STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017474	A. BUILDING: _____ B. WING _____	C 08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITES AT BELOIT (THE)	2122 PIONEER DRIVE BELOIT, WI 53511

(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 From 07/29/2026 through 08/11/2026, Surveyor conducted 2 complaint investigations and a standard survey at Suites At Beloit, a CBRF located in Beloit, WI. Five deficiencies were identified. Four of the 5 deficiencies were repeat - See Statement of Deficiency (SOD) 7BFM11, dated 01/05/2023, KEVY11, dated 07/12/2021, and 1T9T11, dated 05/12/2021 The 2 complaints were substantiated. Census: 38	N 000		
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 3 of 3 residents reviewed received their medications as prescribed. Resident 3 did not receive his/her brimonidine .2% eye drops and latanoprost eye drops as prescribed. Resident 4 did not receive his/her benefiber powder as prescribed.	N 352		

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

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N 352	Continued From page 1 Resident 1 did not receive his/her polyethylene glycol powder as prescribed. This is a repeat deficiency, see Statement of Deficiency (SOD) 1T9T11, dated 05/12/2021. Findings include: On 07/29/2026 at approximately 10:00 AM, Surveyor arrived at the facility to conduct a complaint investigation alleging that residents were not getting their medications as prescribed. On 07/29/2026 at approximately 1:45 PM, Surveyor completed a medication cart audit with Caregiver C and identified the following: Example 1 - Resident 3 On 07/29/2026 at approximately 1:45 PM, Surveyor observed 2 bottles of eyedrops for Resident 3. The first bottle of brimonidine .2% eye drops was dated 04/08/2026 and was over half full. The second bottle of latanoprost .005% eye drops were dated 02/23/2026 and was about 3 quarters empty. Caregiver C stated that Resident 3 did not usually refuse his/her medications. Caregiver C acknowledged the dates on the brimondine .2 % eye drop bottle was 04/08/2026 and the latanoprost .005% eye drop bottle was 02/23/2026. At approximately 11:30 AM, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider's facility on 07/15/2024. Resident 3's physician order included the following: -Brimondine .2% eye drop (Start Date: 11/25/2025) - Instill 1 drop into both eyes 2 times a day	N 352		

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SUITES AT BELOIT (THE)	2122 PIONEER DRIVE BELOIT, WI 53511

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N 352	Continued From page 2 -Latanoprost .005% eye drop (Start Date: 11/25/2025) - Instill 1 drop into both eyes at bedtime. Surveyor reviewed the Medication Administration Record (MAR), dated 04/09/2026 through 07/29/2026, for Resident 3. Resident 3's MAR indicated that the brimondine .2% eye drops and latanoprost .005% eye drops had been administered daily. At approximately 3:09 PM, Surveyor discussed concern with Executive Director A that Resident 3 had not gotten the brimondine .2 % eye drops, dated 04/08/2026 and latanoprost .005% eye drops, dated 02/23/2026 that were prescribed daily. Executive Director A acknowledged that both bottles of eye drops should have been administered and gone by 07/29/2026. On 08/03/2026 at 11:12 AM, Surveyor interviewed Pharmacy Tech D. Pharmacy Tech D confirmed that 1 bottle of the brimondine .2% eye drops contained a 25-day dose with 20 drops per ml. Pharmacy Tech D confirmed that the last order date for the brimondine .2% eye drop medication was 04/08/2026. Pharmacy Tech D confirmed that 1 bottle of latanoprost .005% eye drops contained a 25-day dose with 20 drops per ml. Pharmacy Tech D confirmed the last order date for the latanoprost .005 % eye drop medication was 02/23/2026. Example 2 - Resident 4 On 07/29/2026 at approximately 1:50 PM, Surveyor observed 1 bottle of benefiber powder for Resident 4. The bottle of benefiber powder was dated 12/22/2025 and was almost empty.	N 352		

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N 352	Continued From page 3	N 352		

Caregiver C stated that Resident 4 did not usually refuse his/her medications. Caregiver C acknowledged the date on the benefiber powder bottle to be 12/22/2025.

At approximately 12:00 PM, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the provider's facility on 02/26/2024. Resident 4's physician order included the following:

-benefiber powder (Start Date: 10/23/2025) - Dissolve 2 grams (1 teaspoon) in 8oz of liquid and drink by mouth 2 times daily.

Surveyor reviewed the Medication Administration Record (MAR), dated 04/09/2026 through 07/29/2026, for Resident 4. Resident 4's MAR indicated that the benefiber powder had been administered daily.

At approximately 3:09 PM, Surveyor discussed concern with Executive Director A that Resident 4 had not gotten the benefiber powder, dated 12/22/2025 that were prescribed daily. Executive Director A acknowledged that the benefiber powder, dated 12/22/2025, should have been administered and gone by 07/29/2026.

On 08/03/2026 at 11:12 AM, Surveyor interviewed Pharmacy Tech D. Pharmacy Tech D confirmed that 1 bottle of the bebfiber powder contained a 38-day dose. Pharmacy Tech D confirmed that the benefiber powder had been ordered by the facility 2 times in the last 6 months with delivery dates of 12/22/2025 and 06/25/2026.

Example 3 - Resident 1

On 07/29/2026 at approximately 1:55 PM, Surveyor observed 1 bottle of polyethylene glycol

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SUITES AT BELOIT (THE)	2122 PIONEER DRIVE BELOIT, WI 53511

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N 352	Continued From page 4	N 352		

powder for Resident 1. The bottle of polyethylene glycol powder was dated 03/13/2026 and was over half full. Caregiver C stated that Resident 1 did not usually refuse his/her medications. Caregiver C acknowledged the date on the polyethylene glycol powder bottle to be 03/13/2026.

At approximately 12:10 PM, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 09/18/2025. Resident 1's physician order included the following:

-polyethylene glycol powder (Start Date: 04/13/2026) - Dissolve 1 capful in 8 ounces of liquid and drink daily for constipation.

Surveyor reviewed the Medication Administration Record (MAR), dated 04/09/2026 through 07/29/2026, for Resident 1. Resident 1's MAR indicated that the polyethylene glycol powder had been administered daily.

At approximately 3:09 PM, Surveyor discussed concern with Executive Director A that Resident 1 had not gotten the polyethylene glycol powder, dated 03/13/2026 that were prescribed daily. Executive Director A acknowledged that the polyethylene glycol powder, dated 03/13/2026, should have been administered and gone by 07/29/2026.

On 08/03/2026 at 11:12 AM, Surveyor interviewed Pharmacy Tech D. Pharmacy Tech D confirmed that 1 bottle of the polyethylene glycol contained a 30-day dose. Pharmacy Tech D confirmed that the polyethylene glycol powder was last ordered by the facility on 03/13/2026.

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N 419	Continued From page 5	N 419		
N 419	83.37(3)(c) Medication storage: locked cabinet. Administered by facility. The CBRF shall keep medicine cabinets locked and the key available only to personnel identified by the CBRF. This Rule is not met as evidenced by: Based on observation and interview, the provider did not keep all medications administered by the facility locked in 1 of 1 resident rooms. This is a repeat deficiency, see Statement of Deficiency (SOD) 7BFM11, dated 01/05/2023. Findings include: The facility is licensed to serve up to 54 residents who may be advanced age, physically disabled, have irreversible dementia/Alzheimer's disease, advanced age, and/or be terminally ill. On 07/29/2026, Surveyor toured the facility and observed the following medications unsecured in Resident 2's room near Resident 2's bed: -Triamcinolone acetonide .1% cream -Nystatin topical powder On 07/29/2026 at 3:09 PM, Surveyor conducted an exit conference and shared findings with Administrator A and Nurse Manager B. Administrator A acknowledged that the medications were in Resident 2's room. Administrator A stated that s/he will be sure to get all the medications locked up in Resident 2's room.	N 419		

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N 431	Continued From page 6	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 record review and interview, the provider did not ensure 1 of 2 residents reviewed had their health monitored and recorded in their record. Resident 1's blood sugars were not monitored and/or documented as ordered. This is a repeat deficiency, see Statement of Deficiency (SOD), 7BFM11, dated 01/05/2023	N 431		

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and KEVY11, dated 07/12/2021.

Findings include:

On 07/29/2026 at approximately 11:30 AM, Surveyor reviewed Resident 1's facility record. Resident 1 was admitted to the provider's facility on 09/18/2025 with a diagnosis of diabetes. Resident 1's Medication Administration Record (MAR), dated 05/07/2026 to 07/29/2026 had a physician ordered blood sugar check once weekly (Start Date 05/28/2025.) The MAR indicated to See Diabetic MAR for May 2026, June 2026 and July 2026.

On 07/29/2026 at approximately 1:30 PM, Surveyor requested the diabetic MAR for Resident 1 from Nurse Manager B and Administrator A. Nurse Manager B stated that Resident 1 did not have his/her blood sugars checked weekly and did not have a diabetic MAR. Surveyor reviewed the MAR's with Nurse Manager B. Nurse Manager B stated the "See Diabetic MAR was written on the MAR in error."

On 08/03/2026 at 11:12 AM, Surveyor interviewed Pharmacy Tech D. Pharmacy Tech D confirmed that Resident 1 had a written order with a start date of 05/28/2025 to check blood sugars weekly on Wednesdays.

On 08/06/2026 at 1:12 PM, Surveyor interviewed Dr. E. Dr. E stated that Resident 1 had a diagnosis of diabetes and was taking medication for diabetes. Dr. E stated that Resident 1 should be taking his/her blood sugars weekly as ordered.

On 08/11/2026 at 1:27 PM., Surveyor reviewed concern with Administrator A that Resident 1's blood sugars were not documented weekly on the

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N 431	Continued From page 8 diabetic MAR. Administrator A stated that s/he was taking notes and would ensure with Nurse Manager B that Resident 1's weekly blood sugars would be documented going forward.	N 431		
N 491	83.44(2)(c) Interior floors, walls and ceilings. Every interior floor, wall and ceiling shall be clean and in good repair. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the facility's walls, ceilings and floors were in good repair. Findings include: On 07/29/2026 at 10:30 AM, Surveyor toured the provider's facility with Director of Envi Srv F. Surveyor observed the following concerns: Ceilings: -The ceiling in the dining room had several large open areas to the duct work. Carpeting and flooring: - carpets were stained throughout the main hallways -there were several spots in the main hallways on the carpet that had dark thick color that appeared burned Walls: -The walls along the hallways have many scrapes and gouges taken out.	N 491		

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N 491	Continued From page 9 -The dining room wall corners have dents and scrapes on all the corners -All walls need to be painted on the main areas of the facility. On 07/29/2026 at approximately 11:15 AM, Surveyor interviewed Director of Envi Srv F. Director of Envi Srv F stated that the large holes in the ceiling were from a leak with the sprinkler system back in early June. Director of Envi Srv F stated that there was a change in the maintenance position. Director of Envi Srv F had the new maintenance person on the tour and stated that s/he was being trained. Director of Envi Srv F stated that the facility would continue to work on the ceiling, walls and floor. On 07/29/2026 at approximately 3:09 PM, Surveyor reviewed concern with Administrator A. Administrator A acknowledged that the ceilings, floors and walls has some concerns. Administrator A stated that s/he would work with maintenance going forward with the concerns.	N 491		
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 be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping	N 525		

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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 record review and interview, the provider did not conduct all quarterly fire drills for 2025. There was no documented fire drill for 2025 to simulate during sleeping hours.

This is a repeat deficiency. See Statement of Deficiency (SOD), 7BFM11, dated 01/05/2023.

Findings include:

On 07/29/206 at approximately 1:30 PM , Surveyor reviewed the facility's documented fire drills. Documentation included only 2 fire drills conducted in 2025. The 2 drills that were documented did not include a drill simulated during sleeping hours. Surveyor asked Administrator A if there was a simulated drill completed in 2025. Administrator A was unaware of a simulated sleeping drill during 2025.

On 07/29/2026 at approximately 3:09 PM, Surveyor discussed concern that records did not include documentation of the required 2025 fire drills, to include 1 simulated sleeping drill, with Administrator A. Administrator A acknowledged they were unable to provide documentation of all quarterly 2025 fire drills. Administrator A stated that s/he will ensure drills get completed for 2026.