STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020726	A. BUILDING: _____ B. WING _____	C 08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL ASSISTED LIVING KAUKAUNA SOUTH	548 FRANCES ST KAUKAUNA, WI 54130

(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 08/24/2026, Surveyor conducted a complaint investigation at Bethel Assisted Living Kaukauna South. Additional information was collected through 08/27/2026. The complaint was substantiated and 5 deficiencies were identified. Census: 2	N 000		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on 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, when a psychotropic medication was prescribed on an as needed basis for Resident 1, the CBRF did not ensure the individual service (ISP) included the rationale for use and a detailed description of the	N 408		

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

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N 408	Continued From page 1 behaviors which indicate the need for the medication; did not monitor at least monthly for the inappropriate use of PRN psychotropic medication; and did not document the effectiveness of the medication or the presence of any side effects. Resident 1 was prescribed ABH-1 gel as needed every 4 hours for severe anxiety or agitation and was administered the medication 15 times between 07/01/2026 - 08/24/2026. The provider did not update the ISP to include the use of the medication or the detailed descriptions of the behaviors which indicated the need for it, did not monitor monthly for inappropriate use and did not consistently document the effectiveness of the medication. Finding include: On 08/24/2026 at 10:15 AM, Surveyor interviewed Caregiver C. S/he said Resident 1 displays exit seeking and aggressive behaviors. Caregiver C said Resident 1 is prescribed a "cream PRN for when [s/he] is too aggressive. I used it this morning...[s/he] was aggressive and trying to leave. It didn't work." Surveyor and Caregiver C subsequently reviewed the electronic medication administration record (MAR). Caregiver C verified the documentation that s/he administered 0.5 mg ABH-1 Gel at 7:45 AM and did document that it was ineffective. Caregiver C said the computer system does not prompt caregivers to follow up or document for effectiveness. On 08/24/2026 at 12:00 PM, Surveyor reviewed Resident 1's complete record. Resident 1 was admitted on 5/05/2026, had diagnoses to include	N 408		

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N 408	Continued From page 2 dementia, had an activated power of attorney for health care and relied on staff administration for medication. The July and August 2026 MARs indicated Resident 1 was prescribed .5 mg ABH-1 Gel since admission "as needed for severe anxiety or agitation." and was administered a total of 15 times between 07/01 - 08/24/2026. Surveyor also reviewed observation notes that corresponded with the dates of medication administration and noted the following: 07/14 - no anxiety/agitation documented 07/15 - anxiety, aggression and "trying to elope" 07/17 twice - no anxiety/agitation documented 07/20 - no anxiety/agitation documented 07/21 - pushing the door trying to get out 07/26 - at 1:00 pm documented elopement attempts 4 times looking for family. The medication was documented as administered at 5:40 PM with no documentation of anxiety or agitation. 07/29 - no anxiety/agitation documented 08/13 - exited the building, looking for family's house and redirected back inside 08/16 - exited the building, looking for family's house and redirected back inside 08/17 - very anxious and upset, PRN seemed to help 08/22 - exited the building and took 2 hours to redirect back inside. PRN was given, now sitting and eating. 08/23 twice - no anxiety/agitation documented 08/24 - documentation of exit seeking after 10:00 AM, but no documentation of anxiety/agitation around 7:45 AM when the medication was administered.	N 408		

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N 408	Continued From page 3 The only documentation of effectiveness was on 08/17 and 08/22. Surveyor reviewed Resident 1's ISP. The ISP was silent to the use of PRN psychotropic medications. Surveyor reviewed the record for documentation of monthly PRN psychotropic reviews. One review was completed on 05/31/2026 for a previously prescribed PRN medication (lorazepam); however no reviews were in the record for PRN ABH-1 Gel. Surveyor interviewed Nurse Practitioner E on 08/24/2026 at 2:34 PM. NP E said Administrator A has contacted him/her to report Resident 1 "keeps eloping" and requesting medication changes to prevent elopement. NP E said Resident 1 is prescribed PRN ABH-1 Gel and but caregivers report it "doesn't do anything when [s/he]'s severely agitated." NP E said it is challenging for him/her to make decisions about medications changes without consistent documentation of behaviors or effectiveness of current medication. Surveyor interviewed Administrator A on 08/26/2026 at 3:55 PM and reviewed the aforementioned concerns. Administrator A did not offer additional information. Cross Reference: N0408 DHS 83.37(1)(i) PRN Psychotropic Medication N0433 DHS 83.38(1)(i) Behavior Management	N 408		
N 427	83.38(1)(c) Leisure time activities.	N 427		

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N 427	Continued From page 4 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: Leisure time activities. The CBRF shall provide a daily activity program to meet the interests and capabilities of the residents. Employees shall encourage and promote resident participation in the activity program. The CBRF shall develop and post the activity schedule in an area available to residents. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not provide a daily activity program to meet the interests and capabilities of the residents. The posted activities on the calendar were not encouraged or promoted and was not developed to match the capabilities and interests of 2 of 2 residents. This is a repeat deficiency. See Statement of Deficiency Q5QB11, dated 05/07/2026. Findings include: On 08/24/2026 at 10:03 AM, Surveyors arrived at the facility. Caregiver C was the only caregiver present and s/he was providing direct supervision to Resident 1 who was actively exit seeking. Resident 2 was the only other individual living in the facility and s/he remained in his/her room until 11:05 AM. During the remainder of the onsite visit until 1:15 PM, Resident 1 needed nearly constant supervision from Caregiver C due to persistent	N 427		

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N 427	Continued From page 5 exit seeking. An activity calendar was posted for August 2026. For the week beginning 08/24, the following activities were scheduled: 08/24 - 10:00 AM let's move 2:00 PM social hour 7:00 PM tik tack doe 08/25 10:00 AM better move 2:00 PM uno anyone 7:00 PM walk outside 08/26 10:00 AM let's move 2:00 PM armchair catch 7:00 PM daily events 08/27 10:00 AM get moving 2:00 PM let's dance 7:00 PM juice on deck 08/28 10:00 AM better move 2:00 PM social group 7:00 PM baseball brewers 08/29 10:00 AM better move 2:00 PM afternoon movie 7:00 PM card game Surveyor did not observe Caregiver C offer a structured activity at 10:00 AM, or any other point. During the onsite visit, Caregiver C tried to redirect Resident 1 to sit independently in the	N 427		

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N 427	Continued From page 6	N 427		

living room to watch music videos. Resident 1 said s/he liked the music and at times was agreeable to watch the videos. However, Caregiver C did not stay and engage with Resident 1 and Resident 1 did not remain in the living room for more than 10 minutes. Surveyors observed times when Resident 1 was walking through the common area and could still hear the music and s/he would break into dance. Caregiver C did not engage in dancing with Resident 1 or attempt to extend his/her interest in dancing to the music.

Surveyor conducted an interview with Caregiver C at 10:15 AM and asked if the activities on the posted activity calendar are offered. Caregiver C said Resident 2 likes to walk in the courtyard but that happens independently because Resident 1 is a very high elopement risk and needs most of Caregiver C's attention in the facility. Caregiver C said when Resident 2 is out in the courtyard that is considered the "let's move" activity. Caregiver C said activities are not offered to Resident 1 because of his/her disease progression. Caregiver C said, "Maybe we will watch TV with [Resident 1], [s/he] can't play cards or anything. Basically, it's music videos. Sometimes [s/he] will dance. [S/he] is a good dancer."

Surveyor reviewed the activity calendar for the month of August and "lets [sic] move or "better move" was listed 22 times and "cards" or "uno" were listed 4 times.

At 11:06 AM, Resident 2 entered the living room while the music videos were playing on TV. Surveyor asked if s/he liked the music and Resident 2 said, "No...it's on quite a bit." Surveyor noted the music was 90's hip hop and asked Resident 2 what kind of music s/he prefers.

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N 427	Continued From page 7	N 427		

Resident 2 said s/he did not like the music that was playing but loves Elvis and The Beach Boys. Surveyor asked if activities are offered at the facility and s/he said, "Not really...there is nothing to do here. I miss seeing my [family] who would take me for malts."

On 08/24/2026 at 2:34 PM, Surveyor interviewed Nurse Practitioner (NP) E. NP E expressed concern the caregivers do not attempt to develop or offer meaningful activities to Resident 1 which s/he could benefit from. NP E said they "could try painting, coloring, jewelry making...something [s/he] can get [his/her] hands on or be more interactive with. Bring him/her to a park or something. It seems a lot of time [s/he] just wants to go outside and get fresh air" and NP E said Resident 1 could benefit from taking supervised walks with staff.

On 08/24/2026 at 3:19 PM, Surveyor interviewed Lead Caregiver D. Lead Caregiver D said s/he frequently engages in movies, singing or dancing with Resident 1 and finds s/he does not experience the same degree of behaviors as the other staff. Lead Caregiver D said, "They don't engage with [him/her]. When I'm here...we sit down and watch TV together. I say, 'Let's watch an Elvis movie together' because Resident 2 loves Elvis movies," Lead Caregiver D said Resident 1 is satisfied to watch Elvis movies too as long as Lead Caregiver D is present and interacting with him/her. Lead Caregiver D said sometimes s/he will sit in the courtyard with both residents, but s/he would not feel comfortable with other caregivers bringing Resident 1 outside in any capacity because they struggle to effectively manage his/her elopement behavior and could not effectively supervise both residents at the same time. Lead Caregiver D said the

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N 427	Continued From page 8 home could benefit from being staffed with 2 caregivers to better meet Resident 1's needs, but that does not consistently happen. On 08/25/2026 at 9:18 AM, Surveyor interviewed Power of Attorney (POA) B. POA B expressed concern that Resident 1 is "so bored." POA B said Resident 1 could benefit from activities and said, "[S/he] loves music, [s/he] loves to dance, [s/he] likes to party. Anything with dancing and music...[S/he] loves action movies. [S/he] loves to go outside and walk. That was [his/her] thing, walking and going to stores and shopping...[S/he] likes dogs." POA B acknowledged Resident 1's attention span is not long and s/he is very "busy" pacing and moving through the facility but there are things s/he may be willing to do, including activities like balloon toss. Surveyor reviewed Resident 1's complete resident record at 12:00 PM. Resident 1's current Individual Service Plan (ISP) read, "To receive monitoring of activity participation." An observation note dated 07/22/2026 authored by Administrator A, "Resident loves to watch Christmas movies when [s/he] gets upset turn these on. Give [him/her] snacks, walk with [him/her]. You need to engage with [him/her] not just say no when try's [sic] to do something. This will calm [him/her] down. Do activity's [sic] with [him/her]. Dance with [him/her]." Cross Reference: N0433 DHS 83.38(1)(i) Behavior Management	N 427		

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N 433	Continued From page 9	N 433		
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 observation and interview, the provider did not meet the behavior management needs of Resident 1, resulting in at least 1 elopement and other incidents of exiting through the delayed egress doors. Specifically, on 08/14/2026, Resident 1 successfully eloped from the facility and was discovered by family when they arrived for a visit, and on 08/22/2026, Resident 1 exited the building again, wandered into traffic and community neighborhoods for 1 hour and 25 minutes while staff were unable to successfully intervene. The facility did not complete assessments after either incident to ensure the individualized service plan (ISP) was updated to reflect Resident 1's supervision needs or effective, individualized interventions to prevent elopement or manage agitation. Findings include: The Department received a complaint alleging concerns with a resident elopement. On 08/19/2026 the provider submitted a self-report that read in part, "Elopement 8/14/26	N 433		

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N 433	Continued From page 10 3:45 PM...Resident pushed on egress doors till [sic] they opened and [s/he] got out the door of the facility while staff was helping another resident in the bathroom. Staff heard the door alarm and went after resident [s/he] was on the sidewalk. Family had seen [sic] resident on side walk as staff had gone out the door...Action Taken to Ensure Resident's Health, Safety, and Well-Being - Resident is already on 30 min checks. Staff to keep [him/her] occupied to prevent [him/her] from trying to elope...MD is aware and reassessing [his/her] meds. [S/he] will also be seeing in house Psychiatrist...to adjust [his/her] medications due to [his/her] behaviors." OBSERVATIONS AND INTERVIEWS ON 08/24/2026: Surveyor made observations of Resident 1 between 10:30 AM and 1:15 PM. Surveyor observed Resident 1 was persistently exit seeking. The facility is equipped with delayed egress doors which alarm when pressure is applied. Surveyor observed Resident 1 trigger the alarms at least 12 times while trying to exit the facility. Caregiver C stayed either within line of sight or very close proximity of Resident 1. When Caregiver C would intervene at the door, Resident 1 was not easily redirected and would yell, scream and swear at Caregiver C. During other interactions, Surveyor observed Caregiver C offer cookies to Resident 1 and suggest s/he sit independently in the living room and watch his/her preferred music videos. However, the interventions were not successful in mitigating the behavior for more than 10 minutes.	N 433		

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N 433	Continued From page 11 Caregiver C told Surveyors this is typically how Resident 1 acts and s/he needs nearly constant supervision. Caregiver C said in the 4 hours prior to Surveyor's arrival, Resident 1 set off the door alarms approximately 20 times. Caregiver C said Resident 1 sometimes "gets out" and then staff have to try to get him/her back in the building. Resident 1 said the last time Resident 1 got out was 2 days prior. Caregiver C said sometimes two caregivers are present which allows one of them to assist the other resident and do cleaning/cooking tasks, but acknowledged it doesn't always happen and today s/he was the only caregiver. Surveyor observed Resident 2 was the only other resident living in the home. Resident 2 was in his/her room upon Surveyor's arrival and did not come out until 11:05 AM. At that time, Resident 2 requested Caregiver C make him/her pancakes. Caregiver C agreed, but repeatedly had to leave the kitchen to respond to Resident 1's exit seeking attempts. During these incidents, Resident 1 yelled and swore at Caregiver C. When Resident 1 was yelling and the alarms were going off, Surveyor observed that Resident 2 appeared distressed and was visibly sighing and shaking his/her head. Resident 2 did not receive the meal until 11:53 AM, which ultimately was an alternative to pancakes because there was no syrup in the home. Surveyor interviewed Resident 2 at 11:10 AM and 11:25 AM. Resident 2 said s/he doesn't like living at the facility, s/he thinks Resident 1 is too loud and s/he doesn't like the door alarms which "go off all day every day." At 12:05 PM and 12:35 PM, Surveyor observed	N 433		

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Administrator A attempt to manage Resident 1's behavior by verbally contradicting the resident's belief that his/her family was outside or coming to the facility. This approach increased Resident 1's agitation. During a subsequent interaction at 12:40 PM, Resident 1 said to Administrator A, "I am 2 minutes from whooping your [expletive]." Administrator A turned his/her back to Resident 1, stayed in close proximity said, "Go for it." Surveyor observed Administrator A appeared to be joking, however Surveyor also noted the response had the propensity to escalate the situation.

Surveyor interviewed Administrator A at approximately 12:45 PM. S/he explained, "Some days good some days not. I'm afraid for [his/her] safety. It's not the [caregivers], they are trying everything under the sun. There are times I need 3 people out here. When [s/he]'s really bad it's pretty much one to one with [him/her]." Administrator A said s/he's been talking with Nurse Practitioner (NP) E today about medication adjustments and referral for psychiatric services.

RECORD REVIEW:

Surveyor reviewed Resident 1's complete record on 08/24/2026 at approximately 12:10 PM. Resident 1 had diagnoses to include dementia and an activated power of attorney for healthcare.

Observation notes reviewed for July and August 2026 documented agitation and persistent exit seeking:

-07/05: "Hard time going to bed very combative and aggrisive [sic]..."
-07/07: "Aggressive after dinner, wandering and trying to get out from one door to the other,

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(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
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redirection is not working, the staff is following [him/her] around."
-07/15: "alot [sic] of anxiety, aggressive behaviors and tried to elope..."
-07/21: "pushed the door trying to get out..."
-07/22: "Resident loves to watch Christmas movies when [s/he] gets upset turn these on. Give [him/her] snacks, walk with [him/her]. You need to engage with [him/her] not just say no when try's [sic] to do something. This will calm [him/her] down. Do activity's [sic] with [him/her]. Dance with [him/her]." Author: Administrator A
-07/22: "was trying to get out of the house." When staff intervened, "[s/he] through [sic] a plate toward staff and it break [sic] into pieces"
-07/26: "pushed the door and went out the house 4 times...said [s/he] is looking for [family]." -07/31: "Res pushed the door attempting to go out of the house to find [his/her] [family]. Staff re-directed [him/her]...Res pushed the door open into the court yard and went outside, staff redirected [him/her] back in the house within a few min. [sic]"

-08/13: "pushed the door and alarm went off...redirected [him/her] back in the house [s/he] said [s/he] is looking for [family]"
-08/14: Elopement incident as documented in self-report authored by Caregiver C.
-08/16: "went out into the court yard, [s/he] said [s/he] is trying to get to [family]"
-08/21: "MD was updated on all the times resident has gotten out the door that [his/her] medications are not working and that [s/he] needs a locked facility."
-08/22: "pushed out the front door at 6:40 AM, 2 staff here, they could not get [him/her] back in, resident was going house to house yelling trying to get in the houses, crossed (street) over by other house, was yelling, traffic was stopping,

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N 433	Continued From page 14 [Administrator A] was notified, told them to get [him/her] back in the house. I [Manager B] was called at 7:50, to try and talk [him/her] back in, with no success, i [sic] went to the facility, did get [him/her] back in at 8:15am...prn was given...8:30 AM now sitting at eating." Author: Lead Caregiver D Resident 1's current Individual Service Plan read in part, -Attitude (updated: 05/20/2026) - To receive complete assistance and care from staff redirecting negative attitudes. [S/he] has a sense of humor but can also be strong headed if [s/he] wants. [S/he] does say inappropriate things at times but [s/he] can be easily redirected." Surveyor note: specific strategies for redirection were not identified and surveyor did not observe Resident 1 to be easily redirectable. -Aggressive/Combative (updated 08/24/2026) - To receive complete assistance and aiding in alleviating aggressive/combative situations... [s/he] will get agitated between 2pm to 4pm, keep [him/her] busy around that time. [S/he] loves candy and sweets. Offer [him/her] snacks often on and off during the day." -Wandering/Elopement (updated 08/24/2026) - To receive full supervision and redirection from staff to avoid and prevent wandering episodes. [S/he] is on 30 min checks, as [s/he] likes to open doors and look outside to see if [his/her] family is there. [S/he] thinks they are across the street. Watch [him/her] closely to make sure [s/he] doesn't elope out of the building. Watch [him/her] closely as [s/he] will go into the kitchen and take food and hide it all over the house, bed, down [his/her] pants...[S/he] will exit seek from all doors. [S/he] will continuously try the doors to get out." Surveyor note: the instruction for 30 minute	N 433		

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checks was inconsistent with staff interview and Surveyor's observation that Resident 1 needed constant supervision at times and the ISP did not identify strategies or interventions for redirecting Resident 1 back inside the building during times when s/he successfully exits.

The only assessments in the record were a preadmission assessment dated 05/04/2026 and a 14 day assessment dated 05/20/2026. There were no documented assessments after the elopement on 08/14/2026 and the incident on 08/22/2026.

ADDITIONAL INTERVIEWS:

Surveyor interviewed Administrator A on 08/26/2026 at 3:55 PM and reviewed the aforementioned concerns. Administrator A did not offer additional information. Surveyor requested Administrator A provide the ISP update history in ECP (the electronic record system) for the categories of Aggressive/Combative and Wandering/Elopement, to show evidence of any potential ISP updates prior to Surveyor's arrival onsite. Administrator A agreed to try to get the information and send by the end of the day. As 5:00 PM on 08/26/2026, Administrator A did not send evidence to show the ISP was updated in those categories prior to 08/24/2026.

Surveyor interviewed NP E on 08/24/2026 at 2:34 PM. NP E stated that when s/he is present at the facility, s/he does not observe the same level of aggression or exit seeking behaviors as reported by staff. NP E explained that Resident 1 is generally cooperative when NP E takes the time to explain his/her actions, engage, and build rapport. Furthermore, NP E stated Administrator A has requested medication changes, however

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without direct observation of the behaviors or frequent updates and corresponding documentation from the provider, s/he does not have the necessary information to inform potential medication adjustments. NP E said s/he believes some caregivers simply tell Resident 1 "no" or contradict his/her reality and indicated those are not effective interventions to mitigate his/her dementia related behaviors.

Surveyor inquired about the provider's efforts to collaborate on meeting Resident 1's behavioral management needs. NP E said s/he was contacted today, 08/24/2026, by Administrator A about Resident 1's behaviors and was aware of the 08/16 and 08/22 incidents.. NP E said s/he would review his/her records for dates of other notifications during July and August. On 08/26/2026 at 4:55 PM NP E sent an email and wrote that during July s/he received 1 notification on 07/29/2026 reporting Resident 1 was "trying to get outside more, but [s/he] was redirectable." Next in "mid-to-late August...[s/he] was becoming more aggressive and eloping more often...I saw [Resident 1] today; [s/he] was definitely more on edge and less redirectable than in the past... [Resident 1] mentioned experiencing pain when trying to use the bathroom (and) [his/her] urine is extremely dark and malodorous. I ordered treatment for a suspected UTI because staff have been unable to obtain a urine sample. I will follow up with [Administrator A] next week to check on [his/her] progress."

Surveyor interviewed Lead Caregiver D on 08/24/2026 at 3:19 PM. Lead Caregiver D stated that s/he does not experience the same difficulties with Resident 1 as the other caregivers and said, "I don't have a problem with [him/her] and [s/he] has never left the building when I'm

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there." Lead Caregiver D recalled when Resident 1 left the building on 08/22/2026 and s/he had to respond to the facility to help Caregiver C. Lead Caregiver D said Resident 1 was outside for more than an hour and was disruptive to neighbors by banging on their doors. Lead Caregiver D said there is 1 neighbor who will come over and help staff get Resident 1 inside if s/he sees a caregiver is having difficulty doing it. Lead Caregiver D stated when s/he arrived onsite on 08/22, Resident 1 went right back inside. Surveyor asked about caregivers' approaches and Lead Caregiver D said, "They don't engage with [him/her]" and Resident 1 gets focused on leaving to find [his/her] family. Lead Caregiver D said the situation impacts Resident 2 who "gets upset with (the door alarms)...especially...if it's a lot. [S/he] will get upset...if [Resident 1] is screaming at [the caregivers]." Lead Caregiver D concluded by saying, "I don't have a hard time managing [him/her]. It's not perfect. But [s/he]'s good with me."

Surveyor interviewed Power of Attorney (POA) B on 08/25/2026 at 9:18 AM. POA B expressed concern the provider is not adequately managing Resident 1's dementia related behaviors. POA B recalled on 08/14/2026, s/he arrived at the facility for a visit and observed Resident 1 outside alone, "which was dangerous." After several minutes, Caregiver C came out looking for Resident 1. POA B pointed out the facility is only home to 2 residents so they should be able to provide better care to Resident 1. POA B also said s/he was told the home would be staffed with 2 caregivers to better supervise Resident 1 and it obviously was not on 08/14/2026 when Resident 1 eloped. POA cried during the interview about his/her care concerns for Resident 1 and said s/he would be requesting the managed care organization find a

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N 433	Continued From page 18 different facility to better meet Resident 1's needs. Cross Reference: N0408 DHS 83.37(1)(i) PRN Psychotropic Medication N0427 DHS 83.38(1)(c) Leisure Time Activities N0489 DHS 83.44(1)(a) Rooms Clean and Free From Odors	N 433		
N 454	83.42(1) Resident record maintained. The CBRF shall maintain a record for each resident at the CBRF. Each record shall include all of the following: (a) Resident ' s full name, sex, date of birth, admission date and last known address; (b) Name, address and telephone number of designated contact person, and legal representative, if any; (c) Medical, social, and, if any, psychiatric history; (d) Current personal physician, if any; (e) Results of the initial health screening under s. DHS 83.28(4) and subsequent health examinations under s. DHS 83.38(1)(g); (f)Admission agreement; (g) Documentation of significant incidents and illnesses, including the dates, times and circumstances; (h) Assessments completed as required under s. DHS 83.35(1); (i) Individual service plan and resident satisfaction evaluation; (j) Documentation to accurately describe the resident's condition, significant changes in condition, changes in treatment and response to treatment; (k) Results of the annual resident evacuation evaluation; (l) Documentation of sensory impairment of the resident as required under s. DHS 83.48(7)(b); (m) Summary of discharge information as required under s.DHS 83.31(7); (n) Any department-approved	N 454		

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N 454	Continued From page 19 resident-specific waiver, variance or approval; (o) Physician ' s orders or other authorized practitioner ' s written orders for nursing care, medications, rehabilitation services and therapeutic diets; (p) Current list of the type and dosage of medications or supplements; (q) Results of the quarterly psychotropic medication assessments as required in s. DHS 83.37(1)(h)1; (r) Documentation of administration of all medications, supplements, the person administering the medications or supplements, any side effects observed by the employee or symptoms reported by the resident, the need for PRN medications and the resident ' s response, refusal to take medication, omissions of medications, errors in the administration of medications and drug reactions; (s) Photocopy of any court order or other document authorizing another person to speak or act on behalf of the resident, or other legal documents as required which affect the care and treatment of a resident; (t) Documentation of all other services including rehabilitation services, treatments and therapeutic diets; (u) Completed notice of pre-admission assessment requirement under s. DHS 83.30; (v) Nursing care procedures and the amount of time spent each week by a registered nurse or licensed practical nurse in performing the nursing care procedures. Only time actually spent by the nurse with the resident may be included in the calculation of nursing care time; (w) Plans of care for terminally ill residents; (x) Date, time and circumstances of the resident's death, including the name of the person to whom the body is released. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not maintain the complete	N 454		

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resident record for 2 of 2 residents that resided at the CBRF. Physician orders, legal representative documentation and admission agreements were not maintained at the facility.

This is a repeat deficiency. See Statement of Deficiency Q5QB11, dated 05/07/2026.

Findings include:

On 08/24/2026 at 10:11 AM, Surveyor contacted Administrator A from the facility by phone requested the complete resident records for Resident 1 and Resident 2. Administrator A said s/he would bring the records from his/her office in Menasha.

On 08/24/2026 at 10:15 AM, Surveyor interviewed Caregiver C. Caregiver C said the only resident records s/he has access to are the records in ECP (electronic record keeping system.) S/he said there were not paper records located at the facility for either of the 2 residents. At 12:00 PM, Surveyor reviewed Resident 1 & Resident 2's records in ECP. The records did not include, admission agreements, physician's orders for medications or services, or copies of court orders/other documentation regarding legal representatives.

On 08/24/2026 at 11:39 AM, Administrator A arrived at the facility with two stacks of loose papers. S/he said 1 stack was for Resident 1 and the other for Resident 2. Surveyor asked if the records were the complete records for each resident and Administrator A said, "For now, yes. They don't have a whole lot." Administrator A said his/her assistant was in the process of organizing resident records and if s/he returned the office and located any additional records s/he would fax

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N 454	Continued From page 21 them by the end of the day. At 3:17 PM, Administrator A faxed 39 pages of additional documentation from Resident 2's record. Surveyor reviewed the paper records and faxed documentation provided by Administrator A and noted they contained signed admission agreements and physician orders. In addition, Resident 1's record contained documentation activation of his/her power of attorney due to incapacitation and Resident 2's court orders for guardianship and court order for involuntary medication and treatment. Surveyor noted this documentation is required to be maintained in the resident records which is to be kept at the facility. Surveyor interviewed Administrator A on 08/26/2026 at 3:55 PM and reviewed the aforementioned concerns. Administrator A did not offer additional information	N 454		
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. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not make reasonable attempts to keep Resident 1's room clean and free from odor. Findings include: On 08/24/2026 at 10:35 AM, Surveyor observed Resident 1's room while accompanied by Resident 1 and Caregiver C.	N 489		

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N 489	Continued From page 22 Surveyor observed the room had a strong odor. The white fitted sheet on the bed had stains and crumbs and was not properly placed on the mattress. There was no mattress protector under the sheet, only a cloth incontinence pad. The pillow did not have a pillow case and was stained; including one dark colored stain approximately 2 inches long by 1 inch wide. There was a blue recliner with cloth fabric in the room. The recliner had both dark and light colored stains scattered over most of the fabric in the seat areas and arms. The floor and tops of the registers had dust and debris and were in need of cleaning. Caregiver C acknowledged Surveyor's observations and said when s/he arrived for work at 6:00 AM this morning, this was the condition of the room and s/he had not had time to clean it since then. Caregiver C said Resident 1's room and sheets are usually cleaned at shift change when there are 2 staff present. S/he said that is necessary because on caregiver needs to occupy Resident 1 while the other cleans. Caregiver C confirmed the room cleaning did not occur today. Caregiver C acknowledged the odor but could not articulate what the source was. Surveyor returned to Resident 1's room at approximately 12:35 AM, accompanied by Administrator A and Resident 1. Upon entry to the room, Surveyor observed Caregiver C was mopping the floor but the odor in the room persisted. Resident 1 quickly became agitated and demanded everyone leave. Administrator A said it is hard to keep Resident 1's room clean because s/he doesn't like people in his/her room and also because s/he "destroys it" and "smears stuff." Administrator A agreed the room had an odor and attributed it to Resident 1' body odor and hair product.	N 489		

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N 489	Continued From page 23 Surveyor interviewed Lead Caregiver D on 08/24/2026 at 3:19 PM. S/he confirmed Resident 1 gets upset when caregivers try to clean the room and it's important to do it while Resident 1 is occupied with another caregiver. Lead Caregiver D attributed the room odor to Resident 1 hiding food in his/her room and said the pillow is stained because s/he carries it around. Surveyor interviewed Power of Attorney (POA) B on 08/25/2026 at 9:18 AM. POA F said when s/he visited last on 08/14/2026, Resident 1's room had an odor similar to feces and there was feces on a surface in his/her room. Surveyor reviewed Resident 1's record on 08/24/2026 at 12:00 PM. Resident 1 had diagnoses to include dementia and his/her current individual service plan (ISP) indicated s/he relied on staff assistance with upkeep of his/her room and housekeeping needs. The ISP was silent to any tendency to "destroy" the room, smear things or get upset when caregivers try to clean. The ISP did not identify interventions to meet Resident 1's needs in this area. Surveyor interviewed Administrator A on 08/26/2026 at 3:55 PM and reviewed the aforementioned concerns. Administrator A did not offer additional information. Cross Reference: N0433 DHS 83.38(1)(i) Behavior Management	N 489		