STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017991	A. BUILDING: _____ B. WING _____	C 03/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANN ST HOUSE	321 ANN STREET TOMAH, WI 54660

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N 000	Initial Comments On 03/12/2026, Surveyor conducted a complaint investigation at Ann St House. Data collection continued through 03/19/2026. The complaint was substantiated. Three deficiencies were identified. One of 3 deficiencies was a repeat violation (see SOD 98QT11, dated 10/22/2025). Census: 8	N 000		
N 164	83.12(4)(b) Reporting when law enforcement is called. A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a written report was sent to the department when law enforcement was called to the CBRF (community based residential facility) in response to an incident that jeopardized the health, safety, or welfare of residents on 03/03/2026. This is a repeat deficiency. See Statement of Deficiency (SOD) EK2G11, dated 11/18/2020 and	N 164		

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

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N 164	Continued From page 1 SOD 98QT11, dated 10/22/2025. Findings include: This provider serves up to 8 residents in the client groups of alcohol/drug dependent, developmentally disabled, emotionally disturbed/mental illness, traumatic brain injury, terminally ill, and physically disabled. On 03/12/2026 at 9:45 AM, Surveyor asked Caregiver D if there had been any police intervention in the past 3 months. Caregiver D stated the police were called a few days ago due to an incident involving Resident 2 being physically aggressive towards staff and kicking on other resident's room doors. Caregiver D stated Resident 2 had received a citation from the incident. On 03/12/2026 at approximately 10:00 AM, Surveyor asked House Manager (HM) A about their incident reporting process. HM A stated staff, including him/herself, would fill out an incident report and send it to Administrator C for review. On 03/12/2026, Surveyor requested Resident 2's record for review including the incident report for when police were recently called to the facility. Resident 2 was admitted to the facility on 08/23/2022 and had diagnoses that included in part unspecified intellectual disabilities, anxiety, and depression. The individual service plan (ISP) dated 11/11/2025, indicated Resident 2 had a suicidal crisis safety plan. Resident 2's ISP was checked "no" next to displaying aggressive/combative and destructive behaviors.	N 164		

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N 164	Continued From page 2 An incident report indicated on 03/03/2026 at 7:05 PM, Resident 2 began yelling at another resident. The other resident yelled back and slammed their room door. Resident 2 started kicking at the other resident's door. A caregiver intervened and Resident 2 approached the caregiver grabbing their face. The caregiver was able to remove his/her hands and Resident 2 began kicking at doors again. Eventually, Resident 2 walked away with the day caregiver and went outside. The police were contacted, and Resident 2 received a ticket. On 03/12/2026, Surveyor reviewed the department's file for the provider and did not find a self-report for the incident on 03/03/2026. On 03/12/2026 at 10:35 AM, Surveyor interviewed Senior Manager (SM) B and Administrator C. Administrator C stated s/he had been on leave and SM B was responsible for sending in self-reports. SM B stated s/he had not sent the department a self-report for the police intervention with Resident 2 on 03/03/2026 and would send one in today. Surveyor did not receive any self-reports from the provider by the end of the day.	N 164		
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 3 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1's legal representative was immediately notified when Resident 1 did not return to the facility on 07/09/2025 and had an overnight stay with family. Findings include: On 11/12/2025, the Department received a complaint regarding resident supervision concerns. On 03/12/2026 at 10:35 AM, Surveyor interviewed Administrator C. Administrator C stated prior to 07/09/2025, when Resident 1 had an overnight stay with family, Resident 1 could have approved visits with family during the day for up to 2 hours between medication administration times. Administrator C stated Resident 1 would have needed his/her guardian's permission for family visits and overnight stays. Administrator C confirmed Resident 1 did not return the night of 07/09/2025 and had an overnight visit with family. Administrator C stated staff tried to contact the guardian via phone, but there was no documentation to support this. Administrator C stated with this type of incident they would typically contact the residents' guardian and follow their instructions. On 03/12/2026, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 05/19/2025, was protectively placed, and had a guardian.	N 169		

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N 169	Continued From page 4 On 11/10/2025 at 9:35 AM, an email from Guardian E to Administrator C indicated Guardian E had inquired about an incident in July 2025 that had occurred. On 11/10/2025 at 10:44 AM, an email from House Manager (HM) F to Administrator C indicated there was no incident report for July 2025, but staff observation notes from 07/09/2025 and 07/10/2025 indicated Resident 1 had been with family on an overnight stay. Staff observation notes from July 2025 included the following: 07/10/2025 at 07:45 AM - Resident 1 left last night to go with family and indicated to staff s/he would be back in the afternoon the following day. 07/10/2025 at 11:45 AM - Resident 1's probation officer called the provider due to Resident 1 missing his/her in office visit. Resident 1's July 2025 Medication Administration Record (MAR) indicated Resident 1 was "with family" for the scheduled medications on 07/10/2025 at 8:00 AM and 2:00 PM. The medications had not been signed as administered on 07/10/2025 for those times. On 03/13/2026 at 11:55 AM, Surveyor interviewed Guardian E. Guardian E confirmed Resident 1 needed permission from him/her for family visits. Guardian E stated s/he was not aware of the incident in July 2025 until September 2025 when Resident 1's parole officer mentioned it. Guardian E stated s/he had no messages left from the provider informing him/her of the incident. On 03/17/2026 at 1:26 PM, Surveyor interviewed Caregiver G. Caregiver G stated s/he worked the	N 169		

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N 169	Continued From page 5 morning of 07/10/2025 and had called Resident 1's guardian to update him/her about Resident 1 staying overnight with family that morning leaving a message. The provider did not immediately notify Resident 1's legal representative when Resident 1 did not return to the facility on 07/09/2025 and had an overnight stay with family. Resident 1 missed his/her morning medication pass and did not return to the facility until the afternoon of 07/10/2025. Caregiver G stated they called Guardian E the next morning on 07/10/2025 to notify him/her about the incident, but Guardian E stated s/he found out about the incident in September 2025 from Resident 1's parole officer. Cross Reference N0386 DHS 83.35(3)(a) Comprehensive Individualized Service Plan	N 169		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care.	N 386		

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This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure Resident 1 had a comprehensive individualized service plan (ISP) that identified Resident 1's need related to supervision.

Findings include:

On 11/12/2025, the Department received a complaint regarding resident supervision concerns.

On 03/12/2026 at 10:35 AM, Surveyor interviewed Administrator C. Administrator C stated prior to 07/09/2025, when Resident 1 had an overnight stay with family, Resident 1 could have approved visits with family during the day for up to 2 hours between medication administration times. Administrator C stated Resident 1 would have needed his/her guardian's permission for family visits and overnight stays. Administrator C confirmed Resident 1 did not return the night of 07/09/2025 and had an overnight visit with family. Administrator C stated they now had guidelines for Resident 1's supervision needs in his/her ISP.

On 03/12/2026, Surveyor reviewed Resident 1's record.

Resident 1 was admitted on 05/19/2025, was protectively placed, and had a guardian.

A pre-admission assessment dated 05/07/2025, indicated Resident 1 had informed consent issues with social activities. The assessment indicated Resident 1 could leave the home with

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friends or relatives. The assessment indicated a question mark next to Resident 1 having restrictions on family communication by phone or in person.

An ISP titled "Initial Assessment" dated 05/19/2025, indicated Resident 1 was on parole with a no alcohol or illicit drugs as a condition. The ISP did not indicate details or guidance of Resident 1's supervision needs.

Staff observation notes from July 2025 included the following:
07/10/2025 at 07:45 AM - Resident 1 left last night to go with family and indicated to staff s/he would be back in the afternoon the following day.
07/10/2025 at 11:45 AM - Resident 1's probation officer called the provider due to Resident 1 missing his/her in office visit.

An ISP titled "6 Month Assessment" updated 11/10/2025, had the following update under Family Relationships, "Per guardian, [Resident 1] is not allowed to have unsupervised visits with family. There will be discussion with [Guardian E] on when this can be lifted." The ISP did not indicate any further details regarding Resident 1's supervision needs.

On 11/11/2025 at 13:58 PM from Guardian E to Administrator C, read in part, "I had given [him/her] the ability to go with family for a few hours basically until H.S. (bedtime) medications."

On 03/13/2026 at 11:23 AM, Surveyor interviewed Caregiver G. Caregiver G stated Resident 1 needed his/her guardian's permission for overnight stays and to visit with family for up to 2 hours during the day. Caregiver G stated it was Resident 1's responsibility to call Guardian E.

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N 386	Continued From page 8 On 03/13/2026 at 11:55 AM, Surveyor interviewed Guardian E. Guardian E confirmed Resident 1 needed permission from him/her for family visits. Guardian E stated Resident 1 or staff would reach out for permission. Guardian E stated s/he thought the provider knew Resident 1's supervision needs. Guardian E stated the ISP was updated in November 2025. On 03/14/2026 at 3:44 PM, Surveyor received an email from Licensee H. The email read in part regarding the incident in July 2025, "Clear written guidelines had not been provided by guardian at that point." The email indicated that House Manager (HM) F and Administrator C were responsible for updating resident ISPs. The provider did not ensure Resident 1 had a comprehensive ISP when it was not indicated in the ISP prior to the incident in July 2025 that Resident 1 needed permission from his/her guardian for family visits during the day and overnight stays. The ISP did not indicate Resident 1 was only able to be out with family during the day for 2 hours and did not indicate who was responsible for obtaining the guardian's permission. Cross Reference N0169 DHS 83.12(5)(a) Notification: Incident, Injury, Changes	N 386		