STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013967	A. BUILDING: _____ B. WING _____	C 08/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY VILLAGE LLC	200 LIBERTY PLACE TOMAH, WI 54660

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 08/07/2026, Surveyor conducted a complaint investigation at Liberty Village LLC. Data collection continued through 08/19/2026. One of the 2 complaints were substantiated. Three deficiencies were identified. One of the 3 were repeat violations (see SOD UWVK11, dated 12/02/2025). Census: 15	N 000		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 was assessed when his/her needs, condition and abilities changed. Resident 1 had multiple falls and increased behaviors with no documented assessments	N 381		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013967	A. BUILDING: _____ B. WING _____	C 08/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY VILLAGE LLC	200 LIBERTY PLACE TOMAH, WI 54660

(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 381	Continued From page 1 completed after each incident. Findings include: On 05/15/2026, the department received a complaint alleging resident behavior concerns. This provider is licensed to serve up to 22 residents in the client groups physically disabled, advanced aged, and irreversible dementia/Alzheimer's. On 08/07/2026, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 01/06/2026 and had an activated Power of Attorney for Health Care (POAHC). Diagnoses included advanced dementia. A 30-day assessment was completed on 02/23/2026. This assessment summarized Resident 1 as: - Independent with ambulation, transfers, and bed mobility. - Independent with toileting and use of incontinence products. - Low fall risk with minimal history of falls. - Wandered in public areas but not intrusive; easily redirected. - Did not exhibit any destructive or abusive behaviors. - Did not exhibit any aggressive or combative behaviors. - Loss of verbal skills progressing. A hospice note indicated services started on 05/18/2026. Incident reports since Resident 1's admission	N 381		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013967	A. BUILDING: _____ B. WING _____	C 08/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY VILLAGE LLC	200 LIBERTY PLACE TOMAH, WI 54660

(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 381	Continued From page 2 included the following: 05/13/2026 - Resident 1 became aggressive towards staff using a raised voice and blocked the kitchen entrance with his/her body. Resident 1 "firmly" grabbed staff by their scrub top. Later that day, Resident 1 held a fork 4 inches from staff's neck threatening them. 05/17/2026 - Resident 1 had an unwitnessed fall in his/her room. Resident 1 resisted help and emergency medical services (EMS) were called to assist. 05/25/2026 - Resident 1 had an unwitnessed fall in his/her room. Approximately 10 minutes later, Resident 1 had another witnessed fall. 05/30/2026 - Resident 1 had an unwitnessed fall in his/her bathroom. 06/04/2026 - Resident 1 had an unwitnessed fall in his/her room. EMS were called to evaluate. 06/05/2026 - Resident 1 had an unwitnessed fall in his/her room. 06/08/2026 - Resident 1 had an unwitnessed fall in his/her room. Staff discovered a scrotal injury while changing his/her incontinence product. Resident 1 was sent out to be medically evaluated and did not return to the facility. On 08/07/2026 at 3:10 PM, Surveyor interviewed Interim Director (ID) B, Staffing Coordinator (SC) C, and Licensed Practical Nurse (LPN) D. ID B indicated when a resident had a change in condition it was their protocol for a new assessment to be done for that resident. ID B confirmed s/he could not find any other	N 381		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013967	A. BUILDING: _____ B. WING _____	C 08/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY VILLAGE LLC	200 LIBERTY PLACE TOMAH, WI 54660

(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 381	Continued From page 3 assessments since the 30-day assessment on 02/23/2026 and could not confirm if Resident 1 was reassessed after his/her falls, new behaviors, or change in condition. The provider did not ensure Resident 1 was reassessed when s/he had multiple falls, new behaviors, or change in condition since 05/13/2026. Cross Reference: N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0433 DHS 83.38(1)(i) Behavior Management	N 381		
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 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 record review and interview, the provider did not ensure Resident 1's individual service plan (ISP) was reviewed and revised when there was a change in Resident 1's needs,	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013967	A. BUILDING: _____ B. WING _____	C 08/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY VILLAGE LLC	200 LIBERTY PLACE TOMAH, WI 54660

(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 389	Continued From page 4 abilities, physical and mental condition. This is a repeat deficiency. See SOD UWVK11, dated 12/02/2025. Findings include: On 05/15/2026, the department received a complaint alleging resident behavior concerns. This provider is licensed to serve up to 22 residents in the client groups physically disabled, advanced aged, and irreversible dementia/Alzheimer's. On 08/07/2026, Surveyor reviewed the provider's policies and procedures and Resident 1's record. The Significant Change in Condition policy and procedure, read in part after a fall the, "RN or designee updates resident ISP to reflect changes." Resident 1 was admitted to the facility on 01/06/2026 and had an activated Power of Attorney for Health Care (POAHC). Diagnoses included advanced dementia. FALLS The Fall Procedure policy and procedure did not address reviewing and updating a resident's ISP after a fall. Resident 1's last individual service plan (ISP) was undated and printed on 08/07/2026. The ISP indicated Resident 1 was independent with ambulation, transfers, and toileting. The ISP indicated Resident 1 was at a high risk for falls due to cognitive impairment and unsteady gait. The ISP did not list fall prevention interventions.	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013967	A. BUILDING: _____ B. WING _____	C 08/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY VILLAGE LLC	200 LIBERTY PLACE TOMAH, WI 54660

(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 389	Continued From page 5	N 389		

The ISP indicated Resident 1 was at a low risk for wandering. The ISP indicated Resident 1 had no physical disabilities and was independent with daily activities. The ISP indicated Resident 1 was on 2-hour safety checks.

Incident reports since Resident 1's admission included the following:

05/17/2026 - Resident 1 had an unwitnessed fall in his/her room. Resident 1 resisted help and emergency medical services (EMS) were called to assist. Resident 1 had no injuries.

05/25/2026 - Resident 1 had an unwitnessed fall in his/her room. Approximately 10 minutes later, Resident 1 had witnessed fall and hit his/her head. Resident 1 was medically evaluated.

05/30/2026 - Resident 1 had an unwitnessed fall in his/her bathroom. EMS were called to evaluate Resident 1 and s/he had no injuries.

06/04/2026 - Resident 1 had an unwitnessed fall in his/her room. EMS were called to evaluate, and Resident 1 had no injuries.

06/05/2026 - Resident 1 had an unwitnessed fall in his/her room. Resident 1 was not medically evaluated and had no significant injuries.

06/08/2026 - Resident 1 had an unwitnessed fall in his/her room. Staff discovered a scrotal injury while changing his/her incontinence product. Resident 1 was sent out to be medically evaluated and did not return to the facility.

Staff observation notes for Resident 1 from 05/01/2026 to 06/08/2026 included the following additional fall not documented in the incident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013967	A. BUILDING: _____ B. WING _____	C 08/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY VILLAGE LLC	200 LIBERTY PLACE TOMAH, WI 54660

(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 389	Continued From page 6 reports: 06/01/2026 - Resident 1 had a fall on 05/29/2026. A self-report, indicated on 05/25/2026 Resident 1 was medically evaluated for a fall and diagnosed with nondisplaced left 7th and 8th rib fractures and contusions on both hips. The report indicated 2-hour checks were implemented. On 08/07/2026 at 1:29 PM, Surveyor interviewed Caregiver A. Caregiver A indicated Resident 1 would fall and staff would not know due to him/her getting him/herself back up. Caregiver A indicated fall interventions included frequent checks and redirection. On 08/07/2026 at 2:01 PM, Surveyor interviewed Caregiver F. Caregiver F indicated s/he had to check on Resident 1 frequently. Caregiver F indicated s/he was not sure what other fall prevention interventions were in place for Resident 1 but s/he also made sure Resident 1 was sitting before s/he left him/her. On 08/07/2026 at 3:10 PM, Surveyor interviewed Interim Director (ID) B, Staffing Coordinator (SC) C, and Licensed Practical Nurse (LPN) D. ID B indicated s/he had updated Resident 1's ISP with his/her change in fall risk and 2-hour safety checks. ID B indicated s/he did not update Resident 1's ISP with new fall interventions after each fall. MENTAL HEALTH - BEHAVIORS Resident 1's last individual service plan (ISP) was undated and printed on 08/07/2026. The ISP indicated under "wandering", Resident 1 needed occasional redirection and/or interventions. The ISP indicated staff would gently redirect Resident	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013967	A. BUILDING: _____ B. WING _____	C 08/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY VILLAGE LLC	200 LIBERTY PLACE TOMAH, WI 54660

(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 389	Continued From page 7	N 389		

1 to common areas from other residents' rooms as needed and to give Resident 1 time to understand directions. The ISP indicated Resident 1 required to be "lightly" monitored to prevent destructive or abusive behaviors. Staff were to keep the environment quiet and redirect Resident 1 with his/her cat, food and beverages, to call his/her child, games, or assisting with a task. The ISP indicated Resident 1 was occasionally verbally aggressive. Staff were to leave Resident 1 alone and check on him/her later. Staff were directed to speak slowly and clearly, give one step directions, and give him/her extra time to process. Other interventions described in the ISP for Resident 1 included playing music, therapeutic conversation, 2-hour safety checks, and taking him/her for a walk around the building.

A hospice note indicated services started on 05/18/2026.

Staff observation notes for Resident 1 from 05/01/2026 to 06/08/2026 included the following incidents:

05/03/2026 - While staff was trying to pass medications, Resident 1 went into another resident's room, put sanitizer into his/her soda bottle and was angry when staff would not let him/her drink it, was eating plant dirt, and grabbed a scissors off the medication cart.

05/05/2026 - Resident 1 was yelling at staff and getting close to their face.

05/06/2026 - Resident 1 wandered into another resident's room and threw little jelly containers at him/her. Resident 1 was slamming doors and wandered into two other residents' rooms.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013967	A. BUILDING: _____ B. WING _____	C 08/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY VILLAGE LLC	200 LIBERTY PLACE TOMAH, WI 54660

(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 389	Continued From page 8 05/11/2026 - Resident 1 was wandering into other resident's rooms. 05/12/2026 - Resident 1 was "slapping" string cheese on staff's face and took staff's cup. Resident 1 attempted to get into another resident's room. 05/13/2026 - Resident 1 had been chasing his/her cat and following the cat into other resident's rooms. Resident 1 was aggressive towards staff using a raised voice and physically blocking staff from exiting a doorway. Resident 1 "firmly" grabbed staff's scrub top. 05/14/2026 - Resident 1 was wandering into other resident's rooms. It took 10 minutes for staff to get Resident 1 out of the room. 05/15/2026 - Resident 1 was wandering into other resident's rooms. Resident 1 backed staff into a corner while raising his/her voice. Resident 1 followed staff around, which obstructed him/her from providing other residents' care. Staff required the med passer's assistance. Per the staff note, "I would not have been able to get dinner served without the help of the med passer because of [Resident 1] being right behind me at all times. [S/He] makes it impossible to help others when s/he is out of his/her room." 05/16/2026 - Resident 1 followed staff where they went when s/he was out of his/her room. Per staff note, "Without help from the med passer most cares for other residents would not have gotten done and some were done an hour late." 05/22/2026 - Resident 1 was wandering into other resident's rooms and had attempted to exit.	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013967	A. BUILDING: _____ B. WING _____	C 08/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY VILLAGE LLC	200 LIBERTY PLACE TOMAH, WI 54660

(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 389	Continued From page 9 05/23/2026 - Resident 1 was wandering into other resident's rooms, smashed ice from the freezer onto the counter, and was trying to tickle staff. 05/26/2026 - Resident 1 came out of his/her room without pants or underwear on and was difficult for staff to redirect. Resident 1 exited the wing into the staff break room and it took 3 different staff to redirect him/her back to his/her room. 05/28/2026 - Resident 1 was wandering into other resident rooms. 05/29/2026 - Resident 1 was wandering the halls exit seeking and had grabbed the med passer's hair. Resident 1 was wandering into other resident's rooms and had been difficult to redirect. Resident 1 had got into another resident's face while wandering into their room. Resident 1 had grabbed another resident's knick knack from their room and would not initially give it back. After supper, Resident 1 got uncomfortably close to staff attempting to touch them and kissed their head. 05/30/2026 - Resident 1 was wandering into other resident's rooms and observed trying to eat puzzle pieces. 05/31/2026 - Resident 1 was observed during the shift chewing puzzle pieces, opening the breaker box door, standing in a public bathroom in the dark with the water running, trying to eat non-edible items, and taking anything s/he found back to his/her room. Resident 1 was behind staff in the nurse's station playing with his/her hair and it took 10 minutes to redirect Resident 1 to move so staff could get out of his/her chair.	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013967	A. BUILDING: _____ B. WING _____	C 08/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY VILLAGE LLC	200 LIBERTY PLACE TOMAH, WI 54660

(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 389	Continued From page 10 06/03/2026 - Resident 1 was wandering into other resident's rooms and attempting to exit seek. Resident 1 attempted to corner staff by blocking their path. 06/04/2026 - Resident 1 urinated by a door leading outside and tried to expose him/herself in the dining room. 06/06/2026 - Resident 1 was wandering into other resident's rooms, urinated on the floor in the hallway, poured juice all over the counter, and spit ice cream all over staff, the table, and the floor. Resident 1 was trying to push staff out of the way during medication pass and when trying to exit another resident's room. 06/08/2026 - Resident 1 would not sit in his/her wheelchair when staff attempted to get him/her in it after a near fall. Resident 1 was combative, yelled, and would stiffen his/her body up. After an unwittnessed fall later in the day, it was discovered Resident 1 had a scrotal injury and was sent to be medically evaluated. Resident 1 did not return to the facility. Staff observation notes for Resident 1 from 05/01/2026 to 06/08/2026 included documentation of the following provider interventions related to Resident 1's behaviors: 05/12/2026 - Per Chief Operating Officer (COO) H's note indicated s/he spoke to Power of Attorney for Health Care (POAHC) E about upcoming primary physician appointment and received consent for hospice evaluation. The note read in part, "Resident has had episodes of increased wandering and becoming intrusive in other resident's rooms."	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013967	A. BUILDING: _____ B. WING _____	C 08/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY VILLAGE LLC	200 LIBERTY PLACE TOMAH, WI 54660

(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 389	Continued From page 11 05/14/2026 - Per ID B's note staff were to use the interventions updated in the ISP and if those were not effective then staff were to give Resident 1 an as needed (PRN) medication. On 08/07/2026 at 1:29 PM, Surveyor interviewed Caregiver A. Caregiver A indicated s/he was not sure Resident 1's behaviors were manageable due to not understanding much with his/her disease progression. Caregiver A stated Resident 1 was mostly verbally aggressive but was disruptive, would threaten staff, would wander into other resident's rooms, was trying to eat non-edible items, and was starting to get combative. Caregiver A stated interventions in place included frequent checks and redirecting Resident 1. Caregiver A indicated towards the end of Resident 1's admission, they needed 2 staff on the wing Resident 1 resided due to his/her behaviors. On 08/07/2026 at 2:01 PM, Surveyor interviewed Caregiver F. Caregiver F indicated s/he had to check on Resident 1 frequently and s/he was sometimes aggressive but easy to redirect. Caregiver F indicated towards the end of Resident 1's admission s/he almost needed 1:1 staffing due to his/her behavior of wandering into other resident's rooms and occasional aggression towards staff. On 08/07/2026 at 2:27 PM, Surveyor interviewed Caregiver G. Caregiver G indicated Resident 1 was hard to redirect. Caregiver G indicated Resident 1 needed 1:1 staffing due to staff having to constantly redirect him/her with wandering and getting into everything. On 08/07/2026 at 3:10 PM, Surveyor interviewed ID B, SC C, and LPN D. ID B indicated s/he had	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013967	A. BUILDING: _____ B. WING _____	C 08/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY VILLAGE LLC	200 LIBERTY PLACE TOMAH, WI 54660

(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 389	Continued From page 12	N 389		

not updated the ISP to reflect Resident 1 was receiving hospice services and had not updated the ISP since 05/14/2026 with behavioral interventions.

REVIEWED AND PARTIES SIGNED
On 08/07/2026 at approximately 11:30 AM, ID B presented Surveyor with Resident 1's last ISP. ID B indicated s/he was unable to find a signature page and was unsure when it was last updated.

Resident 1's last updated ISP was undated and printed on 08/07/2026. The ISP did not contain a signature page.

On 08/07/2026 at 3:10 PM, ID B, SC C, and LPN D. ID B indicated Resident 1's ISP had not been updated since s/he took over as ID in April/May 2026.

On 08/19/2026 at 8:26 AM, Surveyor interviewed POAHC E. POAHC E confirmed s/he reviewed an updated ISP for Resident 1 last in April 2026 but had not met with ID B to review and update his/her ISP since then.

Resident 1 had multiple falls, and his/her ISP was not reviewed and revised with additional fall interventions after each fall. Resident 1 had change in his/her disease progression which led to increased behaviors and admission to hospice services. Resident 1's ISP did not reflect all these behaviors or that s/he received hospice services. The provider was unable to provide evidence of when the ISP was last updated and the signature page of the parties involved.

Cross Reference:
N0381 DHS 83.35(1)(a) Pre-Admission And Ongoing Assessments

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013967	A. BUILDING: _____ B. WING _____	C 08/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY VILLAGE LLC	200 LIBERTY PLACE TOMAH, WI 54660

(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 389	Continued From page 13 N0433 DHS 83.38(1)(i) Behavior Management	N 389		
N 433	83.38(1)(i) Behavior management. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Behavior management. The CBRF shall provide services to manage resident ' s behaviors that may be harmful to themselves or others. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure services were provided to manage residents' behaviors. Findings include: On 05/15/2026, the department received a complaint alleging resident behavior concerns. This provider is licensed to serve up to 22 residents in the client groups physically disabled, advanced aged, and irreversible dementia/Alzheimer's. On 08/07/2026 at 9:21 AM, Surveyor interviewed Interim Director (ID) B. ID B stated their typical staffing pattern was 1 caregiver on each wing of the Community-Based Residential Facility (CBRF) and a med passer floating back and forth. On 08/07/2026 at approximately 9:30 AM,	N 433		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013967	A. BUILDING: _____ B. WING _____	C 08/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY VILLAGE LLC	200 LIBERTY PLACE TOMAH, WI 54660

(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 433	Continued From page 14	N 433		

Surveyor observed the layout of the facility. Upon entrance to the facility was a large dining hall where Residential Care Apartment Complex (RCAC) tenants ate their meals. A hallway spit off into two wings on either side of the dining hall containing the CBRF. Each wing had a coded delayed egress door to access the CBRF. Residents could move freely out the door, but an alarm would sound. Both wings had approximately 11 resident rooms on each side with a current census of 15.

On 08/07/2026, Surveyor reviewed Resident 1's record.

Resident 1 was admitted to the facility on 01/06/2026 and had an activated Power of Attorney for Health Care (POAHC). Diagnoses included advanced dementia. Per Resident 1's face sheet s/he was discharged from the facility on 06/29/2026.

A hospice note indicated services started on 05/18/2026.

An incident report dated 05/13/2026, indicated Resident 1 became aggressive towards staff using a raised voice and blocked the kitchen entrance with his/her body. Resident 1 "firmly" grabbed staff by their scrub top. Later that day, Resident 1 held a fork 4 inches from staff's neck threatening them.

Staff observation notes for Resident 1 from 05/01/2026 to 06/08/2026 included the following:

05/03/2026 - While staff was trying to pass medications, Resident 1 went into another resident's room, put sanitizer into his/her soda bottle and was angry when staff would not let

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013967	A. BUILDING: _____ B. WING _____	C 08/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY VILLAGE LLC	200 LIBERTY PLACE TOMAH, WI 54660

(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 433	Continued From page 15	N 433		

him/her drink it, was eating plant dirt, and grabbed a scissors off the medication cart.

05/05/2026 - Resident 1 was yelling at staff and getting close to their face.

05/06/2026 - Resident 1 wandered into another resident's room and threw little jelly containers at him/her. Resident 1 was slamming doors and wandered into two other residents' rooms. Per the staff note, "the residents in those rooms are scared."

05/11/2026 - Resident 1 was wandering into other resident's rooms.

05/12/2026 - Resident 1 was "slapping" string cheese on staff's face and took staff's cup. Resident 1 attempted to get into another resident's room. Resident 1 was yelling.

05/13/2026 - Resident 1 had been chasing his/her cat and following the cat into other resident's rooms. Resident 1 was aggressive towards staff using a raised voice and physically blocking staff from exiting a doorway. Resident 1 "firmly" grabbed staff's scrub top.

05/14/2026 - Resident 1 was wandering into other resident's rooms. It took 10 minutes for staff to get Resident 1 out of a room.

05/15/2026 - Resident 1 was wandering into other resident's rooms. Resident 1 backed staff into a corner while raising his/her voice. Resident 1 followed staff around, which obstructed him/her from providing other residents' care. Staff required the med passer's assistance. Per the staff note, "I would not have been able to get dinner served without the help of the med passer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013967	A. BUILDING: _____ B. WING _____	C 08/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY VILLAGE LLC	200 LIBERTY PLACE TOMAH, WI 54660

(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 433	Continued From page 16	N 433		

because of [Resident 1] being right behind me at all times. [S/He] makes it impossible to help others when s/he is out of his/her room."

05/16/2026 - Resident 1 followed staff where they went when s/he was out of his/her room. Per staff note, "Without help from the med passer most cares for other residents would not have gotten done and some were done an hour late."

05/22/2026 - Resident 1 was wandering into other resident's rooms and had attempted to exit.

05/23/2026 - Resident 1 was wandering into other resident's rooms, smashed ice from the freezer onto the counter, and was trying to tickle staff.

05/26/2026 - Resident 1 came out of his/her room without pants or underwear on and was difficult for staff to redirect. Resident 1 exited the wing into the staff break room and it took 3 different staff to redirect him/her back to his/her room.

05/28/2026 - Resident 1 was wandering into other resident rooms.

05/29/2026 - Resident 1 was wandering the halls exit seeking and had grabbed the med passer's hair. Resident 1 was wandering into other resident's rooms and had been difficult to redirect. Resident 1 had got into another resident's face while wandering into their room. Resident 1 had grabbed another resident's knick knack from their room and would not initially give it back. After supper, Resident 1 got uncomfortably close to staff attempting to touch them and kissed their head.

05/30/2026 - Per staff note, "Yesterday while passing meds, writer was stopped by a resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013967	A. BUILDING: _____ B. WING _____	C 08/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY VILLAGE LLC	200 LIBERTY PLACE TOMAH, WI 54660

(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 433	Continued From page 17	N 433		

stating that they did not feel comfortable with [Resident 1] walking around in the kitchen as they did not feel it was unsanitary and did not feel like eating meals when this resident is in there. Resident had also told writer that they feel as though the rest of the residents are being ignored because of all the time that staff needs to spend redirecting this resident. This resident had wandered into every other resident's rooms at least once during second shift, and every resident had at different times told med passer they felt they had no privacy in their own rooms because [Resident 1] keeps wandering into their rooms." Resident 1 was wandering into other resident's rooms and observed trying to eat puzzle pieces.

05/31/2026 - Resident 1 was observed during the shift chewing puzzle pieces, opening the breaker box door, standing in a public bathroom in the dark with the water running, trying to eat non-edible items, and taking anything s/he found back to his/her room. Resident 1 was behind staff in the nurse's station playing with his/her hair and it took 10 minutes to redirect Resident 1 to move so staff could get out of his/her chair.

06/03/2026 - Resident 1 was wandering into other resident's rooms and attempting to exit seek. Resident 1 attempted to corner staff by blocking their path.

06/04/2026 - Resident 1 urinated by a door leading outside and tried to expose him/herself in the dining room.

06/06/2026 - Resident 1 was wandering into other resident's rooms, urinated on the floor in the hallway, poured juice all over the counter, and spit ice cream all over staff, the table, and the floor. Resident 1 was trying to push staff out of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013967	A. BUILDING: _____ B. WING _____	C 08/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY VILLAGE LLC	200 LIBERTY PLACE TOMAH, WI 54660

(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 433	Continued From page 18 the way during medication pass and when trying to exit another resident's room. Resident 1 had taken food from another resident's during mealtime. 06/08/2026 - Resident 1 would not sit in his/her wheelchair when staff attempted to get him/her in it after a near fall. Resident 1 was combative, yelled, and would stiffen his/her body up. After an unwittnessed fall later in the day, it was discovered Resident 1 had a scrotal injury and was sent to be medically evaluated. Resident 1 did not return to the facility. Resident 1's last individual service plan (ISP) was undated and printed on 08/07/2026. The ISP indicated Resident 1 was independent with ambulation and transfers. The ISP indicated under "wandering", Resident 1 needed occasional redirection and/or interventions. The ISP indicated staff would gently redirect Resident 1 to common areas from other residents' rooms as needed and to give Resident 1 time to understand directions. The ISP indicated Resident 1 required to be "lightly" monitored to prevent destructive or abusive behaviors. Staff were to keep the environment quiet and redirect Resident 1 with his/her cat, food and beverages, to call his/her child, games, or assisting with a task. The ISP indicated Resident 1 was occasionally verbally aggressive. Staff were to leave Resident 1 alone and check on him/her later. Staff were directed to speak slowly and clearly, give one step directions, and give him/her extra time to process. Other interventions described in the ISP for Resident 1 included playing music, therapeutic conversation, 2-hour safety checks, and taking him/her for a walk around the building.	N 433		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013967	A. BUILDING: _____ B. WING _____	C 08/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY VILLAGE LLC	200 LIBERTY PLACE TOMAH, WI 54660

(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 433	Continued From page 19 A hospital note dated 06/08/2026, read in part, "...it is apparent that [Resident 1] is struggling in current environment, needing more care than can be provided there." On 08/07/2026 at 1:29 PM, Surveyor interviewed Caregiver A. Caregiver A indicated s/he was not sure Resident 1's behaviors were manageable due to not understanding much with his/her disease progression. Caregiver A stated Resident 1 was mostly verbally aggressive but was disruptive, would threaten staff, would wander into other resident's rooms, was trying to eat non-edible items, and was starting to get combative. Caregiver A stated interventions in place included frequent checks and redirecting Resident 1. Caregiver A indicated towards the end of Resident 1's admission, they needed 2 staff on the wing Resident 1 resided due to his/her behaviors. Caregiver A stated it got to a point where other residents feared Resident 1 and would refuse to come down to dinner. Caregiver A indicated s/he brought these concerns to management but was told they could not have a second staff and the other residents could lock their doors. Caregiver A indicated not all the residents on the wing had locks on their room doors. Caregiver A indicated one time it took 40 minutes and 3 staff to redirect Resident 1 away from another resident's room door. On 08/07/2026 at 2:01 PM, Surveyor interviewed Caregiver F. Caregiver F indicated s/he had to check on Resident 1 frequently and was sometimes aggressive but easy to redirect. Caregiver F indicated towards the end of Resident 1's admission s/he almost needed 1:1 staffing due to his/her behavior of wandering into	N 433		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013967	A. BUILDING: _____ B. WING _____	C 08/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY VILLAGE LLC	200 LIBERTY PLACE TOMAH, WI 54660

(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 433	Continued From page 20 other resident's rooms and occasional aggression towards staff. On 08/07/2026 at 2:27 PM, Surveyor interviewed Caregiver G. Caregiver G indicated Resident 1 was hard to redirect. Caregiver G indicated Resident 1 needed 1:1 staffing due to staff having to constantly redirect him/her with wandering and getting into everything. On 08/07/2026 at 3:10 PM, Surveyor interviewed ID B, Staffing Coordinator (SC) C, and Licensed Practical Nurse (LPN) D. ID B indicated Resident 1 would get agitated towards staff when s/he was told s/he could not do something. ID B indicated Resident 1's condition progressed quickly towards the end of his/her admission. ID B indicated they did education with staff related to managing Resident 1's behaviors and redirection. ID B indicated Resident 1 was not at the appropriate level of care towards the end of his/her admission and was getting to the point of needing 1:1 staff. ID B indicated they had not issued Resident 1 a 30-day notice due to getting Resident 1 hospice services. ID B indicated Resident 1's ISP had not been updated since s/he took over as ID in April/May 2026. Resident 1's record included a substantial number of documented incidents of aggression/agitation towards staff and wandering into other resident's rooms because of his/her disease progression. The provider did not ensure an effective behavior management plan was implemented. Cross Reference: N0381 DHS 83.35(1)(a) Pre-Admission And Ongoing Assessments N0389 DHS 83.35(3)(d) Service Plans Updated	N 433		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013967	A. BUILDING: _____ B. WING _____	C 08/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY VILLAGE LLC	**200 LIBERTY PLACE TOMAH, WI 54660**

(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 433	Continued From page 21 Annually Or On Changes	N 433		