ISP current as of 04/20/2026 and all incident reports and observation notes dating back to 1/01/2026. In addition, on 04/28/2026 Surveyor also reviewed Managed Care Organization (MCO) records including the member center plan (MCP) and visit notes. and MCO visit notes dating back to 01/01/2026. Resident 6 was elderly had diagnoses to include depression and dementia. S/he was protectively placed at the facility and had a legal guardian. FALLS --09/29/2025 incident report: At 11:20 AM, Resident 6 was found with the back of his/her head "soaked in blood." Resident 6 was sent to the emergency room via ambulance. The report indicated the possibility of an unwitnessed fall but caregivers could not determine when or where it may have occurred. --11/11/2025 MCO MCP: "Falls...Intervention: CBRF staff to continue encouraging safe wheelchair positioning while the member self-propels." --02/17/2026 MCO note: "...member had been wheeling [him/herself] around the facility in [his/her] wheelchair when [his/her] feet slipped, causing [him/her] to slide forward and fall out of	N 389		

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N 389	Continued From page 52 the chair onto [his/her] bottom...Staff implemented interventions that include encouraging the member to sit fully back in [his/her] wheelchair while self-propelling..." Surveyor note: Resident 6's electronic record did not contain an observation note, incident report or other documentation of this fall. Surveyor interviewed Caregiver A on 04/20/2026 at 12:29 PM. S/he confirmed Resident 6 is at risk for falls. Surveyor interviewed Caregiver C on 04/22/2026 at 7:34 AM. S/he recalled Resident 6 sustained a head injury in September 2025 and believed it occurred when s/he fell and hit his/her head on the table next to his/her bed. Resident 6's ISP: --Did not include any information about a history of falls, the risk of falls or interventions to prevent falls. SMOKING --11/11/2026 MCO MCP read, "April 2025: smoking apron purchased...Formal Support." --01/12/2026 observation note: after the scheduled 6:00 PM scheduled cigarette, was "demanding" more...another resident come [sic] out of their room just to tell [Resident 6] to knock off [his/her] stuff." Author: Caregiver B --01/21/2026 MCO visit note: caregivers reported "continues to smoke and often forgets when [s/he] last had a cigarette...Staff continue monitoring and encourage [him/her] to follow on a schedule to avoid running out of cigarettes." During the same visit, Resident 6 "stated [s/he] 'hates it here'...writer explained that inquiries have been made to other CBRF's, but there are not openings at this time."	N 389		

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N 389	Continued From page 53 --02/10/2026 observation note: "...couldn't wait a few minutes so staff could talk to another staff member on the phone...went outside and started to grab cigarette buds [sic] out of the coffee can...which should not be acceptable." Author: Caregiver B --02/11/2026 observation note: "...seems to be making it a habit on [sic] bringing in cigarette buds [sic] in the building...likes to hide it either in [his/her] jacket pocket, under [his/her] (wheelchair) cushion...or somewhere staff can't find it." Author: Caregiver B --02/12/2026 observation note: "...is now asking for a cigarette every hour even though [s/he]'s supposed to get it every two hours, but...is not comprehending...no matter how many times staff has to repeat...is still digging into the cigarette coffee can..." --02/15/2026 observation note: "...has a sore on [his/her] right pointer finger...staff feels it looks like a smoking burn...is raw but does not have any redness or swelling at this time.." --02/20/2026 MCO visit note: caregivers reported "becomes inpatient regarding smoking and will sometimes ask repeatedly; they redirect [him/her] to other activities since [s/he] runs out of cigarettes quickly..." --03/04/2026 observation note: Resident came inside from 2:00 PM cigarette and staff asked "where did [s/he] put [his/her] cigarette...tends to love hiding (them) in [his/her] pockets or underneath [his/her] cushion..." Staff found it "hidden lighted under [his/her] cushion of [his/her] wheelchair." --03/22/2026 observation note: "saw a glimpse and the resident had the lighter from the office in [his/her] upper jacket pocket. Resident kept lying over and over about not having it but writer asked resident to empty [his/her] pockets and all [s/he] could do was claiming [sic] [s/he] didn't steal it."	N 389		

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N 389	Continued From page 54 Author: Caregiver B. --03/26/2026 observation note -after the scheduled 6:00 PM cigarette, "10 minutes later resident asked for another one because [s/he] claims [s/he] didn't get one and that staff was stealing them from [him/her] and smoking them." The resident was offered a snack to calm down and another staff member tried to explain to Resident 6 that s/he "can't have another one till [sic] 8. Writer had reached out to the administrator about this." Author: Caregiver B Surveyor interviewed Caregiver C on 04/22/2026 at 7:34 AM. S/he confirmed Resident 6's is limited to cigarettes on a 2 hour schedule and his/her smoking materials are kept secured in the medication cart due to safety concerns. S/he said, "[Resident 6] wants to smoke in the building and in his/her room. It is unsafe. [S/he] is supposed to dispose of butts in the can, but we caught [him/her]...bringing them in." Resident 6's ISP had a section titled "Housekeeping/Chores" which read, "Staff to make sure that room is cleaned daily and remove any old cigarette butts for safety. [S/he] may get upset but tell [him/her] your [sic] putting them in a safe place for later use." There was also a section titled, "Self-Abusive Behavior" which read, "[S/he] refuses to use the smoking apron when smoking and continues to try to put cigarettes out on [his/her] chair and ashes fall to [his/her] lap. Surveyor note: the observation notes did not document times when Resident 6 declined the use of the smoking apron. The ISP: --Did not include information about frequent requests for cigarettes or the use of a smoking schedule to ration cigarettes.	N 389		

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N 389	Continued From page 55 --Did not identify interventions when Resident 6 declined use of the smoking apron to ensure Resident 5 was free from burns. --Did not identify the level of supervision needed during smoking to ensure safe disposal of cigarette butts. EXIT SEEKING & BEHAVIORS --01/15/2026 observation note: "non stop [sic] asking for smokes and when [s/he] is not getting [his/her] way is attacking other residents and non stop [sic] knocking on doors." Author: Caregiver A --02/19/2026 observation note: "..been using all the doors to escape out of the facility...not been able to be redirected...no choice but to give resident prn lorz.[sic]" Author: Caregiver A --03/26/2026 observation note: "...has been non stop [sic] blocking the doorways and hallways to allow staff and other residents to go by...tried to scoot resident over in [his/her] wheelchair...resident would start yelling...contacted [Administrator D] and asked [him/her] if prn [sic] could be given to resident and [Administrator D] agreed..." --03/29/2026 observation note: "...has been non stop [sic] exit seeking...going down to the door key pads and trying to put numbers in to open the door...is acting like [s/he] dont [sic] know where [his/her] bedroom is or how to get around the facility like [s/he] don't know where [s/he] is at. [sic]." Author: Caregiver A Surveyor interviewed Caregiver A on 04/20/2026 at 12:29 PM and s/he told Surveyor Resident 6's "behaviors have been getting worse" and s/he is "more forgetful, confused. I've gotten nowhere with [Administrator D]" to find resolution. Caregiver A also described Resident 6 as an "escape artist" and said s/he has "gotten out the door...to the fence." Surveyor asked about	N 389		

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N 389	Continued From page 56	N 389		

interventions and Caregiver A said, "I'll try to keep [him/her] occupied, but the day [s/he] got out, I was here by myself." Caregiver A said it's hard to manage all resident care needs, supervision and daily tasks when s/he is the only caregiver.

Resident 6's ISP had a section titled "Wander Risk" which read, "Shows no signs of wandering/elopement risk. [S/he] has tried to elope when [s/he] had uti (urinary tract infection.)" Surveyor noted the ISP language was contradictory and neither observation notes nor caregiver interviews indicated elopement risk in connection with a UTI.

The ISP:
--Did not include interventions for caregivers to prevent or respond to exit seeking attempts or aggressiveness towards other residents.
--Did not include information about increased forgetfulness or confusion or provide strategies for caregivers to utilize related to those changes.

PRN PSYCHOTROPIC MEDICATION
--3/27/2026 observation note 12:30 AM: "repeatedly requested a cigarette. After being given one, [s/he] requested another within five minutes. It is now past midnight, and [s/he] is refusing to go to bed, insisting on having another cigarette. The writer has declined to provide one, as all other residents are in bed where [s/he] also needs to be...administered a PRN lorazepam to help [him/her] relax and sleep, but [s/he] continues to refuse to remain in [his/her] bed and room. Therefore, the writer will administer a second dose to further assist in calming [him/her] so s/he can rest." Author: Caregiver C

--3/27/2026 observation note 5:30 AM: "...was up all night, even after taking a second dose of

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N 389	Continued From page 57 Lorazepam at 1 a.m....wandered in and out of [his/her] room, making noise and disturbing other residents, which understandably upset them. A regular 1 mg dose of Lorazepam at night might help calm [him/her] and hopefully let [him/her] sleep through until morning." Author: Caregiver C Resident 6's medication administration records indicated Resident 6 was prescribed lorazepam on 01/16/2026 with directions to take 1 tablet by mouth every 2 hours as needed for anxiety. The MAR did not include a description of the behaviors indicating the need for administration. The medication was documented as administered 4 times during March. After each administration, the MAR prompted for charting for follow up for effectiveness, which was not completed. 03/22/2026 7:34 PM: administered by Caregiver C. Caregiver C charted follow up at 7:48 PM, however no indications of effectiveness were noted 03/26/2026 12:43 PM: administered by Caregiver A. Caregiver A charted at 1:45 PM that follow up was "Not Completed." 03/26/2026 7:48 PM: administer by Caregiver B. Caregiver B charted at 9:00 PM that follow up was "Not Completed." 03/27/2026 12:51 AM: administered by Caregiver C. Caregiver C follow up at 2:03 PM, however no indications of effectiveness were noted Surveyor note: Surveyor also reviewed text messages between Caregiver A and Administrator D dated 03/23/2026 where Caregiver A expressed concerns that Caregiver C inappropriately administered 2 doses of PRN lorazepam in the same evening without documentation of the reason why.	N 389		

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N 389	Continued From page 58 Resident 6's ISP had a section titled "Medication Management" which read, "Using psychotropic medications related to specific behaviors. See MAR for medication...Behaviors will be monitored for effectives, appropriate use and possible adverse effects of the PRN medication..." The ISP --Did not include rationale for use and a detailed description of the behaviors which indicate the need for administration of the PRN psychotropic medication. HOSPICE Resident 6's ISP had a section titled "Nursing Procedures" that read, "[S/he] has hospice that comes and monitors [his/her] cares. Monthly visits." Upon request on 04/28/2026, Administrator D provided the hospice plan of care for Resident 6. Surveyor noted it was outdated with a date range of February - April 2025. On 04/27/2026 at 10:00 AM, Surveyor interviewed MCO Care Manager M. S/he stated Resident 6 is no longer a hospice patient and has not been since April of 2025. Resident 6's ISP --Was not updated in include his/her discharge from hospice services. Cross Reference N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse & Neglect N0161 DHS 83.12(3)(a) Investigate Injuries of Unknown Source N0214 DHS 83.15(3)(a) Administrator Shall	N 389		

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N 389	Continued From page 59 Supervise Daily Operations N0287 DHS 83.27(2)(a) Admissions Compatible with the License Class N0427 DHS 83.38(1)(c) Leisure Time Activities N0432 DHS 83.38 (1)(h) Med Administration Appropriate to Needs N0433 DHS 83.38(1)(i) Behavior Management	N 389		
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. This Rule is not met as evidenced by: Based on observation and interview, the facility did not provide a structured daily activity program. Engagement was limited to independent tasks such as coloring, card games, or watching television. On 04/20/2026 during the 7 hours surveyors were onsite, no organized activities were observed. This is a repeat deficiency and is being cited for the second time. See Statement of Deficiency (SOD) R4XS13, dated 04/13/2025.	N 427		

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N 427	Continued From page 60 Findings include: During a tour of the facility beginning at approximately 10:40 AM, Surveyor observed the posted activity calendar. It was outdated and reflected a date of January 2026. Exercise was listed daily for 30 minutes Monday - Friday. Most days on the calendar listed at least 5 activities. Examples included: hallway bowling, Yahtzee, trivia, bingo, ball toss, board games and crafts. RESIDENT INTERVIEWS: On 04/20/2026 at 11:20 AM, Surveyor interviewed Resident 3. S/he said s/he likes to watch TV a lot but added "I get sick of watching TV." Surveyor asked what activities are provided at the facility and s/he said cards, coloring and TV and residents do those things on their own. Resident 3 said there are no outings, even when the weather is nice. On 04/20/2026 at 12:20 PM, Surveyor interviewed Resident 1 regarding the facility's activities. Resident 1 stated, "There are no activities here. Staff just put us in front of the TV and play baby movies or they have us color once in a while, that's it. I don't want to color or watch baby movies all the time...I would participate in activities if staff actually did anything with us." Surveyor asked what type of activities s/he would like to see staff provide and promote and Resident 1 replied, "I would like to play bingo or do trivia." On 04/20/2026 at 3:49 PM, Surveyor interviewed Resident 6 and asked if there are activities at the facility. S/he replied, "coloring" and added s/he wished there was more to do. Surveyor asked if	N 427		

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N 427	Continued From page 61 there were any activities lead by staff like bingo or exercises and s/he said, "Not really." S/he said there were no community activities and reiterated it is "pretty much coloring and playing Uno on your own." OTHER INTERVIEWS: On 04/20/2026 at 12:29 PM, Surveyor interviewed Caregiver A. S/he said they do not have an activity calendar and often don't have time to do activities with residents. On 04/27/2026 at 3:40 PM, Surveyor interviewed Advanced Practice Nurse Practitioner (APNP) L who stated s/he makes monthly visits and s/he "never" observes activities. APNP L said recently s/he offered to take Resident 3 out for ice cream this summer because s/he feels bad there isn't much for him/her to do. OBSERVATIONS: During the onsite visit lasting approximately 7 hours, Surveyors observed 3 residents independently playing cards or coloring and Resident 3 watching TV in the common area. Surveyors did not observe staff offer, encourage or promote activities. During the exit conference with Administrator D and Licensee F on 05/01/2026 at 8:30 AM, Surveyor reviewed the concerns about lack of activities. They did not offer additional information. Cross Reference N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations N0433 DHS 83.38(1)(i) Behavior Management	N 427		

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N 431	Continued From page 62	N 431		
N 431	83.38(1)(g) Health monitoring. 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: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on observations, interviews and record review, the provider did not adequately monitor the health of residents, make necessary arrangements for physical and oral health services or document communication with the resident's physician and other health care providers for 2 of 6 sampled residents including	N 431		

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N 431	Continued From page 63 Resident 1 and Resident 4. Resident 4 experienced recurring episodes of vomiting and diarrhea on 01/08/26, 02/23/26, and 03/04/26, with a further recurrence documented on 04/14/26. Physician rounding forms dated 03/04/26 and 03/27/26 explicitly recommended a GI consultation and colonoscopy, contingent upon guardian approval. As of 04/20/26, the recommended medical appointments had not been scheduled and there was no evidence the guardian was informed. On 04/20/2026, Surveyor observed Resident 1 with several broken teeth and poor dentition. Resident 1 had been complaining of mouth pain for several months and had to receive oral antibiotics and antimicrobial mouth rinse to prevent/eliminate infection. The provider was aware of Resident 1's broken teeth and mouth pain but did not promptly refer or assist the resident to a dentist in an effort to decrease her/his mouth pain and improve the resident's oral health. On 04/20/2026, the day of survey, the provider scheduled an appointment for Resident 1 to see a dentist, within four days the resident was seen and had six (6) upper teeth extracted. In addition, Surveyor observed Resident 1's toenails to be very long and curled under. There was no evidence Resident 1 was being provided routine foot/nail care. On 03/14/2026, staff identified a sore under Resident 1's right armpit and promptly reported it to Administrator D. However, Administrator D did not notify the physician until 04/15/2026, 31 days later. Upon notification, the physician prescribed Resident 1 an oral antibiotic. Resident 1 had diabetes and an order for	N 431		

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Humalog insulin (fast-acting) SS (sliding scale) to be given according to the results of Resident 1's BS (blood sugar) level. The Humalog insulin order directed staff to call the physician if Resident 1's BS level was greater than 400. From 01/01/2026 through 02/23/2026, Resident 1 had thirteen (13) episodes of BS levels over 400 that were not reported promptly to the physician for appropriate intervention.

Findings include:

The Department received a complaint regarding care concerns and lack of administrator follow through.

Resident 1 oral care

On 04/20/2026 at 12:20 PM, Surveyor observed Resident 1's teeth which appeared discolored (yellow to brown) with buildup on the teeth. The bottom front teeth where the gumline met the resident's natural teeth had significant build-up. Surveyor also observed a number of missing upper front teeth and several black spots on the teeth. At that time, Surveyor interviewed Resident 1 regarding the resident's teeth. Resident 1 stated, "I've had four teeth break off in a matter of six (6) months and I still haven't seen a dentist. My mouth is painful...I eat Tylenol like its candy because my mouth hurts so bad. I haven't seen a dentist in years." Surveyor asked Resident 1 "Would you be ok with going to see a dentist?" Resident 1 replied, "Yes, I want to see a dentist. I've been telling [Administrator D] and staff I want to see a dentist, but I never hear anything...I report, report, report, but nothing ever happens."

On 04/20/2026, Surveyor reviewed Resident 1's

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record. Resident 1 was admitted to the facility on 09/06/2023 with diagnoses to include Type II diabetes mellitus. Resident 1's ISPs (Individual Service Plan) dated 03/17/2025 and 04/20/2026 indicated Resident 1 was able to make her/his needs known and required assistance with bathing, dressing and toileting. Additionally, both ISPs stated, "Oral care- monitor and assist, if necessary, with oral care such as brushing teeth to maintain proper oral care...Staff to monitor and observe and update manager/nurse with any changes." Both ISPs for Resident 1 were silent to who was responsible for scheduling or arranging transportation for health care appointments.

On 04/20/2026, Surveyor reviewed Resident 1's observation notes from 01/01/2026 through 04/20/2026 and noted the following:

~01/10/2026- "Resident complained of tooth pain and requested to go to the hospital. I called [Administrator D] to inform [her/him] and [s/he] directed me to apply ice to the area. [S/he] also said [s/he] is trying to book a dentist appointment for the resident...MD was called, and they called in an antibiotic for [her/his] tooth..." ***Note: Resident 1's January 2026 eMAR indicated the resident was prescribed an antibiotic on 01/11/2026 for seven days for a mouth infection.
~01/18/2026- "Resident has been having complaints of tooth pain. Resident requested medication for it so [s/he] was given a PRN to help with [her/his] tooth pain..."
~02/18/2026- "Resident started yelling at staff when [s/he] is going to go see the dentist and how [s/he] hates this place."
~03/02/2026- "After lunch resident was complaining of pain in [her/his] mouth area, so writer gave [her/him] a PRN acetaminophen to help [her/him] cause the pain was a level 10."

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~03/03/2026- "Resident has been in pain cause of [her/his] teeth hurting [her/him]..."
~03/13/2026- "Resident offered shower before lunch and resident stated no [s/he] has a headache and requested PRN for the headache. Resident was not given PRN for headache as resident did not have any medication for it in the cart."
~03/31/2026- "Resident also is having complaints of [her/his] teeth hurting and got a PRN for [her/his] pain per resident request."
~04/17/2026- "Resident refused [her/his] shower today. Resident stated [s/he] didn't want [her/his] shower because [her/his] teeth hurt so [s/he's] skipping it."
~04/20/2026- "Resident has an appointment with dentist on the 24th at 2 PM at 702 E Fondulac street Ripon." This entry was made by Administrator D.

***Note: The day the Surveyors were onsite a dental appointment was scheduled for Resident 1.

On 04/28/2026, Surveyor reviewed Resident 1's January 2026 through April 2026 eMARs which indicated "Acetaminophen 325 mg tablet take two tablets (650 mg) by mouth every four hours PRN (as needed for pain/fever)." The eMARs noted the following:
~January 2026- Resident 1 received the acetaminophen medication a total of twelve (12) times. Once for a headache, six times for tooth pain and five other times with no documented reason.
~February 2026- Resident 1 received the acetaminophen medication a total of eight (8) times. Twice for tooth pain, five times for a headache and once with no documented reason.
~March 2026- Resident 1 received the

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acetaminophen medication a total of five (5) times. Once for a headache, twice for tooth pain and two other times with no documented reason.
~April 2026- Resident 1 received the acetaminophen medication a total of five (5) times, once for tooth pain, twice per resident request, and two other times with no documented reason.
***Note: The above eMARs did not document Resident 1's response to the acetaminophen medication.

On 04/29/2026, Surveyor reviewed Resident 1's physician rounding notes. The following was noted:
~02/02/2026- "Complaints of tooth pain intermittently- Waiting for dental appointment in Ripon. Sent to ED (Emergency Department) this AM-tooth pain...Follow up with dentist. Starting [her/him] on a antibiotic and returning to facility. Start chlorhexidine mouthwash (prescription strength antimicrobial rinse) twice a day. Please call around for dentist appointment."
~03/04/2026- "Follow up with dentist."

On 04/20/2026, Surveyor reviewed Resident 1's record and was unable to find documentation the provider was obtaining routine and emergency dental services for Resident 1 prior to 04/20/2026. Additionally, Resident 1's record did not include documentation when the resident had last received dental services.

On 04/21/2026 at 5:24 PM, Surveyor asked Administrator D to provide all of Resident 1's dental visit/notes from admission through 04/20/2026. On 04/24/2026, Administrator D response was "[Resident 1] has appointment." No additional documentation or evidence was provided.

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N 431	Continued From page 68 On 04/20/2026 at 11:00 AM, Surveyor interviewed Caregiver A regarding Resident 1. Caregiver A stated, "Months ago when I was working one of [Resident 1's] upper teeth broke and fell out. I called [Administrator D] and [s/he] told me to give [Resident 1] a piece of gauze to bite down on to stop the bleeding. [Administrator D] said [s/he] would take it from there." Caregiver A went on to say, "About a week or so after [Resident 1's] first tooth broke off a second tooth broke. [Resident 1] was placed on an antibiotic for possible infection, but [Resident 1] continued to complain on and off about mouth pain and wanting to see a dentist." Surveyor then asked Caregiver A if s/he knew when the last time Resident 1 was seen by a dentist. Caregiver A stated, "I began working here in June 2025 and [Resident 1] hasn't seen a dentist since I've been employed...[Administrator D] tells me [Guardian K] is responsible for making [Resident 1's] dental appointments and [Guardian K] is saying [Administrator D] is responsible. When I tell [Administrator D] what [Guardian K] says, [Administrator D] will say [Resident 1] is on a waiting list...[Administrator D] knows about [Resident 1's] broken teeth and tooth pain because multiple staff have told [her/him]." On 04/22/2026 at 4:20 PM, Surveyor interviewed Caregiver C regarding Resident 1. Caregiver C stated, "[Resident 1] needs to see a dentist [her/his] teeth are falling out and [s/he's] complaining of mouth pain all time for the past six months. [Resident 1] has lost at least three (3) to four (4) teeth over the past six months. When I work, [Resident 1] will get up in the middle of the night and request acetaminophen for mouth pain. There's been times when [Resident 1] refuses to eat dinner because [her/his] mouth is hurting so bad. [Resident 1] also gets headaches from the	N 431		

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mouth pain and will request acetaminophen." Surveyor then asked Caregiver C if s/he knew when the last time Resident 1 was seen by a dentist. Caregiver C stated, "[Resident 1] has never seen a dentist." Surveyor questioned who was responsible for assisting with and obtaining routine and emergency dental services for Resident 1. Caregiver C stated, "Staff can't make appointments because [Administrator D] doesn't want staff doing it...[Administrator D] keeps all the information in [her/his] office in Menasha. [Guardian K] told me [Administrator D] is taking care of setting up a dental appointment for [Resident 1] and [Administrator D] tells me [Guardian K] is taking care of setting up a dental appointment for [Resident 1]...So I don't know what's going on. [Administrator D] told me [Resident 1] has been on a waiting list for a year."

On 04/28/2026 at 2:11 PM, Surveyor again asked Administrator D for dentist visit notes for Resident 1 from admission through 04/20/2026. On 04/28/2026 at 4:49 PM, Administrator D responded, "[Resident 1] was on waiting lists, but [her/his] guardian refused to take [her/him] to Appleton said [s/he] refused to go to Oshkosh. I got [her/him] into see the dentist in Ripon on 04/24/2026...[Resident 1] had teeth pulled." No dental visit notes or documentation was provided.

On 04/21/2026 at 9:20 AM, Surveyor interviewed Guardian K regarding Resident 1. Guardian K stated, "[Resident 1] has had multiple upper teeth break over the past year and needs to see a dentist. [Administrator D] continues to tell me [Resident 1's] on a waiting list to see a dentist for over a year...I've talked with [Administrator D] so many times about [Resident 1] needing to see a dentist because of [her/his] broken teeth and mouth pain, but [Administrator D] always tells me

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[s/he's] looking into it, but no appointment ever gets scheduled." Guardian K went on to say, "[Administrator D] expects me to transport and arrange [Resident 1's] medical appointments...I shouldn't be responsible to set-up dental/medical appointments or provide transportation to the appointments. I have a full-time job and can't always take [Resident 1] to appointments. If I'm available, I will take [Resident 1] to local appointments." Guardian K indicated s/he's never objected to [Resident 1] receiving dental or medical care services outside the city of Ripon.

On 04/30/2026 at 9:35 AM, Surveyor interviewed Resident 1's APNP (Advanced Practice Nurse Prescriber)-L. APNP-L stated, "[Resident 1] has been battling mouth infections for months and has terrible dentition. I've been telling the facility [Resident 1] needs to see a dentist for several months but was told [Resident 1] was on a waiting list. [Resident 1] has had to receive multiple courses of antibiotics and a mouth wash over the last several months to try to keep the bacteria down to prevent infection or a tooth abscess." APNP-L stated, "I feel like [Resident 1] was finally able to see a dentist because 'the state' showed up in the building on 04/20/2026..." APNP-L went on to say [Resident 1] went to the dentist on 04/24/2026 and had six upper teeth extracted.

On 04/22/2026 at 2 PM, Surveyor spoke with DOR (Dental Office Receptionist)-E located at 702 E Fond du Lac Street in Ripon. DOR-E stated their dental practice accepts state insurance and has offices in Milwaukee and Ripon. DOR-E indicated the Ripon location is a satellite office and the dental practice operates out of it every Friday. DOR-E reported an inbound call was received on 04/20/2026 to

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schedule a dental appointment for Resident 1, and an appointment was set for 04/24/2026. DOR-E stated this was the first appointment ever scheduled for Resident 1 at their office. DOR-E reported if they receive a call for patients experiencing pain or urgent care, the patient is evaluated the same day or within the same week at one of their locations. DOR-E indicated emergency walk-ins are always accepted.

On 05/01/2026 at 8:30 AM, during the exit conference, Surveyors shared the above concerns. Surveyors asked again for any routine dental care or dental visits notes for Resident 1 from admission through 04/20/2026. Administrator D confirmed s/he was unable to locate any routine dental care or dentist visit notes for Resident 1 prior to 04/20/2026. Surveyors then asked for documented evidence Resident 1 was on waiting lists for dental services and the facility's attempts to obtain dental services for Resident 1 prior to 04/20/2026. Administrator D confirmed Resident 1's record did not contain any documentation of the facility's attempts to obtain dental services for Resident 1 prior to 04/20/2026. Administrator D also verified s/he did not document any of her/his attempts to obtain dental services for Resident 1 prior to 04/20/2026 or communication s/he had with Guardian K prior to 04/20/2026.

In conclusion, Resident 1 had several broken teeth, poor dentition and had been complaining of mouth pain for several months. The provider was aware of Resident 1's broken teeth and mouth pain but did not promptly refer or assist the resident to a dentist in an effort to decrease her/his mouth pain and improve the resident's oral health. On 04/20/2026, the day of survey, the provider scheduled an appointment for

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N 431	Continued From page 72 Resident 1 to see a dentist and within four days the resident was seen and had multiple upper teeth extracted. Resident 1 foot care On 04/20/2026 at 12:20 PM, Surveyor observed Resident 1 sitting in a wheelchair in her/his bedroom. Resident 1 had socks on both feet, and no shoes. Surveyor asked to check Resident 1's feet and toes. Resident 1 removed both her/his socks from her/his feet and Surveyor observed Resident 1's toenails on both feet to be long and curled under, and in need of clipping. Surveyor spoke with Resident 1 regarding Surveyor's observations of her/his long toenails. Surveyor asked if any staff had offered to cut her/his toenails and when her/his toenails were last cut. Resident 1 could not recall staff offering to cut her/his toenails and did not know the last time her/his toenails were cut. Resident 1 then stated, "Staff don't cut my toenails because I'm a diabetic." On 04/20/2026, Surveyor reviewed Resident 1's record. Resident 1's ISPs dated 03/17/2025 and 04/20/2026 indicated Resident 1 was able to make her/his needs known, ambulated with a walker and required assistance with bathing, dressing and toileting. Resident 1's ISPs did not address foot/nail care or identify any refusals for foot/nail care. On 04/20/2026, Surveyor reviewed Resident 1's record and was unable to find documentation the facility was providing routine foot care for Resident 1. In addition the record contained no evidence Resident 1 was seen by a podiatrist in 2025 through 04/20/2026.	N 431		

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N 431	Continued From page 73 On 04/20/2026, Surveyor reviewed Resident 1's observation notes and noted Administrator D made an entry on 04/20/2026 (the day Surveyors were onsite) indicating, "Resident has a podiatry appointment with our in house podiatrist on the 28th...." On 04/21/2026 at 9:10 AM, Surveyor interviewed Resident 1's Guardian. Guardian K stated "[Resident 1's] toenails are very long, and [s/he] will not wear shoes because it hurts so bad...Staff don't perform foot/nail care for [Resident 1] because of [her/his] diabetes, and I'm concerned [s/he's] not getting any foot/nail care." Guardian K indicated Resident 1 has not been seen by podiatry in a very long time. Guardian K then stated, "I'm always calling and texting [Administrator D] about [Resident 1] needing to be seen by a podiatrist for [her/his] feet/toenails, but all I get from [Administrator D] is [s/he's] looking into it...A podiatry appointment never occurs, and [Administrator D] never follows up with me or arranges any foot care appointments." On 04/20/2026 at 11:00 AM, Surveyor interviewed Caregiver A regarding Resident 1's feet and toes. Caregiver A indicated Resident 1 required assistance with foot/nail care and her/his toenails were long and slightly curled. Caregiver A stated, "[Resident 1's] toenails need to be cut. Staff can't cut them because [Resident 1] is diabetic...I've reported multiple times to [Administrator D] [Resident 1's] toenails are long and need to be cut, but [Administrator D] will say, "What do you want me to do about it, [Resident 1's] guardian can cut them." Caregiver A went on to say, "I don't believe any arrangements were made for [Resident 1] to be seen by the podiatrist. When podiatry comes into the building they only see [Resident 2 and 3]. When I ask podiatry to see	N 431		

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N 431	Continued From page 74 [Resident 1], I'm told they don't have any paperwork for [Resident 1]. Podiatry also told me they sent paperwork to [Administrator D] for [Resident 1], but [Administrator D] doesn't send anything back." Caregiver A indicated s/he did not know why arrangements had not been made for routine podiatrist visits for Resident 1. On 04/21/2026, Surveyor asked Administrator D if the facility had any foot care policy/procedure. On 04/22/2026, Administrator D informed Surveyor the facility does not have a foot care policy but would create one. On 04/28/2026 at 2:11 PM, Surveyor asked Administrator D for any podiatry visit notes for Resident 1 from 2025 through 04/20/2026. On 04/28/2026 at 4:49 PM, Administrator D responded, "[Resident 1] saw podiatry on 02/18/25 at SSM podiatry, I have asked for the office notes." On 05/01/2026 at 8:30 AM, during the exit conference, Surveyors informed Administrator D of the above observation. Surveyors shared Resident 1's record had no documented evidence the resident was being provided routine foot care. Administrator D indicated Resident 1 last saw podiatry on 02/18/2025, but s/he was waiting on the office notes. Administrator D was unable to provide any additional evidence to show Resident 1 was being provided routine foot/nail care in 2025 to 04/20/2026. Resident 1 armpit On 04/20/2026, Surveyor reviewed Resident 1's record. An observation note written by Caregiver A on 03/14/2026 at 12:15 PM, for Resident 1 indicated, "Resident got a shower. Resident has a new sore under [her/his] right armpit. Residents under arm was cleaned well and dried.	N 431		

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[Administrator D] notified." Resident 1's record did not contain documentation to indicate the physician was notified of the sore under the resident's right armpit on 03/14/2026.

On 04/20/2026 at approximately 1:17 PM, Surveyor interviewed Resident 1 regarding the sore in her/his right armpit. Resident 1 indicated the sore in her/his right armpit started over a month ago and stated, "It's painful and itches a lot...I'm finally getting an antibiotic for it."

On 04/20/2026 at 11:00 AM, Surveyor interviewed Caregiver A regarding the above written note for Resident 1. Caregiver A stated, "[Resident 1] had a rash and pus pocket in [her/his] right arm pit. I observed it on 03/14/2026 and notified [Administrator D]. I also sent [Administrator D] a text message on 03/14/2026. I never heard anything and nothing was done about it until 04/16/2026, when the physician wrote an order for an antibiotic to treat the sore in [Resident 1's] armpit sore."

On 04/20/2026, Surveyor reviewed Resident 1's April 2026 eMAR. The eMAR indicated an order dated 04/16/2026 for Doxycycline Hyclate (an antibiotic) 100 mg tablet. Take one tablet by mouth twice daily for ten (10) days for hidradenitis suppurativa (a skin disorder causing painful lumps, abscesses and scarring, often in the armpits).

On 04/30/2026 at 9:35 AM, Surveyor interviewed APNP-L regarding the above sore under Resident 1's armpit. APNP-L verified s/he was never notified of the sore under Resident 1's armpit until 04/15/2026, when Administrator D sent her/him a text message. APNP-L stated, "On 04/15/2026 at 4:47 PM, I received a text message from

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[Administrator D] saying [Resident 1] has an area in [her/his] armpit that's red and dry. I replied immediately and asked for an image. I didn't receive an image of the sore from [Administrator D], so on 04/16/2026, I sent in an order for Doxycycline Hyclate to treat the sore." APNP-L went on to say, "Staff have voiced concerns [Administrator D] is not following through on medical concerns, med orders or changes in residents' condition. Staff also told me they're not allowed to contact me only [Administrator D] can."

On 05/01/2026 at 8:30 AM, during the exit conference, Surveyors shared the above information with Administrator D. Administrator D did not provide any additional information or evidence the physician was promptly notified of the above area to Resident 1's right armpit.

Resident 1 blood sugars

On 04/20/2026, Surveyor reviewed Resident 1's record. Resident 1 had diagnoses to include Type II diabetes mellitus and the facility managed and administered all of Resident 1's medications.

Resident 1 had a physician's order to test the resident's BS (blood sugar) four (4) times a day. Additionally, Resident 1 had a physician's order for Humalog Kwikpen dated 12/22/2024, which indicated, "Inject per SS (sliding scale) subcutaneous three times daily before meals. SS: 70-139=0u; 140-149 =2u; 150-199=4u; 200-249=6u; 250-299=8u; 300-349=10u; 350-399=12u; results greater than 400 call physician."

On 04/20/2026, Surveyor reviewed Resident 1's observation notes from 01/01/2026 through 02/23/2026 and the following was noted:

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~01/28/2026- "Resident had a BS of 574 for [her/his] lunch BS check."
~02/06/2026- "Resident's BS was high for [her/his] 12 PM med pass. Resident's BS was 427...This has been reported to [Administrator D]. [Administrator D's] response is to make sure staff documents this."
~02/23/2026- "Writer checked resident's afternoon BS, and it was high 444 and writer gave [her/him] the max amount of insulin..."

The vital history flow sheet for Resident 1's BS levels from 01/01/2026 through 02/23/2026 documented the following BS results of greater than 400:
~01/02/2026 at 04:06 PM- 441
~01/12/2026 at 11:14 AM- 417
~01/14/2026 at 11:36 AM- 434
~01/19/2026 at 12:01 PM- 413
~01/21/2026 at 03:59 PM- 416
~01/28/2026 at 06:55 AM- 443
~01/28/2026 at 11:48 AM- 574
~01/30/2026 at 04:01 PM- 440
~02/06/2026 at 11:22 AM- 427
~02/06/2026 at 03:44 PM- 429
~02/08/2026 at 03:34 PM- 403
~02/22/2026 at 11:17 AM- 402
~02/23/2026 at 11:51 AM- 444

Resident 1's record did not contain documentation to indicate the physician was promptly notified of the above BS levels greater than 400.

On 04/20/2026 at 3:50 PM, Surveyor interviewed Caregiver A. Caregiver A was unable to locate evidence in Resident 1's record the physician was notified of the BS results on the above dates. Caregiver A stated, "If [Resident 1's] BS levels are

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over 400 prior to meals we're told to notify [Administrator D]...[Administrator D] will tell us to give the highest dose of insulin on [Resident 1's] Humalog SS and [s/he] will follow-up with the physician...[Administrator D] never follows back up with staff regarding what the physician said." Caregiver A confirmed s/he's never notified the physician of the above BS readings for Resident 1 and stated, "[Administrator D] has told staff we're not allowed to reach out to physicians; we can only reach out to [Administrator D]."

On 04/30/2026 at 9:35 AM, Surveyor interviewed APNP-L regarding the above BS levels over 400 for Resident 1. APNP-L verified s/he was never notified of any BS readings over 400 for Resident 1. APNP-L indicated s/he would want to be notified if Resident 1 had elevated BS levels, over 400, as they occur and stated, "If I was made aware, I may have made changes sooner to [Resident 1's] insulin dosing, ordered extra insulin to be given or had staff re-check the resident's BS level."

On 05/01/2026 at 8:30 AM, during the exit conference, Surveyors shared the above information with Administrator D regarding Resident 1's elevated BS levels. Administrator D did not provide any additional information or evidence the physician was notified of the above elevated BS results for Resident 1.

Resident 4 medical appointments

On 04/20/2026 at 3:20 PM, Surveyor reviewed Resident 4's electronic record which indicated

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N 431	Continued From page 79 Resident 4 had a legal guardian. Observation notes dating back to 01/01/2026 documented the following: --02/23: episode of vomiting, decreased appetite and "BM issues." --03/04: "rough night with diarrhea" --04/14: vomiting and "liquid bm" Administrator D notified. On 04/24/2026, Administrator D faxed Surveyor documentation of 2 rounding forms from March 2026 for Resident 4, authored by APNP L: --03/04: discontinuation of a medication due to loose stools. "Consider GI appt/colonoscopy" The document had a handwritten note that read, "Refused." --03/27: "would rec (recommend) colonoscopy ...if guardian/pt (patient) agreeable." This document also had a handwritten note that read, "Refused." On 04/27/2026 at 2:12 PM, Surveyor interviewed Resident 3's guardian. Guardian P said s/he was not informed of the recommendations. Guardian P explained if Resident 3 was refusing a recommended medical procedure, s/he would expect to be informed so s/he could talk to the resident to provide education, encouragement and consider alternatives for diagnoses or treatment. During the exit conference on 05/01/2026 at 8:30 AM, Administrator D confirmed s/he wrote the "refused" notations on the rounding forms. S/he said s/he informed APNP L of the refusals verbally but did not have documentation of the notification. Administrator D s/he would follow up Guardian P but did not offer an explanation about why the refusals were not previously communicated.	N 431		

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N 431	Continued From page 80 Cross Reference: N0169 83.12(5)(a) Notification: Incident/Injury/Change N0214 83.15(3)(a) Administrator Shall Supervise Daily Operations N0448 83.41(2)(a) Nutrition: Diet	N 431		
N 432	83.38(1)(h) Medication administration. 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: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on observation, interviews and record review, the provider did not provide medication services, including procedures to assure the accurate administering of all medications, to meet the needs of residents. In 1 of 1 medication cart, opened insulin pens were discovered without a resident name, pharmacy label or date when the pen was opened or expired. Additionally, a dorm sized refrigerator, which housed Resident 1's insulin pens, was not maintained at the proper temperature according to the drug manufacturer's guidelines.	N 432		

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N 432	Continued From page 81 Resident 1's BS (blood sugar) level was not checked on 02/20/2026 at 8 AM and 12 PM due to a lack of test strips. As a result, staff were unable to determine Resident 1's BS level and did not administer Resident 1's Lantus (a long-acting insulin used to control blood sugar) or Humalog (a fast-acting insulin used to control blood sugar), as staff could not determine whether the insulin should be given or withheld. Resident 2's BS level was not checked on 02/07/2026, 02/09/2026 and 02/20/2026 due to a lack of test strips. As a result, staff were unable to determine Resident 2's BS level and did not administer her/his Januvia (oral diabetic medicine to help control blood sugar levels) during the morning of 02/07/2026, 02/09/2026, and 02/20/2026, as staff could not determine whether the medication should be given or withheld. Findings include: Division of Quality Assurance Insulin Storage Guide publication dated 06/2023 indicated, "...Insulin is available from the drug manufacturers in two basic packages-vials and pens. General insulin storage requirements are as follows: 1. Never freeze: frozen insulin should be thrown away...5. Check Storage guideline specific to the insulin formulation. This is usually in the product package insert...6. Unopened, in-use insulin should be stored in a refrigerator at a temperature of 36 degrees F (Fahrenheit) to 46 degrees F..." ~Review of the Humalog KwikPen Manufacturer's Insert revised 05/2025 indicated, "Store unused Humalog pens in the refrigerator at 36 degrees F to 46 degrees F. Do not freeze ...When stored at room temperature, Humalog KwikPen can only be	N 432		

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used for a total of 28 days, including both not in-use (unopened) and in-use (opened) storage time..."
~Review of the Lantus Solostar Manufacturer's Insert revised 05/2025 indicated, "Before first use keep new pens in the refrigerator between 36 degrees F to 46 degrees F. Do not freeze. Do not use Lantus if it has been frozen ...After 28 days, throw your opened Lantus pen away---Even if it still has insulin in it."

On 04/21/2026, Surveyor asked Administrator D if the facility had a policy and procedure for medication storage including labeling and refrigerated meds. Administrator D indicated the facility follows their pharmacy's policy. Surveyor reviewed the policy from the facility's pharmacy titled "Medication Storage Audit Tips" dated 09/02/2021 which indicated, " ...Prescription meds need prescription labels...Refrigerated meds- ...Log temps daily acceptable temperature range 36 - 46 F...Diabetic Supplies- In-use insulin should be stored in labeled baggie provided by pharmacy. As above prescription meds need prescription label. Insulin pens need to be dated when opened and have expiration marked-use stickers provided by pharmacy..."

On 04/21/2026, Surveyors requested the facility's most recent annual review of the medication administration and storage system. On 04/24/2026, Administrator D sent the review which was completed on 08/12/2025 by the facility's pharmacy titled, "Pharmacist Medication Management Survey." The review documented, "...Any practices identified as unacceptable (U) or caution (C) must be noted and explained in the comment section...(U) Refrigerator temperatures monitored and maintained at 36 - 46 degrees F. Shared fridge with Bethel South noted

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temperature 26 degrees F when opened. No log...(C) All medications including OTC are properly labeled and short-dated products have been clearly labeled with expiration dating..."

On 04/20/2026 at 2 PM, Surveyor and Caregiver B observed a dorm sized refrigerator shared between Ripon South and North. The refrigerator was located within the medication room on the south side and housed Resident 1's medications. Located in the refrigerator were multiple unopened Lantus Solostar pens and Humalog KwikPens for Resident 1. A thermometer inside the refrigerator on the shelf read 28 degrees F. Caregiver B verified the temperature on the thermometer was 28 degrees F. Surveyor asked Caregiver A and B if the facility monitors or logs the temperatures for the refrigerator to ensure temperatures were within accepted parameters. Both Caregiver A and B indicated staff do not monitor or record temperatures for the medication refrigerator, which housed Resident 1's insulin medication.

On 04/20/2026 at 3:20 PM, Surveyor observed the facility's medication cart with Caregiver A. The top drawer of the med cart contained an opened Humalog KwikPen and an opened Lantus Solostar pen, which were loose in the drawer and not stored in a labeled baggie. The Lantus insulin pen contained no resident name, pharmacy label or date to confirm when the pen was opened or expired. The Humalog pen was for Resident 1 and did not contain a date to determine when the pen was opened or expired. Caregiver A verified the insulin pens in the med cart were opened and prescribed for Resident 1. Caregiver A confirmed the Lantus insulin pen did not contain a resident's name or pharmacy label and both insulin pens did not contain any dates to determine when the pens

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N 432	Continued From page 84 were opened or expired. On 05/01/2026 at 8:30 AM, during the exit conference, Surveyors shared the above observations with Administrator D. No additional information was received. Resident 1 On 04/20/2026, Surveyor reviewed Resident 1's record which indicated the resident was admitted to the facility on 09/23/2023 with diagnosis to include diabetes. Additionally, the facility managed and administered all of Resident 1's medication. Resident 1 had a physician's order for staff to check Resident 1's BS level four times daily and as needed. In addition, Resident 1 had physician's order for Lantus insulin at 8 AM and 8 PM and Humalog insulin sliding scale before meals at 8 AM, 12 PM and 4 PM. Both insulins were to be given based on the results of Resident 1's BS level. On 04/20/2026, Surveyor reviewed Resident 1's observation notes for February 2026. On 02/20/2026 at 1:30 PM, Caregiver A documented, "Resident did not get [her/his] Humalog and Lantus for [her/his] 8 AM and 12 PM med pass. Resident is out of test strips. Resident's test strips did just get dropped off so for PM med pass resident should have it. Resident's test strips were placed in top drawer..." On 04/20/2026, Surveyor reviewed Resident 1's February 2026 eMAR (electronic Medication Administration Record) which revealed the following documentation by Caregiver A on 02/20/2026:	N 432		

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N 432	Continued From page 85 ~Test BS at 8 AM and 12 PM- "No pass Reason: Other Problems- Not able to complete, no test strips, will be coming in today." ~Humalog insulin at 8 AM and 12 PM- "No pass Reason: Other Problems- Not able to complete no test strips, will be coming in today." ~Lantus insulin at 8 AM- "No pass reason: Other problems- Not able to complete, no test strips, will be coming in today." The vital history flow sheet for Resident 1 on 02/20/2026 did not include documentation of BS levels for 8 AM or 12 PM. The flow sheet revealed Resident 1's BS level at 3:39 PM was 325. On 04/20/2026 at 4 PM, Caregiver A acknowledge the above documentation and stated, "I documented 'No Pass Reason-Other Problems' on the February eMAR because [Resident 1] did not have any test strips available...I couldn't check [Resident 1's] BS or give [her/him] insulin because I didn't know what [her/his] BS was." On 04/20/2026 at 4:15 PM, both Caregiver A and B indicated [Administrator D] is always made aware of supply shortages, specifically when there's no test strips, and numerous times supplies don't arrive. Resident 2 On 04/20/2026, Surveyor reviewed Resident 2's record which indicated the resident was admitted to the facility on 05/18/2022 with diagnosis to include diabetes. Additionally, the facility managed and administered all of Resident 2's medication.	N 432		

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N 432	Continued From page 86 Resident 2 had a physician's order for staff to check Resident 2's BS level twice daily at 8 AM and 4 PM. In addition, Resident 2 had a physician's order for Januvia 25 mg tablet by mouth daily in the morning with directions to hold if BS was less than 100. On 04/20/2026, Surveyor reviewed Resident 2's observation notes for February 2026. On 02/20/2026 at 1:30 PM, Caregiver A documented, "Resident did not get [her/his] BS checked this morning for 8 AM med pass. Resident did not get it checked due to being out of strips and meter being broken. Resident's package will be coming with new meter and strips [Administrator D] ordered..." On 04/20/2026, Surveyor reviewed Resident 2's February 2026 eMAR (electronic Medication Administration Record) which revealed the following documentation by Caregiver A and B: ~02/07/2026- Test blood sugar at 8 AM and 4 PM- "No Pass Reason: Other Problems- Out of strips." ~02/07/2026- Januvia 25 mg tablet at 8 AM- "No Pass Reason: Other Problems." ~02/09/2026- Test blood sugar at 8 AM- "No Pass Reason: Other Problems- No strips." ~02/09/2026- Januvia 25 mg tablet at 8 AM- "No Pass Reason: Other Problems- No strips to check BS." ~02/20/2026- Test blood sugar at 8 AM and 4 PM- "No Pass Reason: Other Problems- Not able to complete no test strips. Will be coming in today." ~02/20/2026- Januvia 25 mg tablet at 8 AM- "No Pass Reason: Other Problems- Held not able to complete. No test strips. Will be coming in today."	N 432		

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N 432	Continued From page 87 On 04/20/2026 at 4:15 PM, Caregiver A and B acknowledge the above documentation and indicated they documented 'No Pass Reason-Other Problems' on the February eMAR because Resident 2 did not have any test strips available. Caregiver A and B confirmed there were no test strips available to check Resident 2's BS level to determine if the Januvia medication should be given or held. Both Caregiver A and B indicated [Administrator D] is always made aware of supply shortages, specifically when there's no test strips, and numerous times supplies don't arrive. On 05/01/2026 at 8:30 AM, during the exit conference, Surveyors shared the above information regarding the lack of test strips for Resident 1 and 2. Administrator D stated, "Staff never called me about the test strips...Staff can call pharmacy themselves and order more test strips." Surveyors questioned Administrator D how often s/he audits residents eMARs. Administrator D stated, "I do quite often...I try at least every other day." Surveyors asked Administrator D if s/he seen the above documentation in Resident 1's and 2's February eMARs. Administrator D indicated s/he did not and gave no further explanation. Cross Reference N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations N0352 DHS 83.32(3)(h) Resident Rights to Receive Medications	N 432		
N 433	83.38(1)(i) Behavior management. As appropriate, the CBRF shall teach residents	N 433		

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N 433	Continued From page 88 the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Behavior management. The CBRF shall provide services to manage resident ' s behaviors that may be harmful to themselves or others. This Rule is not met as evidenced by: Based on record review and interview, the facility did not ensure staff were adequately trained to manage Resident 3 ' s behavioral health needs. Resident 3 had diagnoses of schizoaffective disorder, intellectual disability and intermittent explosive disorder and a documented history of property destruction and aggression during mental health crises. On 03/23/2026, Resident 3 experienced a significant behavioral episode. During this event, caregivers did not implement established de-escalation techniques and Resident 3's behaviors escalated to the point of law enforcement intervention and injury to staff. On 04/14/2026, Resident 3 became verbally aggressive and angry with staff related to his/her perceived delay in having needs met. The caregiver did not implement established de-escalation techniques. As of 04/20/2026, caregivers did not demonstrate competency of individualized interventions to manage Resident 3's behavioral health needs and meaningful updates to the ISP were not made.	N 433		

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N 433	Continued From page 89 Findings include: The Department received a complaint alleging behavior management concerns. INTERVIEWS: On 04/20/2026 at 11:20 AM, Surveyor interviewed Resident 3. S/he said, "[Caregivers] get frustrated because I've been having a lot of behavior problems." Resident 3 recalled a time recently when "all the TVs" were not working, s/he got frustrated and the police had to come. Resident 3 said s/he really likes to watch TV. Resident 3 was remorseful and felt bad the police were called. On 04/20/2026 at 11:02 AM, Caregiver B volunteered concerns about an incident with Resident 3 on 03/23/2026. S/he said, "[Resident 3] is a sweet [person] until you say the wrong thing, then [s/he] gets angry real quick. We had incident about a month ago, we couldn't find [his/her] TV remote, I told [him/her] we might have a get a new remote or look for it. We looked for it for about 45 min...(then) told [him/her] [s/he] had to wait. [S/he] had...the biggest fit of all times, throwing [his/her] walker, saying [expletives]." Caregiver B said s/he had to seek assistance from Caregiver C, which wasn't ideal because Caregiver C prefers not to work with Resident 3. Caregiver B said the situation escalated, became physical and both Caregiver C and Resident 3 ended up on the ground with Resident 3 pulling Caregiver C's hair. Caregiver B said other residents were present and s/he tried to protect them. Caregiver B said, "I will admit to this. I know it's abuse, but I had to put pressure on [his/her] shoulder to get [Resident 3] to let go...We had to call the cops." Caregiver B added, "I've always been told if you want to get someone	N 433		

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to release someone, use a pressure point ...I know it's not the right thing to do but I never got trained on how to take care of the situation..." During a follow up interview at 4:42 PM, Caregiver B said s/he did know what Resident 3's diagnoses were and commented, "I know it's not really a diagnosis, but I call it inner child syndrome...[S/he] acts more like a child than an adult." Caregiver B said s/he felt like Resident 3's behaviors are intentional and s/he could do better to control outbursts. Caregiver B said Administrator D did not follow up with him/her after the incident and s/he did not receive retraining in preventing or managing his/her behaviors. Caregiver B said Administrator D just "put a snarky note in the Home Base app."

On 04/20/2026 at 12:29 PM, Surveyor interviewed Caregiver A. S/he expressed concern about how Caregiver B handled the situation with Resident 3. Caregiver A said the following morning s/he found the remote quickly in Resident 3's dresser and added s/he thought Resident 3 was antagonized during the incident. Caregiver A said, "I came in the next day and found a bruise on [Resident 3]'s foot and shoulder...The shoulder was from [Caregiver B] "pressure pointing" Resident 3. Caregiver A indicated s/he felt using a pressure point was completely inappropriate. Caregiver A said Caregivers B and C remain ill equipped to manage Resident 3's mental health needs. Caregiver A said Caregiver C "won't give [him/her] food or do cares" and s/he brings Resident 7 with him/her when s/he administers medications to Resident 3. Caregiver A said Administrator D is aware but the situation persists. Caregiver A showed Surveyor a 04/08/2026 message s/he wrote in the "Home Base" application which read, "[Caregiver C] is afraid to work with [Resident 3]

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after what happened [s/he] locks [him/herself] in the staff room and dishes from dinner were still there this morning when I came in."

Surveyor interviewed Caregiver C on 04/23/2026 at 9:00 AM. S/he volunteered concerns regarding the incident on 03/23/2026. S/he recalled that the cable system was switched to Roku on that day, and by 6:00 PM, Resident 3 and staff were unable to locate the necessary remote for Resident 3's TV. Caregiver C stated that Resident 3 was disappointed, as s/he loved watching TV. Caregiver C explained that Caregiver B did not handle the situation well, repeatedly telling Resident 3 that the remote could not be found and saying "no," s/he could not watch TV. Caregiver C stated, "[Caregiver B] didn't let it go, [s/he] kept telling [Resident 3] 'no' over and over again...and [Resident 3] got mad....[S/he] was screaming and swearing threw [his/her] walker across the hallway..." Caregiver C said Resident 3 continued to escalate and started "attacking" him/her, requiring intervention from Caregiver B. Caregiver C said at first they could not reach Administrator D, but eventually did and s/he instructed them to call police. Caregiver C said s/he was injured during the incident and required emergency room treatment.

Caregiver C acknowledged in hindsight, there were opportunities on 03/23 for staff to have disengaged and/or offer a distraction like a snack. Caregiver C described a lack of training both before and after the incident. S/he stated, "I am still trying figure out how to deal with [him/her] and talk to [him/her]. It's been traumatizing to me. It's why I don't want to be around [Resident 3]." Caregiver C said s/he's felt "paranoid" around Resident 3 since last year when Resident 3 became aggressive with him/her. Caregiver C

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stated, "I'm afraid...so right now when meds are being given, I have a co-worker do it...I can't go in there (his/her room) by myself." Caregiver C said s/he often works the 3rd shift alone. S/he acknowledged once s/he brought Resident 7 along to administer Resident 3's medications but said usually, s/he enlists help from caregivers at the neighboring sister facility. Caregiver C said s/he did not receive training before or after the 3/23 incident with Resident 3 in preventing or managing his/her behaviors.

RECORD REVIEW:

On 04/20/2026 at 10:28 AM, Surveyor reviewed Resident 3's electronic record.

The face sheet and current individual service plan (ISP) did not include diagnoses information for Resident 3.

The ISP read in part, "To receive complete assistance and aiding in alleviating aggressive/combative situations...staff to watch [him/her] closely when [s/he] gets frustrated...direct [him/her] to [his/her] room to calm down. Call [Guardian J]. If [Guardian J] can't get [him/her] to calm down, please call [Administrator D.]
--The section went on to detail a behavioral incident with Caregiver C on 02/07/2025 which included physical aggression and property damage. It was noted, "[Administrator D] was called and [s/he] tried to calm [Resident 3] down but instead [s/he] got all stirred back up screaming and swearing, hitting staff..." No new interventions were identified in connection with the incident.
--The next update dated 02/11/2026 read, "[Advanced Practice Nurse Practitioner (APNP) L]

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said...if a scheduled meal is delayed...simple, concrete reassurance should be used" and an immediate snack offered. APNP L instructed, "food should not be withheld in an attempt to teach waiting ....Staff should avoid arguing, lecturing, or explaining rules, as the resident does not have the cognitive capacity to understand concepts. The focus should remain on meeting basic needs promptly to prevent distress and behavioral escalation."
--The ISP was silent to any behavioral incidents after 2/11/2026.

Prior to the onsite visit, the Surveyor reviewed Department records and found no evidence the provider had self-reported the incident or submitted a misconduct incident report (MIR). After Surveyors arrived onsite and made a general request for documentation of investigations, Administrator D provided (on 04/22/2026) a self-report and a MIR, claiming both had been previously faxed. The documentation provided did not include evidence of a thorough investigation or retraining with caregivers.

Self-Report: Identified Resident 3's diagnoses as schizoaffective disorder, intellectual disability, bipolar disorder and intermittent explosive disorder.
--The form prompted for "Action Taken to Ensure Resident's Health, Safety, and Well-Being" and Administrator D wrote, "[Resident 3] will use calming down techniques and use [his/her] words when upset instead of hitting...was also told that [s/he] can contact [his/her] MD and [s/he] will talk to [him/her] to try calming [him/her] down..."
--It also read, "was put on 30 min checks again...will follow thru [sic] and go directly to [his/her] room if [s/he] gets upset again to use the

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calming techniques the MD has shown [him/her] by using [his/her] tension ball and listening to music to calm down..."
--Surveyor note: use of the tension ball and listening to music was not included in the ISP and directing Resident 3 to his/her room could be considered a restriction.

MIR: Included a copy of a message from Administrator D sent to all the staff sent via the "Home Base" messaging application. The message began, "So this happened yesterday someone tell me where everyone went wrong?" Administrator D then copied an observation note authored by Caregiver B on 03/23/2026 at 8:15 PM and added comments throughout the note using parentheses. The message read (quoted as written):

--3/23/2026: "Resident was already pretty upset that resident was not going to have [his/her] tv back when staff tried to explain to resident that [s/he] was not able to get [his/her] tv back ((First of all why would you say this to [him/her])))] [s/he] couldn't find [his/her] remote for [his/her] Roku tv so writer went to go get [his/her] meds started ((Why didn't you help [him/her] look for it or go to the other side to see if there was a extra remote)) while writer was in the middle of giving meds and other team member was giving a shower. Resident started to shout in [his/her] room something then resident came out of [him/her] room and shouted, [expletives]. Writer ran and told the other team member to stay in the bathroom because [s/he] was having a behavior, (Why didn't you spend some one on one time with [him/her] to calm [him/her] down)) but team member came out of the shower room and tried to calm but [s/he] wouldn't. ((Why after being told did you come out and try to calm [him/her] down

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when 1 person was already there))) Resident kept coming down the hall closer and closer to staff and other residents, but [s/he] kept screaming at the team member and writer. Resident attacked writer and saying I'm going to kill you, [expletive], but writer had to stand in between another resident (This over stimulated [him/her] right here staff should have gotten other residents back to their rooms and out of the way)) ...writer and other team member kept trying to kept [him/her] from hurting anyone else ((So i take it you all were yelling at [him/her] at this point))) but resident ended up grabbing, hitting and pulled the team member's hair...when [s/he] finally let the team member go. Administer was notified. Cops and paramedics were called because it became too much for staff to handle. (This was poorly done, you should have called [Administrator D] at first sign of [him/her] being upset so i could try to calm [him/her] down or [Guardian J]))"

The MIR included documentation of a subsequent incident involving Caregiver A on 04/14/2026.

--04/14/2026: "Resident had a behavior this morning. Resident was mad that [s/he] wanted [his/her] medications right away when [s/he] came out of [his/her] room. Resident seen [sic] med tech was helping another resident. Staff member told resident that as soon as they were done...they would get [his/her] medications..." Resident 3 began yelling, swearing and subsequently threw his/her walker. "Writer explained again to resident that staff was still helping another person and [s/he] needs to not behave in a matter that is not appropriate."

Surveyor note: Caregiver C's response to

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N 433	Continued From page 96 Resident 3 was contrary to the identified interventions from APNP L to meet Resident 3's needs promptly and/or offer an alternative. Surveyor received and reviewed documentation from Resident 3's managed care organization (MCO) on 04/27/2026. Care Manager M documented a facility visit on 04/10/2026 which read, "Discussed recent behavioral incident and...shared the Behavioral Strategies complied to support staff when [Resident 3] gets frustrated or upset..." The "Support Strategies" were compiled on a 2 page document which read in part, --"[Resident 3] thrives on positive feedback. Staff should provide praise and recognize [him/her] as often as they are able....has a history of physical and verbal aggressive behavior...[S/he]can become anxious easily and this leads to aggression. Aggressive behaviors that have happened in the past - striking staff, tipping furniture, and throwing objects...Below are some common triggers that have been known to escalate behaviors and interventions/strategies that have been effective in deescalating the behaviors..." --Triggers: changes in routine, uncertainty about what is next, worried s/he is in trouble and being corrected by peers. --Signs of impending behavior: fidgets, paces, frequently asking about the status of items, saying s/he hates someone, crying, ruminating on something bothering him/her. --Interventions: keep him/her informed, provide a timeline if possible, use humor, remind staff are there to support and help[him/her}calm down, redirect to an activity or different topic and talk about upcoming events/outings.	N 433		

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N 433	Continued From page 97 Surveyor note: As of 04/20/2026, Resident 3's ISP was silent to the aforementioned triggers, signs of impending behavior or interventions to prevent/respond to behaviors. On 04/20/2026, Surveyor sent an email to Administrator D requesting all "training" and "retraining" for Caregivers B and C. On 04/24/2026, Administrator D sent Surveyor documentation of the caregivers training; there was no evidence of any training after 03/11/2026. ADDITIONAL INTERVIEWS: Surveyors conducted interviews with APNP L on 04/27/2026 at 3:40 PM and 04/30/2026 at 9:35 AM. APNP L said s/he was aware of the 03/23 incident and said, "I believe I was notified by the administrator by a quick short text of police response" and "they had to call police to calm [Resident 3] down." APNP L said, "I reminded [Administrator D], I'm available 24/7" as an intervention. APNP L reported success in the past with de-escalating Resident 3 over the phone by using a calm voice and redirecting the resident to use positive coping skills. APNP L indicated Resident 3's behaviors are often manageable but expressed concern caregivers are not using established interventions to help prevent them. Specifically, APNP L observed instances where staff spoke to Resident 3 in loud, nearly argumentative tones, rather than utilizing established de-escalation techniques. Surveyor conducted an interview with Guardian J. S/he said, "I really don't care for that place, but I don't know somewhere else for [him/her] to go." Guardian J said Resident 3 can have explosive	N 433		

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behaviors but, "you can't raise your voice, that makes things worse." Guardian J said s/he's repeatedly tried to explain to staff, "You don't get in [his/her] face when [s/he] gets irritated, you keep your distance ...Don't tell [him/her] 'no' and don't tell [him/her] to wait. Those are the phrases to avoid." Guardian J explained Resident 3 is usually easily redirectable and pretty happy with "slightest little" kind gesture.

Surveyor Note: Resident 3's ISP, current as of 04/20/2026, did not include identified interventions such as contacting APNP L, utilizing a calm voice, avoiding the word "no", offering 1-1 staff attention, specific options for distraction/re-direction or providing the resident with space. Furthermore, the listed intervention of contacting Administrator D appeared ineffective for two reasons: the ISP noted a prior incident where Resident 3's behavior escalated after speaking with the Administrator, and during Surveyor's aforementioned interview with Resident 3, s/he stated s/he does not know who Administrator D is.

During the exit conference with Administrator D and Licensee F on 05/01/2026 at 8:30 AM, Surveyor reviewed the aforementioned concerns, including at least two incidents on 03/23/2026 and 04/14/2026, where caregivers did not manage Resident 3's behaviors in a manner consistent with identified interventions. Surveyor also explained Resident 3's ISP had not been updated to provide caregivers with individualized strategies for more effective responses. Administrator D and Licensee F agreed that caregivers did not utilize identified interventions during the 03/23/2026 incident, yet they maintained that staff should have known how to properly intervene. Administrator D and Licensee

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N 433	Continued From page 99 F did not provide additional information about the lack of ISP updates but acknowledged there was no documentation of retraining. Licensee F said s/he talked with Caregiver C after the 03/23 incident and told him/her it was not handled appropriately but did not document the conversation. In summary: Resident 3 had diagnoses of schizoaffective disorder, intellectual disability, bipolar disorder and intermittent explosive disorder and a known history of aggressive behaviors. The provider did not ensure caregivers were equipped to prevent or manage Resident 3's behaviors via training or a detailed ISP based on assessment, input from his/her medical provider, input from his/her MCO care manager or input from his/her guardian. Cross Reference: N0158 83.12(2)(a) Caregiver: Investigating Abuse & Neglect N0161 83.12(3)(a) Investigate Injuries of Unknown Source N0214 83.15(3)(a) Administrator Shall Supervise Daily Operations N0215 83.15(3)(b) Administrator Responsible for Staff Training N0389 83.35(3)(d) Service Plans Updated Annually or On Change	N 433		
N 448	83.41(2)(a) Nutrition: diet. Diets. 1. The CBRF shall provide each resident with palatable food that meets the recommended dietary allowance based on current dietary guidelines for Americans and any special dietary needs of each resident. 2. The CBRF shall provide a therapeutic diet as ordered by a	N 448		

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N 448	Continued From page 100 resident ' s physician. This Rule is not met as evidenced by: Based on interviews and record review, the provider did not ensure Resident 2, 4 and 6 were provided with special dietary needs. Resident 2 did not consistently receive his/her instant breakfast (nutritional supplement), three times a day, from 03/01/2026 through 04/19/2026. The supplement was not given fifty (50) times out of 150 opportunities as caregivers continued to note the supplement was either not available or not documented as given. Resident 6 did not consistently receive his/her instant breakfast (nutritional supplement) as prescribed twice daily from 03/01/2026 through 04/22/2026. The supplement was not given at least 26 of 105 opportunities with documentation from caregivers indicating the supplement was not available. Resident 6 had diagnoses to include adult failure to thrive, weighed 113 lbs. and had a physician's order for "Chocolate Ensure or house supplement equivalent twice daily. Resident 4 was lactose intolerant and did not receive a lactose free diet. Resident 4 experienced incidents of stomach upset and diarrhea. Findings include: The Department received a complaint alleging care concerns.	N 448		

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N 448	Continued From page 101 RESIDENT 4 On 04/20/2026 at 3:20 PM, Surveyor reviewed Resident 4's electronic record. Neither the face sheet nor the individual service plan (ISP) contained diagnoses information or information about food intolerance. The ISP section titled "Eating" read, "Assistance as needed. [S/he] is a picky eater." Observation notes dating back to 01/01/2026 documented the following: 01/08: "after dinner went to [his/her] room to get ready for bed. Resident regurgitated [his/her] meal." 02/23: "not feeling well today...threw up during lunch...not feeling well at dinner...having bm issues today." 03/04: "rough night with diarrhea" 04/14: "has been throwing up and having liquid bm." On 04/20/2026 at 2:00 PM, Surveyor reviewed a message in the "Home Base" application authored by Caregiver B which read, "[Administrator D] strange question...is there certain foods that people who have [acid reflux] cant [sic] have?" Administrator D replied, "Yes tomato produces high acid foods, sometimes ketchup, barbecue [sic] sauce Things [sic] with...vinegar." Administrator D did not ask any follow up questions. On 04/27/2026, Surveyor conducted an interview with Caregiver B. S/he recalled sending the message in early April 2026 because Resident 4 kept throwing up after meals and s/he thought maybe s/he had acid reflux. Surveyor asked if	N 448		

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N 448	Continued From page 102 Resident 4 was on any special diet and Caregiver B said s/he was not. On 04/27/2026 at 1:01 PM, Surveyor interviewed Advanced Practice Nurse Practitioner (APNP) L. Surveyor asked if Resident 4 had any diagnoses or dietary need that may be contributing to the GI symptoms. APNP L replied, "[S/he] is lactose intolerant, [s/he] should be on a dairy free diet..." APNP L said if Resident 4 is not receiving the dairy free diet, it could be contributing to the stomach upset and diarrhea s/he has been experiencing. "Lactose intolerance is a reaction in your digestive system to lactose, the sugar in milk. It causes uncomfortable symptoms after you eat dairy products...Signs and symptoms of lactose intolerance may include: -Bloated stomach. -Intestinal gas. -Nausea and vomiting. -Stomach pain and cramping. -Stomach gurgling or rumbling. -Diarrhea." Source: https://my.clevelandclinic.org/health/diseases/7317-lactose-intolerance, retrieval date 05/06/2026 On 4/28/2026 at 3:50 PM, Surveyor interviewed Caregiver A regarding Resident 4's diet. Caregiver A indicated s/he was not aware of Resident 4 being on a lactose free diet and had no knowledge of any special diet for Resident 4. Caregiver A indicated staff will serve regular milk, cheese and ice cream to Resident 4. On 05/01/2026 at 8:30 AM, Surveyor interviewed Administrator D. S/he confirmed Resident 4 should be on a lactose free diet, but Resident 4	N 448		

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N 448	Continued From page 103 "wants to eat what everyone else wants...if they have ice cream [s/he] will have ice cream...The doctor [APNP L] is aware." Surveyor note: during the aforementioned interview with APNP L s/he did not indicate awareness the special diet was not being followed, the record did not contain evidence APNP L was informed of potential barriers to following the diet and the ISP did not include information indicating Resident 4 had a tendency to refuse the special diet. RESIDENT 6 On 04/20/2026 at 3:24 PM, Surveyor reviewed Resident 6's electronic record. Resident 6 was elderly and weighed 113 lbs. as of 04/15/2026. The current ISP read, "Eating...Needs ensure 3 times a day due to poor eating habits...Give instant breakfast to [him/her] if s/he won't eat a meal." On 04/20/2026 at 4:30 PM, Surveyor interviewed Caregivers A and B. They indicated Resident 6 is supposed to receive a nutritional supplement to maintain a stable weight. Caregiver A then stated, "We're currently out of the instant breakfast and haven't had any for at least two weeks ...We put the instant breakfast on the grocery order, sometimes it gets delivered to the facility, but most of the time we don't receive it." On 04/24/2026, Administrator D provided Surveyor with an order dated 02/12/2026 from APNP L which read, "Chocolate Ensure or house supplement equivalent twice daily." Surveyor note: the information in Resident 6's ISP was not consistent with the order.	N 448		

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N 448	Continued From page 104 On 04/24/2026, Surveyor reviewed Resident 6's MARs (Medication Administration Record) for March and April 2026. The MAR prompted for administration of instant breakfast twice daily at 12:00 PM and 4:00 PM. --March 2026 MAR: documented the supplement was not administered 13 out of 62 times. The reasons were charted as "other" with notations; "out of it at the facility", "ran out", "had none in facility" and "med na". --April 2026 MAR: documented the supplement was not administered 13 out of 43 times. The reasons were charted as "other" with notations; "na" and "med na" On 04/27/2026 at 10:00 AM, Surveyor interviewed managed care organization (MCO) Care Manager M. Care Manager M said Resident 6 had diagnoses to include adult failure to thrive. Surveyor noted this diagnoses was not documented on Resident 6's face sheet or ISP. On 04/27/2026 at 3:40 PM, Surveyor interviewed APNP L. S/he confirmed Resident 6 is frail and there is an order for Ensure dietary supplement or house equivalent twice daily. Surveyor asked APNP L if Instant Breakfast is considered an equivalent to Ensure and s/he replied, "I would be OK if they were doing something." RESIDENT 2 On 04/28/2026, Surveyor reviewed Resident 2's record. The record indicated Resident 2 was admitted to the facility on 05/18/2022 with diagnoses to include paranoid schizophrenia and diabetes.	N 448		

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N 448	Continued From page 105 On 04/28/2026, Surveyor reviewed Resident 2's most recent ISP (Individual Service Plan) dated 11/11/2025, which indicated, "Eating- assist as needed, Snack Monitoring- monitor and document food intake outside scheduled mealtimes. Requires staff assistance with medications...Diabetic Status- Diabetes will be under good control. Resident to maintain controlled blood glucose levels..." On 04/28/2026, Surveyor reviewed Resident 2's March 2026 eMAR (electronic Medication Administration Record) from 03/01/2026 through 03/31/2026. The eMAR indicated, "Instant breakfast three times a day at 9:00 AM, 2:00 PM and 7:00 PM with a start date of 11/01/2025." Surveyor identified concerns with the instant breakfast not being provided because it was either not available or not documented as given. The eMAR documented Resident 2 did not receive the instant breakfast thirty-five (35) times out of 93 opportunities. On 04/28/2026, Surveyor reviewed Resident 2's April 2026 eMAR from 04/01/2026 through 04/19/2026. The eMAR indicated, "Instant breakfast three times a day at 9:00 AM, 2:00 PM and 7:00 PM with a start date of 11/01/2025." Surveyor identified concerns with the instant breakfast not being provided as written because it was either not available or not documented as given. The eMAR documented Resident 2 did not receive the instant breakfast sixteen (16) times out of 57 opportunities. On 04/20/2026 at 4:30 PM, Surveyor discussed Resident 2's instant breakfast with Caregiver A and B. Caregiver A and B verified Resident 2 required the instant breakfast to help Resident 2	N 448		

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N 448	Continued From page 106	N 448		

maintain controlled blood glucose levels. Both Caregiver A and B confirmed the instant breakfast was noted on Resident 2's March 2026 and April 2026 eMARs to be given three times daily at 9 AM, 2 PM and 7 PM. Caregiver A and B further confirmed Resident 2's eMARs documented the instant breakfast was documented as either not given or documented as "Other Problems" because the instant breakfast was not in the building to give. Caregiver A then stated, "We're currently out of the instant breakfast...We haven't had any for at least two weeks or more...We put the instant breakfast on the grocery order, sometimes it gets delivered to the facility, but most of the time we don't receive it."

On 04/21/2026, Surveyor requested the order for Resident 2's instant breakfast from Administrator D. On 04/24/2026, Administrator D responded s/he, "could not find."

On 04/30/2026 at 10 AM, Surveyor interviewed APNP-L regarding Resident 2's instant breakfast. APNP-L indicated s/he saw Resident 2 on 10/30/2025 and noted Resident 2 was having episodes of low blood sugar, but s/he didn't order the instant breakfast. APNP-L then stated, "The instant breakfast must have been a facility intervention or ordered by another provider."

On 05/01/2026 at 8:30 AM during the exit conference, Surveyors inquired about both Resident 2 and Resident 6's instant breakfast. Administrator D told Surveyors s/he was not aware the instant breakfast supply was gone and stated, "Staff should've called me when they were low, but I never received a call."

In conclusion, Resident 2 had an intervention listed on her/his eMARs for staff to provide instant

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N 448	Continued From page 107 breakfast three times daily. The instant breakfast was not consistently provided to Resident 2 as caregivers indicated there often was no supply of the instant breakfast and had documented the instant breakfast was not available. Cross Reference N0214 83.15(3)(a) Administrator Shall Supervise Daily Operations N0389 83.35(3)(d) Service Plans Updated Annually or On Change N0432 83.38 (1)(h) Medication Administration Appropriate to Needs N0450 83.41(2)(c) Nutrition: Menus	N 448		
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 prepare a weekly written menu. The posted menu was not dated, was not followed and caregivers decided on meals on a meal-by-meal basis. Residents expressed dissatisfaction with the meals and the lack of variety. Findings include:	N 450		

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N 450	Continued From page 108 On 04/20/2026 at 10:45 AM, Caregiver B informed Surveyors s/he would be making lunch soon. Surveyors asked what was on the menu for today (Monday) and s/he replied, "We don't have an actual real menu that we stick to. We make whatever. I'll probably make spaghetti." Subsequently, Surveyor observed Caregiver B preparing spaghetti. At 10:52 AM, Surveyor observed a menu taped to the refrigerator. It was a weekly menu, but no dates were included. According to the menu, the lunch meal on Monday was tuna salad sandwich, veggie and fries and the dinner meal was pizza and fruit salad. At 11:14 AM, Surveyor observed a different, undated weekly menu posted on the bulletin board in the common area. According to the menu the lunch meal on Monday was fried rice chicken and veggies and the dinner meal was hot dogs and fries. On 04/20/2026 at 11:15 AM interviewed Resident 6 and asked what was going to be served for lunch. S/he replied, "Pot pie, I think. The food is terrible." During a follow up interview at 3:49 Resident 6 again expressed dissatisfaction with the food and said it is the same old [expletive] every day." On 04/20/2026 at 11:20 AM, Surveyor interviewed Resident 3 and asked if there is a menu at the facility. S/he said s/he didn't know if there was and said s/he eats a lot of sandwiches because s/he doesn't like what is being served. S/he added, "after a while, I get sick of eating the same thing all the time. I get so sick of eating the same thing." Resident 3 also commented that	N 450		

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N 450	Continued From page 109 sometimes there is not enough food. On 04/20/2026 at TIME, Surveyor interviewed Resident 1 about the food. S/he said, "Meals are nasty, staff don't know how to cook...My guardian has to cook me meals and bring them in for me to eat...They don't provide enough food. At breakfast I was given one peach slice, one piece of toast and a small cinnamon roll..." At 5:00 PM, Surveyor interviewed Caregiver B and asked what time dinner would be served. S/he replied, "It is scheduled for 4 or 5:00 PM, so we gotta [sic] figure something out quick to make." Caregiver B was asked if it's typical to wait until the end of the day to choose the dinner meal and s/he replied, "We kind of have to. They don't say what we can make, so we scrounge to figure something out. Like I figured out spaghetti for lunch when you came. There is no menu. They say there is, but we never got a menu." Cross Reference: N0214 83.15(3)(a) Administrator Shall Supervise Daily Operations N0448 83.41(2)(a) Nutrition: Diet	N 450		
N 452	83.41(3)(b) Food safety. Food safety. Whether food is prepared at the CBRF or off-site, the CBRF shall store, prepare, distribute and serve food under sanitary conditions for the prevention of food borne illnesses, including food prepared off-site, according to all of the following: 1. The CBRF shall refrigerate all foods requiring refrigeration at or below 40°F. Food shall be covered and stored in a sanitary manner. 2. The CBRF shall maintain freezing units at 0°F or below. Frozen	N 452		

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N 452	Continued From page 110 foods shall be packaged, labeled and dated. 3. The CBRF shall hold hot foods at 140°F or above and shall hold cold foods at 40°F or below until serving. This Rule is not met as evidenced by: Based on observation and interview, the CBRF did not store food under sanitary conditions. Findings include: On 04/20/2026, Surveyor observed the following food storage concerns at approximately 10:49 AM, while accompanied by Caregiver B: Freezer 1: Bags of shrimp and tatter tots were found in unsealed/open packaging, exposing contents. The shrimp was covered in frost. An unlabeled, undated container of French onion soup was present (contents identified by Caregiver B.) No thermometer was present to ensure the temperature was 0°F or below. Freezer 2: Interior was dirty and contained unsealed bags including an unsealed/open bag of vegetables. Refrigerator: A bowl of unidentifiable food was stored uncovered and unlabeled. Two Tupperware containers contained what appeared to be shredded meat and soup and were not labeled or dated.	N 452		

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N 452	Continued From page 111 Dry Food Storage: Bags and boxes of food on the pantry shelves were not properly sealed, including a box of pasta and bag of pasta. There was a container of butter that was uncovered. A cake pan of what appeared to be chocolate cake was left uncovered and exposed on top of the refrigerator. Surveyor interviewed Administrator D and Licensee F on 05/01/2026 at 8:30 AM and reviewed the aforementioned observations. They did not offer additional information. Cross Reference: N0214 83.15(3)(a) Administrator Shall Supervise Daily Operations	N 452		
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 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 CBRF did not provide a living environment that was clean, safe, comfortable, well maintained or homelike. Furniture was damaged and in poor repair, walls were scraped and damaged and there was exposed metal flooring presenting a tripping hazard. A delayed egress door did not function properly and other doors had deadbolts	N 481		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL RIPON NORTH	530 NORTH UNION STREET RIPON, WI 54971

(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 481	Continued From page 112	N 481		

presenting the potential for delays in exiting. Cleanliness and maintenance concerns were observed throughout the home. There was a shortage of towels and the common use bathroom did not have necessary supplies for hygiene. The home included signs and postings that were restrictive in nature.

This is a repeat deficiency and is being cited for the second time. See Statement of Deficiency (SOD) R4XS13 dated 04/03/2025.

Findings include:

The Deparment received a complaint alleging the facility was dirty and supplies were short.

The provider is licensed to serve up to 8 semi-ambulatory residents from the following client groups: developmentally disabled, advanced aged, physically disabled, traumatic brain injury, terminally ill, emotionally disturbed/mental illness and irreversible dementia/Alzheimer.

Surveyor conducted a tour of the facility on 04/20/2026 at approximately 10:40 AM while accompanied by Caregiver B. Surveyor observed the following

--Ceiling fans and registers were dirty. Registers were in poor repair with pieces of metal detached and extending out from the main assembly.
--Walls were stained, scuffed and dirty. An area of the wall in the living room was badly damaged with scrapes and gouges that removed the paint and exposed the drywall.
--The transition strip was missing from the hallway to the dining room, exposing a raised strip of metal approximately 1/4 inch that created

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a tripping hazard.
--The common bathroom had no soap or single use towels. The toilet paper was not in the holder and rested on the floor. A plunger rested on top of the intended holder. The sink and countertop were dirty and stained. The handheld shower head was not in position and hung down to the floor of the shower.
--All of the furniture was in poor repair. A brown recliner made of faux leather material had small scrapes and tears. The recliner was discolored, the footrest was not in alignment and part of the upholstery was missing. A gray upholstered chair had a prominent, circular shaped stain covering most of the cushion; it was consistent with fluid saturation.
--The frame of a love seat was compromised and the seating area showed pronounced sagging. A second love seat was missing 2 cushions and the 2 cushions that remained were not properly placed to allow for comfortable seating. During an interview with Caregiver A at 12:16 PM, s/he confirmed the furniture is in poor repair and the missing love seat cushions were located outside. S/he explained they were thrown there during the fall of 2025 after a resident had bowel incontinence. At 2:39 PM, Surveyor observed 2 cushions outside matching the other love seat cushions.
--The home contained restrictive signage, including house rules stating residents "must" get along with each other, residents "must" notify staff if not attending a meal and "must" notify and receive advance "permission" to leave the home for home visits or other outside activities.. The rules required all residents to keep all smoking materials locked in the medication cart "unless special permission is given" with access only during scheduled times. The rules did not indicate a process to assess residents and implement

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N 481	Continued From page 114	N 481		

individualized interventions if there were safety or other concerns.

Other observations on 04/20/2026:

--At 11:30 AM, Surveyor observed a linen closet. The closet contained three towels and no washcloths. Surveyor interviewed Caregiver A and s/he verified the linen closet contain a sparse amount of towels and no washcloths. Caregiver A stated, "This linen closet is all we have for supplies to care for the residents. We have to cut up towels to use as washcloths to be able to provide incontinence cares and daily personal hygiene for residents." Caregiver A went on to say, "Staff end up having to buy supplies for the facility such as soap and med cups because the facility doesn't have any."
--At 2:46 PM, Surveyors attempted to exit using the door next to the kitchen. The door had a posted exit sign and signage indicating it was delayed egress and would open in 15 seconds if pressure was applied. When Surveyors applied pressure on the door for more than 30 seconds, the door did not alarm and the lock did not disengage. There were a total of 4 exit doors and 3 of 4 were equipped with dead bolt locking mechanisms which could present an unsafe delay in the event of an evacuation.
--At 3:07 PM, Surveyor observed Resident 1's bedroom blinds were in disrepair with broken slats, there was dark matter on his/her bathroom garbage can and the toilet was dirty with a dark stain in the toilet bowl at the water line. Resident 1's sink persistently dripped and the plumbing from the sink to the wall was rusted.
--At 4:07 PM, Surveyor observed Resident 4's room did not contain toilet paper, soap or anything to dry his/her hands. Caregiver B entered the room and told Resident 4 to "go

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N 481	Continued From page 115 potty." Surveyor pointed out to Caregiver B the lack of toilet paper and hygiene supplies to Caregiver B. S/he said the resident was given toilet paper earlier in the day but s/he "likes to hide it" or use it to dry his/her hands. Caregiver B then left the room and Resident 4 said, "I'm not gonna [sic] go." --At 4:50 PM, Surveyor observed two windows in the kitchen were not functional and would not open. Caregiver B verified the windows were not functional and some of the resident bedroom windows also did not open. During the exit conference on 05/01/2026 at 8:30 AM, with Administrator D and Licensee F, Surveyor reviewed the aforementioned concerns. Licensee F stated s/he is at the facility regularly but did not offer an explanation as to why the environmental concerns had not been addressed. Cross Reference N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations N0492 DHS 83.45(1)(a) Exterior Area N0613 DHS 83.55(4)(a) Bath & Toilet Areas: Privacy	N 481		
N 488	83.44(1)(c) Clothes dryers enclosed and vented Clothes dryers. The CBRF shall enclose any clothes dryer having a rated capacity of more than 37,000 Btu/hour in a one-hour fire resistive rated enclosure. If the clothes dryer requires a vent, the CBRF shall use dryer vent tubing that is of rigid material with a fire rating that exceeds the temperature rating of the dryer. The dryer vent tubing shall be clean and maintained. This Rule is not met as evidenced by:	N 488		

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N 488	Continued From page 116 Based on observation and interview, the provider did not ensure the drier venting was rigid material or that the vent tubing was clean and maintained. Findings include: During a tour of the facility on 04/20/2026 at 10:45 AM while accompanied by Caregiver B, Surveyor observed the laundry room. The dryer venting system, constructed of flexible accordion-style ducting, was found extending through the common space to the exterior wall. On 04/20/2026, Surveyor observed the exterior of the home. The drier vent exhaust from the laundry room had three louvers (slats), one of which was obstructed in the open position. The exhaust duct was visible and covered in a thick layer of lint. NOTE: Dryer vents made from flexible duct, "may be easily kinked or crushed... [leading to] airflow restrictions [that] are a potential fire hazard. ... (Lint can) accumulate in an exhaust duct, reducing the dryer's ability to expel... vapor, which then accumulates as heat energy... [and] causes mechanical failures [that] can trigger sparks, which can cause lint... to burst into flames. Fires generally originate within the dryer but spread by escaping through the ventilation duct, incinerating trapped lint, and following its path into the building wall. House fires caused by dryers are more common than many people realize, based on statistics from the National Fire Protection Agency and the Consumer Product Safety Commission, which cite that around 15,000 fires each year can be attributed to improper lint cleanup and maintenance of the home's clothes dryer. Fortunately, these fires are very easy to prevent." Source:	N 488		

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N 488	Continued From page 117 https://www.nachi.org/dryer-vent-safety.htm, retrieval date 05/05/2026. On 05/01/2026 at 8:30 AM, Surveyor interviewed Administrator D and Licensee F and informed them of the concern. They did not offer additional information. Cross Reference: N0214 83.15(3)(a) Administrator Shall Supervise Daily Operations N0481 83.43(1) Environment Safe, Clean and Comfortable N0492 83.45(1)(a) Exterior Area N0525 83.47(2)(d) Fire Drills N0554 83.48(6)(e) Heat Detector in Laundry Room	N 488		
N 492	83.45(1)(a) Exterior areas. Exterior areas. The CBRF shall maintain the yard, any fences, sidewalks, driveways and parking areas of the CBRF in good repair and free of hazards. This Rule is not met as evidenced by: Based on observation and interview, the CBRF did not maintain the yard and sidewalks in good repair and free of hazards. Findings include: The provider is licensed to serve up to 8 semi-ambulatory residents. On 04/20/2026 at 2:42 PM, Surveyors observed the following: --The concrete sidewalk and courtyard at the facility's primary entrance were in disrepair.	N 492		

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N 492	Continued From page 118 Multiple areas exhibited deterioration, including crumbling concrete with potholes exceeding 6 inches in diameter. In some areas, there were elevation differences between slabs of concrete of up to 2.5 inches. The condition of the courtyard and sidewalk created a tripping hazard for residents. --A light colored recliner located in the courtyard was observed to be in a severely weathered condition, with surface discoloration consistent with mold growth. --Two loveseat cushions from the common area were found discarded outdoors adjacent to the air conditioning unit. The casing of one cushion was torn, leaving the internal foam core exposed. --Two downspouts were found disconnected, resulting in improper drainage that directed stormwater runoff toward the building's foundation. On 05/01/2026 at 8:30 AM, Surveyor interviewed Administrator D and Licensee F and informed them of the concern. They did not offer additional information. During the exit conference on 05/01/2026 at 8:30 AM, with Administrator D and Licensee F, Surveyor reviewed the aforementioned concerns. Licensee F stated s/he is at the facility regularly but did not offer an explanation as to why the concerns had not been addressed. Cross Reference: N0214 83.15(3)(a) Administrator Shall Supervise Daily Operations N0481 83.43(1) Environment Safe, Clean and Comfortable	N 492		

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N 499	Continued From page 119	N 499		
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, polishes, insecticides and toxic substances are labeled and stored in a secure area. Findings include: The provider is licensed to serve up to 8 residents from the following client groups: developmentally disabled, advanced aged, physically disabled, traumatic brain injury, terminally ill, emotionally disturbed/mental illness and irreversible dementia/Alzheimer. During a tour with Caregiver B beginning at approximately 10:40 AM and again at 12:14 PM, Surveyors observed cleaning chemicals in an unlocked furnace room. Caregiver A acknowledged knowing the requirement to keep them secured due to technical assistance provided during the previous survey, but blamed another caregiver for not locking the door. The chemicals included: "Noxon" metal polish with a precautionary label that it is an eye irritant and to keep out of reach of children. "Black Flag" insect killer with a precautionary label to contact poison control with eye or skin exposure. "Rid-a-Bug Flying Insect Killer" with a	N 499		

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N 499	Continued From page 120 precautionary label regarding contact with eyes, skin or inhalation. "Pine-Sol Multi-Surface Cleaner" with a precautionary label regarding exposure to eyes and to contact poison control if exposed. At 10:47 AM and throughout the day until 3:19 PM, Surveyor observed "Mr. Clean Antibacterial Multi Surface Cleaner" in the common use bathroom. It had a precautionary label that read, "CAUTION KEEP OUT OF REACH OF CHILDREN" At 2:02 PM Surveyor observed an unsecured bottle of "Lysol All Purpose" Cleaner in the kitchen. It had a precautionary label indicating "hazards to humans and domestic animals." During the exit conference on 05/01/2026 at 8:30 AM, Surveyor reviewed the concerns with Administrator D and Licensee F. They did not provide additional information. Cross Reference N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations	N 499		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may	N 525		

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N 525	Continued From page 121 be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure fire evacuation drills were conducted at least quarterly with both employees and residents, or that night simulated drills were conducted. Interviews with staff and residents indicated fire evacuation drills are not conducted and they do not know the procedure including the safe meeting place. Documentation of fire drills was not provided during the onsite visit or in response to two subsequent written requests. Findings include: The provider is licensed to serve up to 8 semi-ambulatory residents from the following client groups: developmentally disabled, advanced aged, physically disabled, traumatic brain injury, terminally ill, emotionally disturbed/mental illness and irreversible dementia/Alzheimer. Surveyor interviewed Caregiver A on 04/20/2026 at 12:29 PM (hire date June 2025.) Surveyor asked if fire drills were held at the facility. S/he replied, "We don't do them" and said s/he was unaware of where the safe meeting place would be in the event of an evacuation. Caregiver A also said s/he did not think all the residents would	N 525		

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N 525	Continued From page 122 know what to do or where to meet in the event of a fire. Surveyor asked if s/he has seen or is aware of anyone else conducting fire evacuation drills. S/he said no and further stated s/he has "not seen [Administrator D] or [Licensee F] do them, ever." Surveyor interviewed Caregiver B at 3:13 PM and asked if there was documentation of fire drills at the facility. Caregiver B said there was not and s/he has never observed or participated in a fire drill since hire in November 2025. Surveyor interviewed Resident 6 at 3:40 PM. Surveyor asked if s/he has ever participated in a fire drill. S/he replied, "No." S/he recalled during recent severe weather the sirens were activated and everyone moved to the hallways, but there has never been an evacuation drill where all the residents went outside and gathered in one place. On 04/22/2026 and 04/28/2026, Surveyor sent emails to Administrator D requesting documentation of safety inspection reports including fire drills. Administrator D did not provide documentation or evidence fire evacuation drills were held. During the exit conference on 05/01/2026 at 8:30 AM with Administrator D, Surveyor reviewed concerns there was no evidence that fire drills were conducted. Administrator D said staff "have been taught" and "I will do retraining again." Administrator D stated s/he thought s/he faxed Surveyor documentation of drills. S/he looked through a stack of papers and then stated s/he could not find documentation. Cross Reference N0214 DHS 83.15(3)(a) Administrator Shall	N 525		

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N 525	Continued From page 123 Supervise Daily Operations N0488 DHS 83.44(1)(c) Clothes Dryers Vented N0554 DHS 83.48(6)(e) Heat Detector in Laundry Room	N 525		
N 554	83.48(6)(e) Integrated heat detector in laundry room. CBRFs shall have at least one heat detector integrated with the smoke detection system at all of the following locations or in accordance with the heat detector manufacturer ' s specifications: Laundry room. This Rule is not met as evidenced by: Based on observation and record review, the laundry room did not have a heat detector. This is a repeat deficiency. See Statement of Deficiency OJ9811 dated 06/21/2022. Findings include: During a tour of the facility on 04/20/2026 at 10:45 AM while accompanied by Caregiver B, Surveyor observed the laundry room did not have heat detection. Caregiver B acknowledged the observation. During the exit conference, Administrator D provided documentation of the most recent smoke and heat detector inspection. The inspection identified the address of the facility, which is shared by 2 licensed settings (Bethel Ripon North and Bethel Ripon South.) The report did not verify the Bethel Ripon North laundry room contained heat detection. Cross Reference:	N 554		

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N 554	Continued From page 124 N0214 83.15(3)(a) Administrator Shall Supervise Daily Operations N0488 83.44(1)(c) Clothes Dryers Vented N0525 83.47(2)(d) Fire Drills	N 554		
N 613	83.55(4)(a) Bath and toilet areas: privacy. Bath and toilet rooms shall have door locks to ensure privacy, except where the toilet, bath or shower room is accessed only from a resident room that is occupied by one person. All door locks shall be operable from both sides. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the common use bath and toilet room had functioning door locks to ensure privacy. Findings include: On 04/20/2026 at 3:03 PM, Surveyor observed the lock on the only common use bath/shower was not functioning. When Surveyor shut the door from the inside, the locking mechanism would not fully engage. Caregiver B was present during the observation and said, "the lock has never worked since I've been here." Caregiver B's hire date was November 2025. Caregiver B said s/he recalled a time when Resident 5 was taking a shower and Resident 2 walked in the bathroom. Caregiver B said Resident 5 was upset and "started screaming at [Resident 2]." Surveyor interviewed Resident 6 at 3:59 PM on 04/20/2026. Resident 6 said the bathroom lock didn't work and once s/he walked in on another	N 613		

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N 613	Continued From page 125 resident who was "a little freaked out." On 04/20/2026 at 8:30 PM, Surveyor interviewed Administrator D and Licensee F and informed them of the concern. They did not offer additional information. Cross Reference: N0214 83.15(3)(a) Administrator Shall Supervise Daily Operations N0481 83.43(1) Environment Safe, Clean and Comfortable	N 613		