| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0020631 | A. BUILDING: _____ B. WING _____ | R 08/06/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DIMENSIONS LIVING CUDAHY | 6180 S CREEKSIDE DR CUDAHY, WI 53110 |

| (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<br><br>On 08/04/2026 with information gathered through 08/06/2026, Surveyor conducted a verification visit for SOD VPK211, dated 06/02/2026, at Dimensions Living Cudahy, a Community-Based Residential Facility (CBRF) in Cudahy, WI.<br><br>One deficiency identified. One of 1 deficiency was a repeat deficiency from Statement of Deficiency VPK211, dated 06/02/2026.<br><br>Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed.<br><br>Census: 20 | {N 000} | | |
| {N 481} | 83.43(1) Environment safe, clean, and comfortable<br><br>Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the provider did not ensure the facility was maintained in a safe clean, comfortable, and homelike environment. The facility needed some repairs. This had potential to affect 20 of 20 residents.<br><br>This is a repeat deficiency. See Statement of Deficiency VPK211, dated 06/02/2026.<br><br>Findings include:<br><br>The facility is licensed as a class CNA | {N 481} | | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0020631 | A. BUILDING: _____ B. WING _____ | R 08/06/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **DIMENSIONS LIVING CUDAHY** | **6180 S CREEKSIDE DR CUDAHY, WI 53110** |

| (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 481} | Continued From page 1<br>(non-ambulatory) for up to 20 residents with programs in terminally ill, advanced aged and irreversible dementia/Alzheimer's.<br><br>On 08/04/2026, at approximately 9:03 AM, Surveyor conducted a tour of the facility with Lead Supervisor D and observed the following:<br><br>-Mechanical room 2 flooring contained water and brown residue near furnace.<br><br>-Mechanical room 2 had a pungent odor.<br><br>-Door and door frames throughout facility showed signs of scratches.<br><br>-Walls throughout home showed signs of scraping.<br><br>-Pantry shelving had discoloration and rust colored markings.<br><br>-Sliding door near common living area was missing door handle.<br><br>-Wall plate in the common area was missing 1 of 3 switches.<br><br>On 08/04/2026, at approximately 11:48 AM, Surveyor interviewed Plant Operator E. Plant Operator E confirmed the above-mentioned issues. Plant Operator E reported s/he was responsible for the maintenance throughout facility. Plant Operator E reported s/he was not aware of the above-mentioned issues, and s/he will ensure the above-mentioned issues were addressed. | {N 481} | | |