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	0014550	A. BUILDING: _____ B. WING _____	C 07/17/2026

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AUTUMN BAY OF PEWAUKEE	539 E WISCONSIN AVE PEWAUKEE, WI 53072

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N 000	Initial Comments On 07/14/2026 with information gathered through 07/17/2026, Surveyor conducted a complaint investigation at Autumn Bay Of Pewaukee. Two deficiencies were identified. The complaint was substantiated. Census: 20	N 000		
N 326	83.31(4)(a) Notice of facility initiated discharges Discharge or transfer initiated by CBRF. Notice and discharge requirements. 1. Before a CBRF involuntarily discharges a resident, the licensee shall give the resident or legal representative a 30 day written advance notice. The notice shall explain to the resident or legal representative the need for and possible alternatives to the discharge. Termination of placement initiated by a government correctional agency does not constitute a discharge under this section. 2. The CBRF shall provide assistance in relocating the resident and shall ensure that a living arrangement suitable to meet the needs of the resident is available before discharging the resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the 30-day written advance notice was adhered to when the provider refused readmission from the hospital within the 30-day time frame and did not ensure a living arrangement suitable to meet the needs of the resident was available. On 05/04/2026, Resident 1 was admitted to the	N 326		

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

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N 326	Continued From page 1 hospital due to aggressive behaviors and on 05/04/2026 the provider issued a 30-day involuntary discharge notice due to Resident 1's behaviors (that were harmful to self and others) and inability to provide cares s/he needed. The provider did not reassess Resident 1 for readmission within the 30-day timeframe despite the hospital's claims behaviors had stabilized. Findings include: On 05/13/2026, the Department received a complaint alleging the provider denied readmission from hospital after the resident's behaviors had stabilized. On 07/14/2026, Surveyor reviewed Resident 1's record. S/he was admitted 04/16/2026. Diagnoses included Alzheimer's dementia with behavioral disturbance. Self-Report by Licensee A (incident date 05/04/2026) (summarized): At approximately 12:30 AM on 05/04/2026, Resident 1 flipped another resident out of his/her wheelchair. At approximately 10:00 AM, Family Member C (Resident 1's activated Health Care Power of Attorney (HCPOA)) took him/her to emergency room, and s/he was admitted for an assessment. " ...Thirty day [sic] notice of discharge was issued and not overturned despite hospital stating Resident 1 was stable ..." Involuntary discharge Notice dated 05/04/2026 stated " ...please accept this as our formal 30-day notice of discharge. As you are aware, [Resident 1's] behaviors have markedly escalated to the point of unprecipitated aggressions toward staff and residents. In accordance with DHS 83.31(4)(b)(3) Care is required that is inconsistent with the	N 326		

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N 326	Continued From page 2 CBRF's program statement and beyond that which the CBRF is required to provide under the terms of the admission agreement and this chapter and (5) there is imminent risk of serious harm to the health or safety of the resident, other residents or employees, as documented in the resident's record ..." Emails- 05/05/2026 1:46 PM from Licensee A to Family Member C and managed care organization: " ...After much deliberation, I have decided to give the official 30 day notice of discharge. Please understand that this does not necessarily mean that I would not entertain re-evaluating after medication treatment, but it is imperative to be formalized to ensure [s/he] does not prematurely return ...Thank you for your understanding, and I sincerely hope that the hospital is able to come up with a workable plan ..." 05/07/2026 12:37 PM- From Hospital Discharge Planner B to Licensee A and managed care organization: " ...I'm reaching out today because I spoke with [Family Member C] today and [s/he] mentioned that you provided [him/her] with a 30-day notice on Tuesday, which hospital was not aware of. I was also informed by the [emergency department] social worker that you would be willing to come and reassess [him/her] if [his/her] behaviors have stabilized. Per the RN during rounds [s/he] has been calm and cooperative with no aggression since admission. [S/he] has also been taking all medications crushed in ice cream without issue. [S/he] does continue to have a sitter. If you are willing to come and reassess [him/her] do you want [him/her] sitter free before you reassess him? Or are you moving forward with a 30-day notice and [s/he] cannot return [sic] [S/he] is medically stable for discharge ..."	N 326		

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N 326	Continued From page 3 05/07/2026 12:39 PM- From Hospital Discharge Planner B to Licensee A and managed care organization: " ...In addition, Psychiatry involved for medication adjustment as followed Depakote started Nightly [sic] Seroquel increased as recommended As [sic] needed Haldol/Zyprexa Continued [sic] home dose trazadone, Memantine [sic] ..." 05/07/2026 1:09 PM from Licensee A to Hospital Discharge Planner B and managed care organization: " ...Thank you for reaching out with the updates. I know it's difficult for you to triage the aggressions we have seen when [s/he] doesn't display them but appreciate the med changes. When I initially admitted [him/her], I was willing to do so prior to the sitter cessation with the understanding the hospital environment is unique. However, given the constant behavioral concerns [s/he] exhibited with us, I would like to see the sitter discontinued successfully prior to re-assessing. Likewise, we would like to see a somewhat normal sleep pattern. Regarding the 30 day discharge, I did implement it to protect us should [s/he] not be better managed. I am willing to entertain reassessing pending the above ..." 05/07/2026 1:15 PM From Hospital Discharge Planner B to Licensee A and managed care organization: " ...One more question, staff told me sitter is there to keep him occupied when [s/he] tries to leave [his/her] room and wander. Do you want the sitter completely gone?..." 05/07/2026 1:20 PM from Licensee A to Hospital Discharge Planner B and managed care organization: " ...We didn't have a sitter for [him/her] nor is it feasible. [S/he] has been consuming an entire staff's attention but even that	N 326		

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N 326	Continued From page 4 hasn't been enough with the aggressions ..." 05/11/2026 8:58 AM From Hospital Discharge Planner B to Licensee A, Family Member C and managed care organization: " ...Attached are updated RN, MD, psychiatrist and behavioral therapist notes from Friday through the weekend. As of Friday, sitter was removed and [s/he] has been doing well over the weekend. [S/he] also has been taking medications with ice cream or pudding which appear to help with compliance. Please let me know if you think an on-site would be appropriate and if so, when would you be able to come assess. [sic] ..." 05/11/2026 11:23 AM from Licensee A to Hospital Discharge Planner B, Family Member C and managed care organization " ...Thank you for this information, but I am a little confused. One of my staff was on the unit visiting [his/her family member] yesterday and witnessed [him/her] walking the halls with 2 staff. [S/he] also reported that [Resident 1] is routinely coming into [his/her] room throughout the day. I really am not feeling confident about accepting [him/her] back with this information ..." 05/11/2026 12:55 PM from Hospital Discharge Planner B to Licensee A, Family Member C and managed care organization: " ...This is very concerning that one of your staff members provided you this information without context or understanding. It is my understanding that a proper onsite reassessment has not yet been completed. Your response implies that the hospital is providing false or limited information. I provided every note that was entered over the weekend for full transparency as we are aware of all of [his/her] previous and ongoing behavior concerns. I followed up with both the RN and	N 326		

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N 326	Continued From page 5 Charge RN. All ambulatory patients are required to be accompanied by staff. The Charge RN also shared that the hospital currently has many [certified nursing assistants] in training, which may explain why two staff members were walking with [him/her]. Additionally, staff described [him/her] as "really cute" and indicated that they enjoy spending time with [him/her], which may explain why there were multiple staff members walking with [him/her]. [S/he] does not require 2 staff members to walk with [him/her] in the halls. I was also told that [s/he] has been very appropriate with staff. There have been no reports of [him/her] entering other patients' rooms, no security involvement, and no [as needed] medication administered. The hospital and [Family Member C] will now work with [managed care organization's name] on finding a new placement ..." On 07/17/2026 at 10:06 AM, Surveyor interviewed Licensee A who stated s/he would have issued the 30-day involuntary discharge whether or not Resident 1 had been hospitalized on 05/04/2026. Licensee A stated they initially admitted Resident 1 on 04/16/2026 knowing s/he had behavior issues but were misled by the hospital (same hospital admitted to on 05/04/2026) regarding behaviors. Licensee A stated his/her employee witnessed Resident 1 escorted by security guards out of another hospital patient's room. Licensee A stated because the hospital discharge planner was not completely truthful regarding Resident 1's behaviors exhibited during hospitalization s/he decided to not complete a readmission assessment or accept Resident 1 back. Licensee A stated it was not safe for Resident 1, other residents or staff to readmit Resident 1 due to his/her behaviors.	N 326		

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N 326	Continued From page 6 Cross Reference: N0385 DHS 83.35(2) Temporary Service Plan	N 326		
N 385	83.35(2) Temporary Service Plan. Temporary service plan. Upon admission, the CBRF shall prepare and implement a written temporary service plan to meet the immediate needs of the resident, including persons admitted for respite care, until the individual service plan under sub. (3) is developed and implemented. This Rule is not met as evidenced by: Based on record review and interview the provider did not ensure when there was a change in a resident's needs, abilities or physical or mental condition, the individual service plan (ISP) was reviewed and revised. Resident 1's temporary ISP was not updated to address all of his/her behaviors. Then when Resident 1 flipped another resident over in a wheelchair, s/he was admitted to hospital due to behaviors and the provider issued a 30-day involuntary discharge notice due to behaviors and care needs beyond what the CBRF could provide. Findings include: The facility is licensed as a Class CNA (nonambulatory) CBRF able to serve up to 22 residents within the client groups of irreversible dementia/Alzheimer's, physically disabled, traumatic brain injury, advanced age, terminally ill and emotionally disturbed/mental illness. On 07/14/2026, Surveyor reviewed Resident 1's record. S/he was admitted 04/16/2026.	N 385		

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N 385	Continued From page 7 Diagnoses included Alzheimer's dementia with behavioral disturbance. Daily Flow Sheet Supplement forms (summarized): -04/19/2026- Pushed his/her mattress down the hall towards door then removed mattress from bed again and leaned it against his/her room wall; entered another resident's room and ate other resident's bread; entered a 2nd resident's room and startled visitor; ate bananas s/he took from tables and kitchen; attempted to open and was kicking back door. "[S/he] is very confused and likes to wander. Can be redirected pretty easily. Not aggressive or harming anyone." -04/20/2026- Urinated in hallway and wandered around facility checking other resident's doors; was redirected out of activity closet; exited alarmed door onto the deck and was redirected back in; wandering and numerous exit attempts until approximately 3:00 AM. Was redirected but did not engage in activities for long. When updated by staff, family stated "[s/he's] been like this for a while, & needs distraction." -04/24/2026- Came out of room into hallway naked; Took other resident's cups and bananas from tables and drank from their cups; entered kitchen and took a bunch of bananas then held bananas high so staff could not reach them; opened a package that was in office; grabbed the radio by the kitchen counter; entered other resident's rooms (took another resident's bible, flag and sentimental item from room and at 10:32 PM, pulled sheets off another resident who was in bed). Another resident told staff Resident 1 always knocked on his/her door, s/he was afraid of Resident 1 and Resident 1 was the reason they stayed locked inside their room. -05/02/2026- Attempted to open window and get out; shook back door's doorknob to get out;	N 385		

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opened locked door to get out and redirected back inside; entered another resident's room and grabbed the other resident's wheelchair; and checked all doorknobs.
-05/03/2026- Refused to be changed when incontinent; entered kitchen and grabbed coffee cup and bread; entered another resident's room, put the other resident's pants on and left his/her pants in other resident's room; walked into another resident's room while staff were performing cares, and when asked to leave aggressively refused.
-05/02/2026- Attempted to open window and shook back door's doorknob to get out; opened locked door to get out and redirected back inside; entered another resident's room and grabbed the other resident's wheelchair; and checked all doorknobs.
-05/03/2026- Refused changing when incontinent; entered kitchen and grabbed coffee cup and bread; entered another resident's room, put the other resident's pants on and left his/her pants in other resident's room; walked into another resident's room while staff were performing cares, and when asked to leave aggressively refused.

Behavior Note (dated 04/28/2026 3:00 PM) " ...Swung [his/her] fist in the air toward writer, then jumped toward writer and laughed. Grabbed [sic] writers [sic] shoulders hard, let go when writer pried arms off ...Resident was pulling tablecloth from table. When staff intervened, resident grabbed writers [sic] wrists & squeezed refusing to let go. Writer calmy told resident to release & was able to break free ...Staff removed resident from dining room & distracted resident with a snack ..."

Behavior Log (summarized)

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N 385	Continued From page 9 -04/21/2026- Walked halls naked; pushed through back door and went outside -04/24/2025- Stole another resident's lunch was aggressive with a 2nd resident. -04/26/2026- Attempted to take other resident's food and walking around in dining room; pounded drink on table and played with his/her food; wandering and not redirectable until lunch; entered kitchen and took all bananas; attempted to enter kitchen again when redirected attempted to climb through serving window back into kitchen; wandering into other resident's rooms; attempted to push another resident's wheelchair; attempted to open back door; took items off dining room tables and crushed creamer packages. Staff attempted to redirect with Legos, wooden box, movie, walk outside, coloring, one-to one staff and as needed psychotropic medication but nothing was effective. -04/27/2026- Went into another resident's room, moved stuff around and pulled pants down. Staff redirected. -04/28/2026- Raised fists and attempted to punch a staff member. -04/29/2026- Spit 3:00 PM medications into a cup then dumped them into trash. -05/01/2026- Refused to be changed into clean incontinent product and punched staff; refused to open mouth for as needed psychotropic medication. -05/04/2026 12:00 AM-6:00 AM (summarized)- Hit and flipped another resident out of wheelchair; pushed the Hoyer lift down hallway; pushed his/her mattress into hallway and yanked on other resident's door handles. Daily Sleep Log (dated 04/29/2026-05/03/2026 (summarized) 04/29/2026-Slept 1:00 AM-6:00 AM 04/30/2026- Slept 8:00 PM-6:00 AM	N 385		

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05/01/2026- Slept 7:00 PM-5:00 AM
05/02/2026- Slept 10:00 PM-2:00 AM, 4:00 AM-5:00 AM and 6:00 AM-8:00 AM
05/03/2026- Slept 10:00 PM-12:00 AM, 6:00 AM-7:00 AM (no data 12:00 PM-2:00 PM)

Medical Group Provider Communication Record (signed and dated 04/22/2026 by provider)- " ...See psych as planned- will need time to adjust to new place, use PRN meds for agitation ...Please establish with psychiatry provider at facility ..."

Incident Report dated 05/04/2026 (summarized) Resident 1 and Resident 2 were watching a movie in the common area. Resident 1 tried to push Resident 2's wheelchair then started hitting Resident 2. Staff began redirecting Resident 1 and s/he flipped Resident 2 out of the wheelchair. Staff called 911, police responded and spoke with Resident 1 who did not appear to understand. Police escorted Resident to his/her room and told him/her to stay in room, but Resident 1 left his/her room after police left. Resident 2 was not injured.

Self-Report (incident date 05/04/2026) (summarized) At approximately 12:30 AM on 05/04/2026, Resident 1 flipped another resident out of his/her wheelchair. At approximately 10:00 AM, Resident 1's Health Care Power of Attorney (HCPOA) took him/her to emergency room, and s/he was admitted for an assessment. " ...Thirty day [sic] notice of discharge was issued and not overturned despite hospital stating Resident 1 was stable ..."

Involuntary discharge Notice dated 05/04/2026 stated " ...please accept this as our formal 30-day notice of discharge. As you are aware, [Resident 1's] behaviors have markedly escalated to the

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point of unprecipitated aggressions toward staff and residents. In accordance with DHS 83.31(4)(b)(3) Care is required that is inconsistent with the CBRF's program statement and beyond that which the CBRF is required to provide under the terms of the admission agreement and this chapter and 950 there is imminent risk of serious harm to the health or safety of the resident, other residents or employees, as documented in the resident's record ..."

ISP dated 04/16/2026-
In the section of Behavior Patterns-
1. Medications- "Dependent and compliant"
2. Wandering/Elopement- "High risk of indirect wandering, high risk of elopement especially during sundowning, requires window locks and alarms Maintain locked and alarmed doors at all times; redirect as necessary; document and report concerns ..."
3. Other- "Likes to be affectionate with people but can be intimidating due to [his/her] size-hugs, pats on back, hand holding [sic]. New tendency to try and flush things down the toilet [sic] Tendency to take things apart- mechanicals, electronics, etc. Redirect as necessary [sic]. Keep bathroom door locked when not in use with staff supervision [sic] Keep mechanical room locked at all times [sic] Keep engaged in safe, constructive activates [sic] - blocks, latch box, sorting, breaking down boxes, etc. ..."

The ISP did not identify or address the additional behaviors displayed by Resident 1 or his/her difficulty sleeping.

On 07/17/2026 at 10:06 AM, Surveyor interviewed Licensee A who stated Resident 1's temporary ISP was not updated because it was only a temporary ISP and staff were still getting to

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N 385	Continued From page 12 know him/her. Licensee A stated Resident 1's comprehensive ISP was not due until 30 days after admission, but Resident 1 was hospitalized 05/04/2026 only a couple weeks after admission. Licensee A stated staff tried to manage behaviors with one-to-one supervision, redirection, behavior and sleep monitoring. Licensee A stated Resident 1's behaviors were sudden and unpredictable. Cross Reference: N0326 DHS 83.31(14)(a) Notice Of Facility Initiated Discharges	N 385		