STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0021211	A. BUILDING: _____ B. WING _____	C 07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HATTIES GLEN WAUNAKEE	1001 QUINN DR WAUNAKEE, WI 53597

(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 07/23/2026, the bureau of assisted living southern regional office conducted a complaint investigation at Hattie's Glen a CBRF located in Waunakee, WI. As a result of this survey, 3 violations of DHS Chapter 83 were identified. The complaint was unsubstantiated. Census: 27	N 000		
N 247	83.22(1)-(4) Task specific training. The CBRF shall provide, obtain or otherwise ensure adequate training for employees performing job duties in all of the following: Assessment of residents. All employees responsible for resident assessment shall successfully complete training in the assessment of residents prior to assuming these job duties. Specific training topics shall include: assessment methodology, assessment of changes in condition, sources of assessment information, and documentation of the assessment. Individual service plan development. All employees responsible for service plan development shall successfully complete training in individual service plan development prior to assuming these job duties. Specific training topics shall include: identification of the resident ' s needs and desired outcomes, development of goals and interventions, service plan evaluation and review of progress. Provision of personal care. All employees responsible for providing assistance with activities of daily living shall successfully complete training prior to assuming these job duties. Specific training topics shall include, as appropriate:	N 247		

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
	0021211	A. BUILDING: _____ B. WING _____	C 07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HATTIES GLEN WAUNAKEE	1001 QUINN DR WAUNAKEE, WI 53597

(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 247	Continued From page 1 bathing, eating, dressing, oral hygiene, nail and foot care, toileting and incontinence care, positioning and body alignment, and mobility and transferring. Dietary training. All employees performing dietary duties shall complete dietary training within 90 days after assuming these job duties. Specific training topics shall include: determining nutritional needs, menu planning, food preparation and food sanitation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 3 caregivers received adequate training in provision of personal cares before providing assistance with bathing, eating, dressing, oral hygiene, toileting, incontinence care, and positioning/body alignment. FINDINGS INCLUDE: On 07/10/2026, the Department received a complaint was allegations of inadequate personal care services to meet resident needs. On 07/23/2026, Surveyors arrived at facility for a complaint investigation. EXAMPLE 1: Caregiver C On 07/23/2026, Surveyor reviewed Caregiver C's staff record. On the facility staff roster Caregiver C's position was titled "Caregiver," and his/her date of hire was 10/29/2025. Caregiver C's training record did not have documentation related to bathing, eating, dressing, oral hygiene,	N 247		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0021211	A. BUILDING: _____ B. WING _____	C 07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HATTIES GLEN WAUNAKEE	1001 QUINN DR WAUNAKEE, WI 53597

(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 247	Continued From page 2 toileting, incontinence care, and positioning/body alignment. On 07/23/2026, Surveyor looked up Caregiver C on the state of Wisconsin Department of Safety and Professional Services (DSPS) certification database. Caregiver C was not documented as a certified nursing assistant (CNA). EXAMPLE 2: Caregiver D On 07/23/2026, Surveyor reviewed Caregiver D's staff record. On the facility roster Caregiver D's position was titled "Caregiver," and his/her date of hire was 12/30/2025. Caregiver D's training record did not have documentation related to bathing, eating, dressing, oral hygiene, toileting, incontinence care, and positioning/body alignment. On 07/23/2026, Surveyor looked up Caregiver D on the state of Wisconsin Department of Safety and Professional Services (DSPS) certification database. Caregiver D was not documented as a certified nursing assistant (CNA). EXAMPLE 3: Med Tech E On 07/23/2026, Surveyor reviewed Med Tech E's staff record. On the facility roster Med Tech E's position was titled "Med Tech," and his/her date of hire was 07/13/2026. Med Tech E's training record did not have documentation related to bathing, eating, dressing, oral hygiene, toileting, incontinence care, and positioning/body alignment. On 07/23/2026, Surveyor reviewed the facility July 2026 staff schedule. Med Tech E was documented as "training," from 07/13/2026 to	N 247		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0021211	A. BUILDING: _____ B. WING _____	C 07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HATTIES GLEN WAUNAKEE	1001 QUINN DR WAUNAKEE, WI 53597

(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 247	Continued From page 3 07/16/2026. Med Tech E was documented as working as a "PM Float," on 7/18/2026 & 07/19/2026. Med Tech E was documented as training on medication administration on 07/20/2026. Med Tech E was documented as "AM Caregiver Upstairs," on 07/21/2026. On 07/23/2026, Surveyor looked up Med Tech E on the state of Wisconsin Department of Safety and Professional Services (DSPS) certification database. Med Tech E was not documented as a certified nursing assistant (CNA). EXIT INTERVIEW: On 07/23/2026 at 2:00 PM, Surveyor discussed the above concerns with Administrator A and Director B. Administrator A and Director B acknowledged that 3 of 3 staff records reviewed did not contain complete documentation of training in personal cares. Administrator A and Director B acknowledged Caregiver C, Caregiver D and Med Tech E were not CNA's. Director B reported that pervious administrator hadn't documented staff training and since 07/13/2026 s/he has implemented personal cares training for all staff expected to complete personal cares on residents. Director B was able to show Surveyor personal cares training modules s/he planned to obtain documentation of completion as soon as possible.	N 247		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s	N 387		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0021211	A. BUILDING: _____ B. WING _____	C 07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HATTIES GLEN WAUNAKEE	1001 QUINN DR WAUNAKEE, WI 53597

(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 387	Continued From page 4	N 387		

legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not involve the resident and the resident's legal representative, as appropriate, in developing the individual service plan (ISP) and the resident or the resident's legal representative signed the plan acknowledging their involvement in, understanding of an agreement with the plan.

On 07/23/2026, Two of the 3 ISPs reviewed were not signed by the resident or resident's legal representative, as appropriate.

FINDINGS INCLUDE:

On 07/23/2026, Surveyors arrived at facility for a complaint investigation.

EXAMPLE 1: Resident 1

On 07/23/2026, Surveyor reviewed Resident 1's facility record. Resident 1 was admitted to the facility on 10/27/2025. Resident 1 was documented as having an activated power of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0021211	A. BUILDING: _____ B. WING _____	C 07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HATTIES GLEN WAUNAKEE	1001 QUINN DR WAUNAKEE, WI 53597

(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 387	Continued From page 5 attorney (Family Member F). On 07/23/2026, Surveyor reviewed Resident 1's individualized service plan (ISP) dated 12/07/2025. The ISP wasn't signed by Resident 1 or Family Member F. EXAMPLE 2: Resident 2 On 07/23/2026, Surveyor reviewed Resident 2's facility record. Resident 2 was admitted to the facility on 06/01/2026. Resident 2 was documented as his/her own decision maker. On 07/23/2026, Surveyor reviewed Resident 2's ISP dated 07/09/2026. The ISP wasn't signed by Resident 2. EXIT INTERVIEW: On 07/23/2026 at 2:00 PM, Surveyor discussed the above concerns with Administrator A and Director B. Administrator A reported s/he started his/her role on 07/13/2026 and had been working towards updating ISPs. Administrator A and Director B acknowledged Resident 1 nor Resident 2 had signed their own ISPs. Director B verified that Resident 2 was his/her own person, and the Family Member F was Resident 1's activated power of attorney. Director B acknowledged Family Member F hadn't signed Resident 1's current ISP.	N 387		
N 489	83.44(2)(a) Rooms clean and free from odors. The CBRF shall keep all rooms clean and shall make reasonable attempts to keep all rooms free from odors.	N 489		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0021211	A. BUILDING: _____ B. WING _____	C 07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HATTIES GLEN WAUNAKEE	1001 QUINN DR WAUNAKEE, WI 53597

(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 489	Continued From page 6 This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that 4 resident apartments were free from odors. There were 4 resident rooms that smelled strongly of urine. Findings include: On 07/23/2026 at 9:30 AM Surveyor toured the physical environment. OBSERVATIONS: There was a strong smell of urine in hallway outside of Resident 4's room. The odor worsened as Surveyor entered Resident 4's room. Resident 4 appeared clean and was wearing clean clothing. The odor seemed to be coming from furniture and flooring. There was a strong smell of urine in hallway outside of Resident 5's room. The odor worsened as Surveyor entered Resident 5's room. Resident 5 appeared clean and was wearing clean clothing. The odor seemed to be coming from furniture and flooring. There was a strong smell of urine in hallway outside of Resident 6 and 7's room. The odor worsened as Surveyor entered Resident 6 and 7's room. Residents 6 and 7 appeared clean and was wearing clean clothing. The odor seemed to be coming from furniture and flooring. There was a strong smell of urine in hallway outside of Resident 8's room. The odor worsened as Surveyor entered Resident 8's room. Resident 8 appeared clean and was wearing clean clothing. The odor seemed to be coming from furniture and flooring.	N 489		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0021211	A. BUILDING: _____ B. WING _____	C 07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HATTIES GLEN WAUNAKEE	1001 QUINN DR WAUNAKEE, WI 53597

(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 489	Continued From page 7 On 07/23/2026 at 12:30 PM, Surveyor interviewed Administrator A. Administrator A acknowledged that there were a few rooms that did smell strongly of urine. Administrator A stated that s/he was trying to eliminate the odor by thoroughly cleaning the carpeting and replacing furniture. Administrator A stated that s/he had been in contact with at least 2 resident families and are working with them to get the furniture replaced.	N 489		