STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019048	A. BUILDING: _____ B. WING _____	07/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IBERIAS HOUSE OF HOPE LLC	1920 MADERA ST WAUKESHA, WI 53189

(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 with information gathered through 07/28/2026, Surveyor conducted a standard survey at Iberias House Of Hope LLC. Seven deficiencies were identified. Five of 7 deficiencies were repeat violations. See Statement Of Deficiency 1QO611, dated 12/14/2023. Census: 8	N 000		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each employee was screened for clinically apparent communicable disease including tuberculosis (TB) by a physician, physician assistant, clinical nurse practitioner or registered nurse within 90 days prior before the start of employment for 2 of 2	N 220		

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

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N 220	Continued From page 1	N 220		

employees reviewed.

Caregiver B and Caregiver C were not screened for communicable disease.

This is a repeat violation. See Statement Of Deficiency 1QO611, dated 12/14/2023.

Findings include:

The facility is licensed as a CLASS CNA (nonambulatory) CBRF able to serve up to 16 residents within the client groups of physically disabled, developmentally disabled and emotionally disturbed/mental illness.

On 07/23/2026, Surveyor reviewed Caregiver B's and Caregiver C's employee records.

Example 1- Caregiver B
Caregiver B was hired 04/04/2026. His/her record contained a TB test completed 04/15/2026. The record did not contain a communicable disease screen.

Example 2- Caregiver C
Caregiver C was hired 04/27/2026. His/her record contained a TB test completed 05/01/2026. The record did not contain a communicable disease screen.

On 07/28/2026 at approximately 3:15 PM, Surveyor interviewed Licensee A regarding missing employee communicable disease screens with Licensee A who stated s/he would email Caregiver B's and Caregiver C's to Surveyor by 1:00 PM on 07/24/2026.

On 7/24/2026 at 1:07 PM, Surveyor received an email from Licensee A stating " ...Additionally, we

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N 220	Continued From page 2 have the Tb [sic] test but I was not aware that we had to have the communicable disease screening done when doing the Tb [sic] test. Moving forward we will make sure to have that done ..." On 07/28/2026 at 3:00 PM, Surveyor discussed concern regarding employee communicable disease screens with Licensee A who stated s/he contacted the clinic that conducted Caregiver B's and Caregiver C's TB tests and was told because communicable disease screens were not ordered to be completed with the TB tests, they were not done. Licensee A stated s/he scheduled Caregiver B's and Caregiver C's communicable disease screens at the clinic for next week.	N 220		
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 the resident right to receive medication in the dosage and intervals as prescribed by the physician for 3 of 7 residents reviewed. Staff documented administration of 227 doses of polyethylene glycol from a 14-dose bottle for Resident 1. Staff documented administration of 46 doses of polyethylene glycol from a 14-dose bottle for Resident 2. Staff documented	N 352		

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N 352	Continued From page 3	N 352		

administration of 161 doses of psyllium fiber powder from a 72-dose bottle for Resident 3.

This is a repeat violation. See Statement Of Deficiency 1QO611, dated 12/14/2023.

Findings include:
The facility is licensed as a Class CNA (nonambulatory) CBRF able to serve up to16 residents within the client groups of physically disabled, developmentally disabled and emotionally disturbed/mental illness.

On 07/23/2026 at 1:09 PM, Surveyor inspected the medication closet with Licensee A and on 07/23/2026 Surveyor reviewed Resident 1's Resident 2's and Resident 3's records.

Example 1- Resident 1
The medication closet contained 1 bottle of polyethylene glycol 3350 for Resident 1.
Pharmacy label stated (Photos 1 and 2):
Polyethylene glycol 3350 take 17 grams dissolved in 8 oz. liquid in the morning.
Quantity: 238 grams (Note: 14 days' worth)
Dispensed date: 07/18/2025.
Licensee A stated the bottle was approximately ¼ full.

Resident 1 was admitted 08/22/2024.

Physician orders included polyethylene glycol 3350 dissolved 17 grams in 8 oz. liquid in the morning (start date: 07/17/2025).

Medication administration record (MAR) received via email from Licensee A on 07/24/2026 at 1:17 PM:
From 08/01/2025-08/31/2025, 10/01/2025-12/31/2025, 02/01/2026-05/31/2026

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N 352	Continued From page 4	N 352		

and 07/01/2026-07/22/2026 staff documented administration of 227 doses of polyethylene glycol to Resident 1.

Annual Assessment dated 06/18/2026:
In the area of Medications Care " ...Resident takes 12-17 doses of medications per day with staff assistance ..."

Individual Service Plan (ISP) dated 07/29/2026 (received 07/29/2026 at 9:53 AM via email from Licensee A):
In the area of General Questions: " ...Medications administered by staff ..."

Example 2 - Resident 2
The medication closet contained 1 bottle polyethylene glycol 3350 for Resident 2.
Pharmacy label identified (Photos 3 and 4):
Polyethylene glycol 3350 take 17 grams dissolved in 8 oz. liquid in the morning.
Quantity: 238 grams (Note: 14 days' worth)
Dispensed date 06/05/2026.
Licensee A stated the bottle was approximately ¼ full.

Resident was admitted 01/02/2017.
Physician orders included polyethylene glycol 3350 take 16 grams dissolved in 8 oz. liquid in the morning (start date 08/26/2025).

MAR:
From 06/06/2026-07/22/2026, staff documented administration of 46 doses of polyethylene glycol to Resident 2.

ISP dated 03/19/2026:
In the area General Questions " ...Medications administered by staff ..."

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N 352	Continued From page 5 Example 3 - Resident 3 The medication closet contained 1 bottle Psyllium Fiber powder for Resident 3. Pharmacy label identified (Photo 5): Fiber laxative 3.4 gram Take 1 tablespoonful mixed in 8 oz. of liquid in the morning. Quantity 72 tablespoons (note: 72 days' worth) Dispensed date: 07/24/2025 Licensee A stated the bottle was approximately ½ full. Resident 3 was admitted 10/01/2017. Physician orders included take psyllium fiber powder 1 tablespoon mixed in 8 oz. water in morning (start date 07/24/2025). MAR (received via email 07/27/2026 at 9:59 AM from Licensee A): From 08/01/2025- 07/21/2026, staff documented administration of psyllium fiber powder 161 times to Resident 3 and documented every other day instead of daily. ISP dated 03/19/2026: In the area General Questions " ...Medications administered by staff ..." On 07/23/2026 3:11 PM, Surveyor interviewed Pharmacy Tech D who stated Resident 1's polyethylene glycol 3350 was last dispensed on 07/18/2025. Pharmacy Tech D stated Resident 2's polyethylene glycol was last dispensed on 06/05/2026. Pharmacy Tech D stated Resident 3's psyllium fiber powder was last dispensed 07/24/2025. On 07/23/2026 at 1:09 PM while inspecting the medication cart with Licensee A, Surveyor	N 352		

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N 352	Continued From page 6 interviewed him/her. Licensee A stated staff held Resident 1's polyglycol for loose stools. Licensee A stated the pharmacy representative who audited the medication carts was supposed to stop pharmacy from delivering several bottles of Resident 2's polyethylene glycol per month. Licensee A stated Resident 3's psyllium fiber powder might be ordered "as needed". On 07/28/2026 at 3:00 PM, Surveyor discussed concern of medication administration with Licensee A who stated due to Resident 1's, Resident 2's, and Resident 3's regular bowel movements staff felt they did not need the polyethylene glycol or psyllium fiber powder. Licensee A stated since 07/23/2026 the physicians changed the orders to as needed.	N 352		
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 observation, record review and interview, the provider did not ensure each	N 381		

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resident's needs, abilities, physical and mental condition were assessed prior to admission and when there was a change in needs, abilities or condition.

Need for chest strap, seatbelt, and foot straps on wheelchair were not assessed for Resident 4 and subsequently the devices were not addressed on his/her individual service plan (ISP).

This is a repeat violation. See Statement Of Deficiency 1QO611, dated 12/14/2023.

Findings include:

On 07/23/2026 at 8:18 AM, Surveyor observed Resident 4 in living room sitting in wheelchair. A chest strap was attached to wheelchair, bilateral foot straps were attached to the footrests and secured around his/her feet (Photo 11), and a seat belt was attached to the wheelchair and fastened around his/her waist (Photo 12) .

On 07/23/2026 at 8:25 AM, Surveyor observed Caregiver F secure the Velcro strap around Resident 4's chest. Resident 4 was then assisted onto the van to go to day programming.

On 07/23/2026 at 3:39 PM after Resident 4 arrived home from day programming, Surveyor interviewed Resident 4, Caregiver E and Caregiver F. Resident 4 was seated in his/her wheelchair with chest strap velcroed around chest, seat belt fastened around waist and foot straps secured. Resident 4 demonstrated s/he was able to independently unfasten seat belt and stated s/he was unable to unfasten chest strap and foot straps independently. Caregiver E stated the chest strap and foot straps were for positioning and the seat belt prevented Resident

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N 381	Continued From page 8 4 from falling forward out of wheelchair. Caregiver E stated chest strap, seat belt and foot straps were used whenever Resident 4 was in the wheelchair. Caregiver F stated the chest strap, seat belt and foot straps were on the wheelchair when Resident 4 received it approximately 4-5 months ago and the managed care organization (MCO) determined need for the devices. On 07/23/2026, Surveyor reviewed Resident 4's record. S/he was admitted 01/25/2021. Diagnoses included cerebral palsy and seizure disorder. Assessment dated 02/11/2026: In the area of Fall Risk- " ...client is not considered a fall risk and does not require monitoring ..." In the area of Mobility Status- " ...Moderate assistance needed with ambulation ...Total assistance needed when transferring ...needs moderate assistance with positioning in chair and in bed ..." In the area of Physical Disabilities- "is wheelchair bound ...will maintain independence with wheelchair ...Staff to assist resident with wheelchair ..." In the area of Transportation- "Resident receives rides from [name of transportation company] ...Facility will assist resident with transportation ..." The assessment did not identify or address chest strap, seat belt or foot straps. ISP dated 03/12/2026- The ISP did not identify or address chest strap, seat belt or foot straps. MCO Care Plan dated 06/01/2026 (received via email from Licensee A on 07/27/2026 at 9:59 AM):	N 381		

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N 381	Continued From page 9 In the area of Other Information and Member Specific Plans Of Care "DME/DMS [Durable Medical Equipment/Disposable Medical Supplies] Inventory and Plan" The MCO Care Plan did not identify or address chest strap, seat belt or foot straps. On 07/28/2026 at 3:00 PM, Surveyor discussed concern of no assessment for Resident 4's chest strap, seat belt or foot straps with Licensee A who stated the chest strap helped him/her sit up straight and the seat belt was used during transportation to day programming. Licensee A stated because Resident 4 was paralyzed from the waist down, the foot straps prevented his/her feet from falling off the wheelchair foot rests. Licensee A stated s/he thought the seat belt was not needed. Licensee A stated s/he thought the devices were addressed on the ISP.	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.	N 389		

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This Rule is not met as evidenced by:
Based on observation, record review and interview the provider did not ensure the individual service plan (ISP) was updated when there was a change in condition or needs for 2 of 3 residents reviewed.

Resident 1's ISP was not updated to address behaviors that resulted in his/her personal items being kept in basement and issuance of a 30-day involuntary discharge notice.

Resident 2's ISP was not updated to include use of bilateral ½ siderails on beds.

This is a repeat violation. See Statement Of Deficiency 1QO611, dated 12/14/2023.

Findings include:

Example 1- Resident 1
On 07/23/2026 at 12:39 PM while touring facility with Licensee A, Surveyor observed Resident 1's bedroom. The room was empty except for the bed; no curtains were on the window or decorations on the walls. Resident 1 was lying in bed covered (including head) with a blanket, his/her head was on a pillow with no pillowcase and the mattress was bare (Photos 6 and 7). The room smelled strongly of urine.

At 12:43 PM, Surveyor toured the basement with Licensee A where Resident 1's dresser, television, laundry basket, folded clothes and hanging clothes were observed (Photos 8 and 9).

On 07/23/2026 at 12:40 PM, Surveyor interviewed Licensee A who stated Resident 1's clothes and personal belongings were kept in the basement. Licensee A stated Resident 1's

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television was replaced twice after s/he broke it. Licensee A stated because Resident 1 mixed clean and dirty clothes together and because Resident 1 smeared feces on bed and bed linens staff washed his/her clothes and linens at least twice a day, and clean clothes were kept in the basement. Licensee A stated Resident 1's dementia was slowly progressing.

On 07/23/2026, Surveyor reviewed Resident 1's record. S/he was admitted 05/22/2024. Diagnoses included Alzheimer's disease and bipolar disorder.

Observation notes:
-07/01/26 10:00 PM "VERY active today, would not sit down from dinner til [sic] about 930 [sic]. Smeared feces all
over [his/her] hands and would not allow staff to give [him/her] a shower."
-07/02/26 2:15 PM " ...had an okay day today [s/he] refused [his/her] shower every time staff tried to help [him/her] ..."
-07/08/26 9:30 PM "Was anxious and moving a lot today ..."
-07/09/26 9:00 PM "RESIDENT REFUSED SHOWER BUT ALLOW STAFF TO CLEAN [him/her] UP AND PUT ON CLEAN CLOTHES ..."
-07/12/26 6:30 AM "10pm [sic] popped [his/her] window out of the frame, was easily redirected and had a good
night after that ..."
-07/13/26 4:15 AM " ...was wandering a lot [sic], seemed anxious, redirected with a snack ..."
-07/13/26 1:45 PM "[Resident 1] is becoming very hard to take care of [s/he] does not listen to nothing [sic] staff says to [him/her] [s/he] refuses [him/her] showers everyday [s/he] just wants to lay in the bed all day ..."
-07/16/26 12:15 AM "12am check: ...was up

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roaming back and forth from [his/her] bedroom to the
bathroom. asked [sic] [him/her] repeatedly to either lay down or come sit in the sitting area ..."
-07/16/26 8:00 PM " ...[Resident 1's] BEEN ANXIOUS ALL DAY UP & DOWN WALKING AROUND THE HOUSE CHECK THE DOORS ..."
-07/17/26 1:15 PM " ...had a okay day today [s/he] refused [him/her] shower after multiple attempts to give [him/her] One [sic] ..."
-07/20/26 9:45 PM " ...a lot of pacing today ..."
-07/22/26 1:45 PM " ... had an okay day today had AM meds breakfast and lunch ...refused [his/her] shower after staff tried several times [sic] [s/he] started to become combative, staff let [him/her]
relax [s/he] did not take [his/her] shower."
-07/23/26 2:15 AM "2am check: [Resident 1] was sleeping [sic] room floor was dry and clean."
-07/23/26 12:15 AM "12am check: [Resident 1] was asleep [sic] room floor was dry and clean had [him/her] get up to use the bathroom and then [s/he] went back to bed ..."

ISP not signed or dated (received from Licensee A via email 07/29/2026 at 9:53 AM):
In the area of Personal Cares
-Dressing "Client needs stand by assistance and possible cueing with dressing."
-Toileting " ...Staff is to also watch for [Resident 1] spreading [his/her] feces and playing in it ..."

In the area of Behavior Patterns
-Wandering "Staff to verify at start of shift that alarm is activated/functioning and in place."
-Self-Abusive Behavior "Not Applicable"
-Destructive of Property or Self "Not Applicable"
-Physically or Mentally Abusive "Not Applicable"
-Self-Abuse "Not Applicable"
-Elopement Risk Behavioral support " ... attempt

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N 389	Continued From page 13 to direct exit seeking to a safe destination staff are to walk resident in enclosed patio area ..." -Exit Seeking Behavior " ...Client is considered a wanderer and requires staff verification that alarm active and functioning." -Psychotropic Monitoring for Behaviors "Not Applicable" In the area of Physical Health -Sleep Patterns "Not Applicable" In the area of Mental and Emotional Health: -Maturation "Lightly monitor and assist when necessary to enforce positive maturation process ... To be able to control anger. Has a history of behavior and emothional [sic] outburst. Requires frequent redirection and monitoring." -Attitude "Not Applicable" -Interaction with Others "Not Applicable" -Aggressive/Combative "Not Applicable" In the area of Physical Health - Chronic Illnesses "Not Applicable" The ISP did not address impaired cognitive status due to Alzheimer's disease including memory loss and poor judgement, combativeness, restlessness, difficulty sleeping, refusals to shower and dress, layering clothes, urinating on clothes, mixing dirty and clean clothes, or need for personal belongings to be kept in basement due to behaviors. MCO Care Plan dated 06/01/2026 (received via email from Licensee A on 07/27/2026 at 9:59 AM): The MCO Care Plan did not identify specific behaviors or need for personal belongings to be kept in basement due to behaviors.	N 389		

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N 389	Continued From page 14 Example 2 - Resident 2 According to the U.S. Food & Drug Administration's Hospital Bed Safety Workgroup, "...Strangling, suffocating, bodily injury, or death can occur when patients or parts of their bodies are caught between rails or between the bed rails and mattresses...Regardless of the purpose for which bed rails are being used or considered, a decision to utilize or remove those in current use should occur within the framework of an individual patient assessment. 2. Because individuals may differ in their sleeping and nighttime habits, creation of a safe bed environment that takes into account patients' medical needs, comfort, and freedom of movement should be based on individualized patient assessment by an interdisciplinary team...3. Use of bed rails should be based on patients' assessed medical needs and should be documented clearly...Bed rail effectiveness should be reviewed on a regular basis...The patient's chart should include a risk-benefit assessment that identifies why other care interventions are not appropriate or not effective if they were previously attempted and determined not to be the treatment of choice for the patient. 4. Bed rail use for treatment of a medical symptom or condition should be accompanied by a care plan (treatment program) designed for that symptom or condition. The plan should present clear directions for further investigation of less restrictive care interventions. The documentation should describe the attempts to use less restrictive care interventions and, if indicated, their failure to meet patients' assessed needs. 5. Bed rail use for patient's mobility and/or transferring, for example turning and positioning within the bed and providing a hand-hold for getting into or out of bed, should be accompanied by a care plan...The care plan should: include	N 389		

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educating the patient about possible bed rail danger to enable the patient to make an informed decision; and address options for reducing the risks of the rail use. 6. The process of reducing and/or eliminating existing use of bed rails should be undertaken incrementally using an individualized, systematic, and documented approach... Bed Rail Safety Guidelines If it is determined that bed rails are required and that other environmental or treatment considerations may not meet the individual patient's assessed needs, or have been tried and were unsuccessful in meeting the patient's assessed needs, then close attention must be given to the design of the rails and the relationship between rails and other parts of the bed. 1. The bars within the bed rails should be closely spaced to prevent a patient's head from passing through the openings and becoming entrapped. 2. The mattress to bed rail interface should prevent an individual from falling between the mattress and bed rails and possibly smothering. 3. Care should be taken that the mattress does not shrink over time or after cleaning. Such shrinkage increases the potential space between the rails and the mattress. 4. Check for compression of the mattress' outside perimeter. Easily compressed perimeters can increase the gaps between the mattress and the bed rail. 5. Ensure that the mattress is appropriately sized for the selected bed frame, as not all beds and mattresses are interchangeable. 6. The space between the bed rails and the mattress and the headboard and the mattress should be filled either by an added firm inlay or a mattress that creates an interface with the bed rail that prevents an individual from falling between the mattress and bed rails. 7. Latches securing bed rails should be stable so that the bed rails will not fall when shaken. 8. Older bed rail designs that have tapered or winged ends are

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not appropriate for use with patients assessed to be at risk for entrapment. Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospital, Long Term Care Facilities, and Home Care Settings 11 9. Maintenance and monitoring of the bed, mattress, and accessories such as patient/caregiver assist items (See Appendix 1: Glossary) should be ongoing. " (Source: "Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings" (Source: https://www.fda.gov/media/88765/download (retrieval date 07/28/2026)).

On 07/23/2026 at 12:25 PM while touring facility with Licensee A, Surveyor observed bilateral ½ siderails in the up position attached to Resident 2's bed (Photo 10). Resident 2 was not in bed.

On 07/23/2026 at 12:25 PM, Surveyor interviewed Licensee A who stated Resident 2 was paralyzed from the legs down, was not a fall risk and did not roll over independently. Licensee A stated the wall side siderail was always left up and the room side siderail was put up and down because Resident 2 held onto it when being turned by staff. Licensee A stated the room side siderail was always left up when Resident 2 was not in bed.

Licensee A stated prior to the current bed, Resident 2 had the same exact type of bed with bilateral siderails, and both the former and current beds were supplied by the managed care organization (MCO). Licensee A stated they did not assess need for Resident 2's siderails because the MCO provided the beds.

On 07/23/2026, Surveyor reviewed Resident 2's

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record.
S/he was admitted 01/02/2017. Diagnoses included mild mental retardation, spastic quadriplegia, and epilepsy.

03/12/2024 MD note stated " ...A face to face evaluation for durable medical equipment has been completed. During the encounter it was determined that [Resident 2] meets medical necessity guidelines for the ordered equipment. Documentation details and assessment are included in this office visit ...DME- Hospital Bed Including Mattress & Half Side Rails ...Associated Diagnosis Spastic quadriplegic cerebral palsy ...

Individual Service Plan dated 02/11/2026:
In the area of Transferring- " ...requires total assistance support including physical and verbal assistance with transferring/ambulation needs ..."
In the area of Walking- " ...Give total assistance to resident with walking needs. Assist with walking devices such as walkers, wheelchair, etc. ..."
In the area or Repositioning- " ...require to be repositioned every 2 hours to decrease risk of skin breakdown ...needs full staff assistance with repositioning in chair and/or bed ..."
The ISP did not address side rails.

MCO Member Centered Care Plan dated 05/01/2026 (received via email from Licensee A on 07/24/2026 at 1:07 PM):
" ...CBRF staff assist with grooming, bathing, dressing, eating, mobility, toileting, transfers, meal preparation, medication management and administration, laundry/chores, telephone use, overnight care and supervision, repositioning and transportation ... hospital bed and wheelchair ...requires positioning in
bed or chair every 2-3 hours and needs

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N 389	Continued From page 18 assistance (Formal/Natural Supports) ... Mechanical Supports: No ... State Approved Restrictive Measures: No ... Low Fall Risk ..." The Member Centered Plan did not address side rails. On 07/28/2026 at 3:00 PM, Surveyor discussed concern of ISPs not updated with changes in condition and needs with Licensee A who stated Resident 2's bed was issued by the MCO with the side rails on it. Licensee A stated Resident 1 displayed symptoms of Alzheimer's disease including poor memory and judgement since admission. Licensee A stated initially Resident 1's behaviors were sexually oriented, and elopement attempts increased and smearing feces started and increased within the past 6 months. Licensee A stated Resident 1 tore his/her window blinds down so now s/he only has curtains which are washed with bed linens daily. Licensee A stated Resident 1 repeatedly took room decorations down and broke his/her television and attempted to elope out his/her window twice. Licensee A stated 4-5 months ago s/he issued a 30-day involuntary discharge notice for Resident 1 due to inability to manage his/her behaviors and cares, but the MCO has not found placement yet. Licensee A stated s/he would update the ISPs. Cross Reference: N0289 DHS 83.27(2)(c) Admissions Compatible With Program Statement N0408 DHS 83.37(1)(i) PRN Psychotropic Medication	N 389		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on	N 408		

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N 408	Continued From page 19 an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure when a psychotropic medication was prescribed on an as needed (PRN) basis, the rationale for use and a detailed description of the behaviors indicating the need for administration of the PRN psychotropic medication were on listed on the individual service plan (ISP) and the administrator or qualified designee monitored at least monthly for the inappropriate use of the PRN psychotropic medication for 2 of 2 residents reviewed. The ISPs did not include rationale for PRN psychotropic(s) and monthly reviews of PRN psychotropics were not completed for 3 of 3 residents reviewed. Findings include:	N 408		

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N 408	Continued From page 20 Per 83.02(41) "Psychotropic medication means a prescription drug, as given in s. 450.01 (20), Stats., that is used to treat or manage a psychiatric symptom or challenging behavior". On 07/23/2026, Surveyor reviewed Resident 1's, Resident 2's and Resident 4's records. Example 1 - Resident 1 Resident 1 was admitted 08/22/2024. Physician orders included hydroxyzine HCL 25 MG 1 tablet every 4 hours as needed for anxiety (start date 05/12/2026). ISP not signed or dated (received from Licensee A via email 07/29/2026 at 9:53 AM): In the area of Behavior Patterns: "Psychotropic Monitoring for Behaviors Not Applicable Rationale for use of PRN Psychotropic Medications Not Applicable In the area of Physical Health: Psychotropic Monitoring for Side Effects Not Applicable Resident 1's record did not contain a monthly PRN psychotropic review. Example 2- Resident 2 Resident 2 was admitted 01/02/2017. Physician orders included lorazepam 0.5 MG 1 tablet twice daily as needed for anxiety. ISP dated 03/19/2026 did not identify need or rationale for PRN lorazepam. Resident 2's record did not contain monthly PRN psychotropic reviews. Example 3- Resident 4 Resident 4 was admitted 01/25/2021. Physician orders included trazadone 50 MG take	N 408		

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N 408	Continued From page 21 ½ tablet at bedtime as needed if not able to sleep withing 30-60 minutes after scheduled dose (start date 07/12/2026). ISP dated 03/12/2026 did not identify need or rationale for PRN lorazepam. On 07/24/2026 at 1:07 PM, Surveyor received an email from Licensee A stating, " ...We do not have monthly psychotropic reviews. I apologize we have been doing them quarterly, not monthly ..." On 07/28/2026 at 3:00 PM, Surveyor discussed concern of not including rationale for use of PRN psychotropic medications on the ISPs or completing monthly PRN psychotropic reviews with Licensee A who stated psychotropic reviews were completed quarterly. Licensee A stated s/he was not aware PRN psychotropic reviews were to be completed monthly and rationale for PRN psychotropics had to be identified on the ISP. Cross Reference: N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes	N 408		
N 539	83.48(3)(b) Sensitivity testing performed Sensitivity testing shall be performed at intervals in accordance with NFPA 72. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the smoke and heat detector system had a sensitivity test performed at intervals in accordance with National Fire Protection Association (NFPA 72 requirements. Findings include:	N 539		

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N 539	Continued From page 22 The facility is licensed as a Class CNA (nonambulatory) CBRF able to serve up to 16 residents within the client groups of physically disabled, developmentally disabled and emotionally disturbed/mental illness. On 07/23/2026, Surveyor reviewed the facility's life safety documentation which did not include 2024 or 2025 heat sensor testing. On 07/23/2026 at 12:15 PM, Surveyor interviewed Licensee A who stated s/he would figure out which company completed the 2024 and 2025 heat sensor testing and submit the testing documents to Surveyor by 1:00 PM on 07/24/2026. On 07/28/2026 at 3:00 PM, Surveyor discussed concern of no documentation of 2024 and 2025 heat sensitivity testing with Licensee A who stated s/he spoke with City Fire Inspector H on 07/28/2026 and the facility checklist included heat sensor testing but the checklist was not provided to the inspector. Licensee A stated City Fire Inspector H told him/her the heat sensors were checked but not documented and s/he would check with the fire protection company if they also completed the testing. On 07/28/2026 at 4:01 PM, Licensee A forwarded Surveyor an email s/he received from City Fire Inspector H (dated 07/28/2026 at 10:44 AM) stating " ...After reviewing the form, it appears that this documentation should be completed by your fire alarm contractor. The form requests information from the inspection company or technician, including a certification number, which I do not have as I am neither the inspecting technician nor the alarm contractor. Additionally,	N 539		

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N 539	Continued From page 23 the required functional testing of the heat detectors must be performed using specialized testing equipment that is not available to me. I recommend contacting [name of fire protection company and phone number], as they may be able to provide the information needed to complete the log. I reviewed the inspection paperwork associated with [facility address and job number), and it does not appear to document the functional testing of the heat detectors ..." As of 07/28/2026 at 4:01 PM, the Department had not received proof of 2024 and 2025 heat sensitivity testing. Cross Reference: N0640 DHS 83.59(2)(b) Solid Core Wood Doors Or Equivalent	N 539		
N 640	83.59(2)(b) Solid core wood doors or equivalent A solid core wood door or an equivalent fire resistive door shall be provided at any interior stair between the basement and the first floor. The door shall have a positive latch and an automatic closing device and normally shall be kept closed. Enclosed furnace and laundry areas with self-closing doors in a split level home may substitute for the self-closing door between the first and second levels. Enclosed furnace and laundry areas shall have self-closing solid core wood doors or an equivalent fire resistive door when located on a common level with resident bedrooms. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure the door between the basement and first floor	N 640		

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N 640	Continued From page 24 automatically closed completely. The door at the top of the basement steps did not automatically close completely. This is a repeat violation. See Statement Of Deficiency 1QO611, dated 12/14/2023. Findings include: The facility is licensed as a Class CNA (nonambulatory) CBRF able to serve up to 16 residents within the client groups of physically disabled, developmentally disabled and emotionally disturbed/mental illness. On 07/23/2026 at 12:51 PM while touring facility with Licensee A, Surveyor tested the automatic door closing mechanism on the door at the top of the basement steps and the door remained opened approximately 5 inches. On 07/28/2026 at 3:00 PM, Surveyor discussed concern of the door at top of basement steps not automatically completely closing with Licensee A who stated since 07/23/2026, s/he contacted maintenance who ordered a tighter spring for the door. Cross Reference: N0539 DHS 83.48(3)(b) Sensitivity Testing Performed	N 640		