STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018837	A. BUILDING: _____ B. WING _____	C 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY COVE ASSISTED LIVING AND MEMORY CAF	1704 GEORGIA STREET STURGEON BAY, WI 54235

(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 07/10/2026, Surveyor conducted 4 complaint investigations at Cherry Cove Assisted Living and Memory Care I. Additional information was gathered through 07/16/2026. One of four complaints was unsubstantiated. Three of four complaints were substantiated, and resulted in 2 deficient practices. Census: 13	N 000		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure an investigation was conducted within the required timeline or was	N 158		

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

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N 158	Continued From page 1	N 158		

reported to the required entities. An investigation into caregiver misconduct was not conducted until 2 months after the incident, the findings of the investigation were dismissed, and subsequently no report to the Department was submitted. Additionally, a resident-to-resident altercation occurred during the same incident on 04/01/2026 that was not investigated and not reported.

Findings include:
On 04/07/2026 and 06/25/2026, the Department received complaints alleging the provider was aware of and was not reporting caregiver misconduct.

On 07/10/2026 Surveyor reviewed Resident 1's record and noted s/he was admitted to the facility on 12/22/2023 with an activated Power of Attorney for Healthcare. Resident 1 had diagnoses including vascular dementia with agitation, mood disturbance, and anxiety, as well as major depressive disorder and sequelae of cerebral infarction.

On 07/10/2026 at 11:00 AM, Surveyor interviewed Administrator A and Assistant Administrator (AA) B. Administrator A stated on or around 04/01/2026 s/he was working at another campus when s/he was informed by AA B that there was an incident that occurred. Administrator A was informed Resident 1 was having behaviors and pouring juice on to other residents and Caregiver F. S/he was informed Caregiver F retaliated by splashing juice on to Resident 1's face. Administrator A stated s/he was not at the facility and it would have been AA B's responsibility to initiate an investigation but that AA B was new to the role and Administrator A did not tell AA B to begin an investigation. Administrator A stated the next 2 months were "extremely busy" and s/he

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N 158	Continued From page 2 did not initiate an investigation until the incident was brought up again by RN G at the end of May. Administrator A stated at the beginning of June 2026 s/he conducted and investigation by having the caregivers submit witness statements. Administrator A stated s/he sent the caregiver's statements, as well as his/her own, to CEO C and Director D for them to make a final determination. Administrator A showed Surveyor a copy of the e-mail s/he sent to CEO C and Director D on 06/02/2026. CEO C replied to Administrator A on 06/02/2026 asking, "Was there something that happened today or recently that prompted to [sic] the investigation to happen now?" Administrator A stated s/he did not respond or have any further e-mail correspondence or directives/ final determinations made from CEO C or Director D regarding the investigation. Administrator A stated s/he did not submit the allegation of caregiver misconduct to the Office of Caregiver Quality as required or submit the investigation to the Department, as the provider did not come to any conclusion per his/her communication with CEO C and Director D. While onsite, Administrator A reviewed the submitted caregiver statements and stated based on the witness statements, s/he would substantiate Caregiver F's misconduct. On 07/10/2026 at 11:00 AM, Surveyor interviewed AA B. AA B recounted the incident as it was relayed to him/her by Caregiver F on 04/01/2026. During the interview AA B initially minimized the incident and Caregiver F's actions. After review of his/her own written statement and review of other witness statements, AA B acknowledged caregiver misconduct occurred. AA B stated s/he did not start and investigation at the time of the incident as s/he had reported it to his/her direct supervisor Administrator A and was not told to begin an investigation.	N 158		

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N 158	Continued From page 3 On 07/10/2026 at 2:00 PM, Surveyor interviewed Dietary Director (DD) H. DD H stated on 04/01/2026 s/he witnessed Resident 1 having behaviors and spilling juice on to the table and other residents. DD H witnessed the event stating, "[Caregiver F] grabbed the pitcher of juice and poured it on [Resident 1.] ... it wasn't meant as a joke ... [Caregiver F] was really upset ... I couldn't believe [s/he] did that. I never would have done that. I don't care how mad you are, you don't ever treat them [the residents] like that." DD H stated the other residents who witnessed Caregiver F's misconduct appeared to be scared. Written Statements: Administrator A noted to CEO C and Director D on 06/02/2026, "Investigation on [sic] [Caregiver F] and [Resident 1] from April 2026. I have to [sic] many of the staff on [sic] that have worked with [Caregiver F] on 04/01/2026 [sic] all have stated the incident on hand in all their statement. [sic] I [Administrator A] was not here when this took place I was working at the Clintonville facility. All statements are being sent to Ashford Martin for further review. To my knowledge this was reported to [AA B] the date of the incident." AA B noted on 06/01/2026, "I [AA B] was sitting in the office doing paperwork when [Caregiver F] came running into the office to let me know that [s/he] accidentally splashed a resident with juice ... [Caregiver F] ... didn't mean for more than a drop or two to splash out but it was a lot more than that. [S/he] wasn't thinking and was acting on instinct. ... told me that [s/he] shouldn't have done that and should know better ... [s/he] did indicate that [Resident 1] went back to [his/her] room afterwards and didn't pour juice on anyone again that day as maybe it was something that	N 158		

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N 158	Continued From page 4 [s/he] needed ... I told [him/her] that it was wrong and [s/he] should know better as [s/he] shouldn't be throwing juice or fighting back with any resident." DD H noted on 06/01/2026, " ... On April 1st, 2026, I witnessed [Resident 1] pour water on [Resident 2] and then s/he poured more water on the table. Then [Caregiver F] the caregiver took a pitcher of juice and splashed it in [Resident 1's] face." Caregiver I noted on 06/01/2026, "[Resident 1] one of our residents, started pouring and throwing fruit punch at residents. [Caregiver F] one of the staff members, was walking past [Resident 1] and [s/he] poured juice on [Caregiver F.] [Caregiver F] grabbed the fruit punch and fake air tossed it to make it scare [him/her] "How would you like it?" [s/he] said. The juice did get all over [Resident 1] ..." Caregiver J noted on 05/14/2026, " ... At some point [Resident 1] tossed some juice onto [Caregiver F] this had [sic] irritated [Caregiver F] ... When [Caregiver F] was getting another resident a cup of juice [Resident 1] had [sic] tossed more juice onto [Caregiver F] this resulted in [Caregiver F] tossing an entire pitcher of juice on [Resident 1.] [Caregiver F] initially had [sic] pretend to dump juice on [Resident 1] and [s/he] laughed at [Caregiver F] this had [sic] almost seemed to agitate [Caregiver F] [his/her] reaction to [Resident 1] laughing at [him/her] was dumping an entire pitcher of juice onto [Resident 1.] After the juice was tossed onto [Resident 1] [s/he] seemed very distraught and flabbergasted that this had happened. [Resident 1] then went to [his/her] room changed clothes and went to bed ..."	N 158		

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N 158	Continued From page 5 Caregiver F noted on 06/02/2026, " ...[Resident 1] was displaying behavior issues all day ... [s/he] came up and got me with some juice ... I was going around with a picture of tea that didn't have a lid I went to just splash a little but the liquid moved faster and created a much bigger splash because of having no lid so it was more than intended, so it stunned [Resident 1] ... the whole situation was completely innocent ..." On 07/16/2026 at 9:15 AM, Surveyor interviewed CEO C and Director D. Both administrators acknowledged they received the e-mail from Administrator A on 06/02/2026 containing the caregiver statements as an investigation. Both administrators reviewed the staff written statements and CEO C stated it was clear Caregiver F's behavior was caregiver misconduct. CEO C could not account for why the investigation was conducted 2 months after the incident occurred, why no further steps, including a review and summary of findings, reporting to the required entities or taking action to protect the resident, were completed when the investigation was brought to his/her and Director D's attention on 06/02/2026. CEO C stated the provider would take immediate steps to protect the residents, make corrections, provide re-education, and review their process of reporting both within the company and to the required entities. Resident-To-Resident Altercation On 07/10/2026 at 11:00 AM, Surveyor interviewed Administrator A and AA B while reviewing the provider's records of the incident that occurred on 04/01/2026. Surveyor reviewed Caregiver F's written statement regarding the incident included, after	N 158		

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N 158	Continued From page 6 Resident 1 poured juice on Resident 2, " ... then [Resident 2] got up and slapped [Resident 1] across the face." Surveyor reviewed Caregiver G's statement written on 06/02/2026 that included after Resident 1 poured a glass of juice on Resident 2, Resident 2, "stood up and backhanded [Resident 1.]" During the interview and review, Caregiver AA B recalled the incident that occurred on 04/01/2026 and stated it was also reported to him/her by Caregiver F that when Resident 1 poured juice on Resident 2, Resident 2 stood up and "slapped" Resident 1. Surveyor reviewed AA B's witness statement did not include the reported resident-to-resident altercation. Both Administrator A and AA B stated they did not complete an investigation into the resident -to-resident altercation and did not report it to the Department as they were unaware it was required.	N 158		
N 219	83.17(1) Licensee conduct caregiver background check Caregiver background check. At the time of hire, employment or contract and every 4 years after, the licensee shall conduct and document a caregiver background check following the procedures in s. 50.065, Stats., and ch. DHS 12. A licensee shall not employ, contract with or permit a person to reside at the CBRF if the person has been convicted of the crimes or offenses, or has a governmental finding of misconduct, found in s. 50.065, Stats., and ch. DHS 12, Appendix A, unless the person has been approved under the department ' s rehabilitation process as defined in ch. DHS 12.	N 219		

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N 219	Continued From page 7	N 219		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not conduct a complete background check for Caregiver E. The provider did not contact the clerk of courts to obtain the final judgement of a disorderly conduct charge found on Caregiver E's Department of Justice (DOJ) background check record within 5 years of hire. The provider did not obtain an out of state background check for Caregiver E when s/he indicated s/he resided outside of the state within 3 years prior to hire.

Findings include:

The provider is licensed to serve up to 20 residents who may have diagnoses including advanced age, physical disability, irreversible dementia/ Alzheimer's disease, terminally ill, developmentally disabled, emotionally disturbed/ mental illness and/ or traumatic brain injury.

On 05/20/2026, the Department received a complaint alleging the provider was not conducting complete background checks.

On 07/10/2026 at 11:00 AM, Surveyor asked Administrator A to review Caregiver E's background check information. Administrator A provided Surveyor with Caregiver E's background check information. Caregiver E was hired on 03/22/2026. Caregiver E's background information check included a "Criminal History Check Authorization Form" where Caregiver E noted s/he lived outside of Wisconsin in Michigan prior to 2024 and had a criminal conviction of

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N 219	Continued From page 8 disorderly conduct. Caregiver E's DOJ report noted a conviction of Disorderly conduct 947.01(1) on 11/26/2025. The record did not include a background check for the state of Michigan or information obtained from the clerk of courts to determine the circumstances related to the disorderly conduct conviction. On 07/16/2026 at 10:50 AM, Surveyor interviewed Director D. Director D stated s/he was responsible for conducting employee background checks. Director D confirmed prior to hiring Caregiver E, the provider did not reach out to the Clerk of Courts to obtain the final judgment of the disorderly conduct conviction or conduct an out of state background check for Caregiver E.	N 219		