STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110458	A. BUILDING: _____ B. WING _____	C 03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM JONATHON	223/225 JONATHON DR JANESVILLE, WI 53548

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N 000	Initial Comments From 03/06/2026 to 03/10/2026, Surveyors conducted a complaint investigation at REM Jonathon, a CBRF in Janesville. Five deficiencies were identified. Census: 5	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 provide Resident 1's legal guardian a 30-day written advance notice of the involuntary discharge. Resident 1 was admitted to the hospital on 01/17/2026 and was discharged from the facility. A written notification of Resident 1's involuntary discharge was provided to Resident 1's case manager on 01/20/2026. Findings include:	N 326		

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

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N 326	Continued From page 1 On 03/03/2026, Surveyor reviewed Resident 1's closed record, that was provided by Area Director A and Program Director B. Resident 1 was admitted to the facility on 11/04/2025 with a diagnosis including Bi-polar, type 2 diabetes and dementia (early stage). Surveyor reviewed a progress note dated 01/17/2026 that documented that Resident 1 was sent to the hospital. There was no other documentation for Resident 1 after his/her hospitalization. On 03/03/2026, at approximately 12:30 p.m., Surveyor asked Program Director B if Resident 1 had returned, or was planning to return, to the facility after the hospitalization on 01/17/2026. Program Director B stated no that Resident 1 required more supervision than what the provider could staff, so Resident 1 involuntarily discharged after s/he was admitted to the hospital. Surveyor asked if a 30-day involuntary discharge was provided to Resident 1's legal representative. Program Director B stated s/he was unsure. On 03/10/2026 at 1:36 p.m., Area Director A provided Surveyor with the involuntary discharge notice that was sent to Resident 1's case manager, dated 01/20/2026, 3 days after Resident 1 was admitted to the hospital. Cross Reference N0381 DHS 83.35(1)(a) Pre-Admission and Ongoing Assessment N0433 DHS 83.38(1)(i) Behavior Management	N 326		
N 346	83.32(3)(b) Rights of Residents: Confidentiality In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Confidentiality. Confidentiality of health and	N 346		

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N 346	Continued From page 2 personal information and records, and the right to approve or refuse release of that information to any individual outside the CBRF, except when the resident is transferred to another facility or as required by law or third-party payment contracts and except as provided in s.146.82(2) and (3), Stats. The CBRF shall make the record available to the resident or the resident ' s legal representative for review. Copies of the record shall be made available within 30 days, if requested in writing, at a cost no greater than the cost of reproduction. This Rule is not met as evidenced by: Based on record review and interview, Resident 1 had his/her confidentiality of health information violated by the provider by sharing his/her diagnosis. There was a documented incident between Resident 1 and Resident 2 as well as Resident 1 and Resident 3 on 12/29/2025. The provider notified Resident 2's health care power of attorney (POA) and his/her case manager about the incident as well as Resident 3's family member, providing the gender and diagnoses of Resident 1. Findings include: On 02/18/2026, the department received a complaint alleging a resident was sexually assaulted in the facility. On 03/03/2026 Surveyors conducted a complaint investigation. The provider is licensed as a class CNA (non-ambulatory) CBRF able to serve up to	N 346		

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N 346	Continued From page 3 6 residents within the client groups of traumatic brain injury, developmentally disabled, advanced age, and emotionally disturbed/mental illness. Surveyor reviewed an incident report, dated 012/29/2025 that documented: "[Resident 1] returned home from the hospital on 12/29/25 at 1pm. [Resident 1] started exploring the house and looking at [his/her fe/male] peers; attempting to talk to them, asking which of [his/her] peers were verbal and then proceeded to attempt to get [Resident 3] to come over on to [his/her] side of the home. Staff verbally redirected [Resident 1] and told [him/her] that [s/he] was being inappropriate. [Resident 1] went back to [his/her] bedroom until [s/he] had heard [Resident 2] enter the restroom. Staff noticed [Resident 1] was standing in his doorway staring into the bathroom. When staff turned around from closing the restroom door; [Resident 1] had [his/her] pants down to the ground. Staff asked [Resident 1] what [s/he] was doing. [Resident 1] said, nothing and [s/he] went back into [his/her] bedroom and stayed in [his/her] room until 3rd shift arrived. When 3rd shift arrived, [Resident 1] went over by the staff and said, "Do you want to get laid?" Staff verbally redirected [Resident 1] by saying; this is inappropriate, I'm your staff member - time to get some rest. Staff reported [Resident 1] later attempted to enter [Resident 2's bedroom while [Resident 2] was asleep. Staff asked [Resident 1] what [s/he] was doing and [Resident 1] returned to [his/her] bedroom. No other events occurred throughout the night." On 03/03/2026 at 12:37 p.m., Surveyor asked Area Director A if Resident 2's POA was notified of the incident on 01/17/2026. Area Director A stated yes and that s/he would send Surveyor the confirmation of who was notified of the incident.	N 346		

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N 346	Continued From page 4 On 03/03/2026 at 1:02 p.m., 01/05/2026 at 10:27 a.m., Area Director A forwarded Surveyor an email that Area Director A sent to Resident 3's family member on 01/05/2026 at 10:27 a.m. that stated, "I wanted to report to you that we are keeping a close eye on all members at the home currently due to our new individual who recently moved in. The [fe/male] member lives on the other side of the home and on 12/29/25 [s/he] had spoken to [Resident 3] asking [him/her] to go to other side of home and was redirected immediately by staff. I wanted to let you know as [Resident 3] may mention [him/her] speaking to [him/her]. Nothing happened but I want you to know we have extra staff on for now as this member has early stage Dementia and has approached other individuals at the home as well speaking to them. We are keeping close eye and working on a potential transfer of the member to an all [fe/male] home closer to [his/her] level." On 03/03/2026 at 1:05 p.m., Area Director A forwarded Surveyor an email that Area Director A sent to Resident 2's POA and case manager on 01/05/2026 at 10:27 a.m. that stated, "I wanted to reach out to report that on 12/29/25 there was an incident where one of our new [fe/male] individuals was seen standing in doorway of bathroom when [Resident 2] was on the toilet and near [his/her] bedroom door. Staff immediately redirected [him/her] away from the area. This member is being very closely monitored due to [him/her] having early stage Dementia as well. Staff are ensuring [Resident 2] is keeping bathroom door closed when using the bathroom now as during incident it was open. Staff do not always know when [s/he] is walking in there right away. [Resident 2] had walked into the new [fe/male] members room a few times when [s/he]	N 346		

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N 346	Continued From page 5 moved here as well. Staff did redirect and knew [Resident 2] was just wanting to see who the new person was. Nothing has happened however, we want to be sure you all know we are closely monitoring the new member. I am also looking into a possible internal transfer of this new member." On 03/03/2026 at 1:07 p.m., Surveyor reviewed the resident roster, noting that the last admission, prior to Resident 1's admission on 11/03/2025, was on 02/06/2024. Surveyor asked Program Director B if there had been any other admissions, other than Resident 1 since 2024. Program Director B stated no, Resident 1 has been the facility's only recent admission and discharge. Surveyor clarified that by stating the "new resident" in an email to family members and case managers, it would be evident who Area Director A was talking about, and then s/he listed his/her gender and diagnoses. Program Director B stated yes. On 03/03/2026 at 1:49 p.m., Surveyor shared the above concerns with Program Director B and Area Director A. Area Director A stated, "Yep, I get it" when Surveyor stated the concerns about sharing Resident 1's dementia diagnoses with other resident's POA, family members and case managers.	N 346		
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	N 381		

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N 381	Continued From page 6 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 record review and interview, the provider did not ensure 2 of 2 residents reviewed had their needs, abilities and physical and mental conditions assessed. Resident 1 was not assessed for sexual behavior concerns. Resident 2's was not assessed for pain or his/her mental or emotional health on 01/17/2026 after s/he was sexually assaulted. The findings include: On 02/18/2026, the department received a complaint alleging a resident was sexually assaulted in the facility. On 03/03/2026 Surveyors conducted a complaint investigation. The provider is licensed as a class CNA (non-ambulatory) CBRF able to serve up to 6 residents within the client groups of traumatic brain injury, developmentally disabled, advanced age, and emotionally disturbed/mental illness. Example 1 - Resident 1 On 03/06/2026, Surveyor reviewed Resident 1's closed record, that was provided by Area Director	N 381		

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N 381	Continued From page 7 A and Program Director B. Resident 1 was admitted to the facility on 11/04/2025 with a diagnosis including Bi-polar, type 2 diabetes and dementia (early stage). On 03/06/2026, Surveyor reviewed Resident 1's November 2025, December 2025 and January 2026 observation notes, which documented: -12/15/2025 "[Resident 1] spent most of [his/her] day in [his/her] room ...[s/he] agreed to taking a shower staff had told [him/er] to get ready for [his/her] shower and to call for staff when [s/he]was ready and [s/he] decided to just take [his/her] clothes off all the way walk out of [his/her] room come to end of hallway close to living room where others clients were completely naked and asked for towels and wash clothes even after staff had told [him/her] to grab [his/her] stuff [s/he] knows where [his/her] towels and wash clothes are and then proceeded to walk naked to the bathroom while staff was telling [him/her] [s/he] cant do that there are other people in this house [his/her] response was yea yea and continued walking into the bathroom got a shower ..." -12/18/2025 [Resident 1] refused to eat breakfast took [his/her]meds and went outside to smoke a few cigarettes but when [s/he] want (sic) out for a cigarette [s/he] had no pants on and just a depends staff has recently talked to him about this when staff seen [s/he] had no pants on staff said [Resident 1] its cold out and you know you need to wear pants [s/he] responds with ya ya and went back to room ..." -12/29/2025 [Resident 1] asked staff if they wanted to get laid last night. Staff told [him/her] that was inappropriate and [s/he] needs to go to bed. [S/he] also headed towards a client's room on [his/her] side but staff saw [him/her] as [s/he]	N 381		

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N 381	Continued From page 8 was standing in the room doorway of the client. [Resident 1] has woken up looking for other clients in the house on the opposite side of the house ..." Note: Resident lived in a coed home and coed hallway. -12/31/2025 " ...we had a meeting on concerns of [his/her] change in condition came to with taking [him/her] to urgent care to get a full evaluation done to see what is going on with [him/her] as to why [s/he] wont eat is weak falling allot (sic) and sodium levels keep on going low change in behavior and change of medications concerns [him/her] not sleeping we then were at hospital for 9 hours ....released [him/her] to go home ..." -12/31/2025 " ...staff went in to check on [him/her] and empty [his/her] catheter [s/he] was seen trying to satisfy [himself/herself]" -01/17/2026 " ...while staff was on the other [Resident 1] got out of [his/her] room without staff knowing [s/he] had gotten out of [his/her] room because [s/he] knows how to shut off [his/her] bed alarm staff got done toileting client came over to [his/her] side noticed [his/her] door was open and [s/he] wasn't in [his/her] room staff thought [s/he] had got out to smoke again but then noticed [his/her] chair was still in the house with [his/her] coat went to check bathroom [s/he] wasn't there so staff had checked [Resident 1] room another client in the house that [s/he] has already been caught going into [his/her] room while [s/he] was sleeping when staff got to the door way [s/he] was sitting on the side of [his/her] bed while [s/he] was laying down in [his/her] bed sleeping [s/he] woke [him/her] up when [s/he] had sat down in [his/her] bed [s/he] was still laying down [s/he] was sitting on the bed closer to [his/her] stomach area and [s/he] was laid down kind of wrapped around [his/her] body while[his/her] hand was fondling [his/her] private	N 381		

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area and whispering something to [him/her] staff couldn't hear staff had asked what [s/he] was doing [s/he] removed [his/her] hand from [his/her] private area rolled [his/her] eyes grabbed [his/her] catheter and staff told [him/her] to get out of [his/her] room and to go to [his/her] room staff then called supervisor eventually ambulance and police officers had came for the incident staff seen ambulance pull up went to go tell [Resident 1] to get ready to go to the hospital and [s/he] was masturbating looked at staff while [s/he] finished satisfying [himself/herself] then was sent out to the hospital."

Surveyor reviewed incident reports from November 2025, December 2025 and January 2026 which documented:
-01/02/2026 "Staff reported that when they went into [Resident 1's] bedroom to empty [his/her] catheter bag, [Resident 1] asked, "can you help me go to sleep" while [s/he] was touching [himself/herself] inappropriately. Staff verbally redirected [Resident 1] and let [him/her] know that it was inappropriate"

On 03/06/2026 at 11:15 a.m., Surveyor requested assessments that have been completed for Resident 1 since December 2025, when s/he started exhibiting concerns with sexual behavior. Program Director B stated that s/he would ask Area Director A to forward any assessments to Surveyor.

On 03/06/2026 at approximately 2:00 p.m., Surveyor shared concern with Area Director A that there were no assessments completed to address behavior interventions for Resident 1's sexual behavior. Area Director A stated that there was no formal assessment completed but they had been trying to get Resident 1 assessed at the

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hospital. Area Director A acknowledged that Resident 1 was sent home from the hospital on 12/31/2025 with a referral to work with [Funding Source] for referral.

Example 2 - Resident 2

On 03/03/2026, Surveyor reviewed Resident 2's record, as provided by Area Director A and Program Director B. Resident 2 was admitted to the facility on 10/13/2017 with diagnoses including, autism, severe developmental disability and anxiety.

Surveyor reviewed an incident report for Resident 2, dated 01/17/2026, that documented:
"On January 17th at approximately 1:00 PM, staff were on the opposite side of the house completing routine rounds. When staff went to check on [Resident 2], they entered their room and observed [Resident 1] sitting on the edge of [Resident 2's] bed. Staff observed [Resident 1] with [his/her] hand down [Resident 2's] shirt, touching [his/her] [chest]. Staff immediately intervened and instructed [Resident 1] to leave the room and return to [his/her] room. [Resident 1] picked up [his/her] catheter bag, rolled [his/her] eyes at staff, and exited the room. Staff escorted [Resident 1] directly to [his/her] room to ensure separation and safety."

On 03/03/2026 at 11:15 a.m., Surveyor asked Program Director B for any assessments that have been completed for Resident 2 in the last 2 months. Program Director B stated s/he would ask Area Director A to send any assessments to the Surveyor.

Surveyor reviewed Resident 2's observation notes which documented,

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N 381	Continued From page 11 -01/18/2026, "[Resident 2] seemed on edge today pacing back and forth more than usually wouldn't take a nap almost as if [s/he] didn't feel comfortable I kept on reminding [him/her] that [s/he] is okay once I showed [him/her] that [Resident 1] wasn't in the house anymore [s/he] seemed to calm down and finally sat down and relaxed and watched TV for a little while until lunch ate 100% of [his/her] lunch then went back to watching tv until dinner still seeming a little on edge [s/he] came and sat by me I think [s/he] felt better when I was closer to [him/her] so [s/he] sat by me most of the night then had dinner ate 100% of [his/her] dinner watched TV until snack ate [his/her] snack then I asked if [s/he] was tired if [s/he] wanted to go to bed then [s/he] wanted to go to [his/her] room and lay down so we got changed and got ready for bed then I tucked [him/her] into bed informed [s/he] was okay to have a good night and [s/he] went to sleep for the night". -01/19/2026, "[Resident 2] seemed a little better today still wanting to stay by me when I came back from a[sic] appointment I sat on [his/her] side we watched tv together ..." On 03/03/2026 at 12:31 p.m., Surveyor stated that s/he had not received any assessments for Resident 2 and asked if any sort of assessment was completed after the incident on 01/17/2026 involving Resident 1 and Resident 2. Program Director B stated that s/he believes an assessment was completed after this incident. On 03/03/2026 at 12:37 p.m., Surveyor asked Area Director A if any assessment was completed for Resident 2 after the incident on 01/17/2026. Area Director A asked what type of assessment. Surveyor asked if there was an assessment for whether or not Resident 2 was able to consent to	N 381		

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N 381	Continued From page 12 Resident 1's behaviors, whether Resident 2 was experiencing any pain, Resident 2's mental state or emotional state was after the incident. Area Director A stated no, no assessment was completed for Resident 2 and Resident 1 was sent out and then discharged.	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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 2 resident's individual service plan (ISP) was updated to include the resident's needs, abilities or physical or mental condition. Resident 2's ISP did not identify his/her needs related to personal cares, communication or behavior management and did not identify program services frequency, approaches or specify methods for delivering needed cares.	N 389		

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	110458	A. BUILDING: _____ B. WING _____	C 03/10/2026

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N 389	Continued From page 13 The findings include: On 03/03/2026 Surveyors conducted a complaint investigation. The provider is licensed as a class CNA (non-ambulatory) CBRF able to serve up to 6 residents within the client groups of traumatic brain injury, developmentally disabled, advanced age, and emotionally disturbed/mental illness. On 03/03/2026, Surveyor reviewed Resident 2's record, as provided by Area Director A and Program Director B. Resident 2 was admitted to the facility on 10/13/2017 with diagnoses including, autism, severe developmental disability and anxiety. Resident 2's ISP dated 01/12/2026 included Program Director B and Program Coordinator C's signature. Resident 2's ISP template was primarily blank did document that Resident 2 was independent with mobility, should be encouraged to walk 15 minutes a day, and on a general diet. The ISP did not identify Resident 2's needs or desired outcomes, program services, frequency and approaches in regard to Resident 2's personal cares and grooming, communication, toileting, or behavioral needs. The ISP did not specify methods for delivering needed care and who was responsible for the care. On 03/03/2026 at 11:16 a.m., Surveyor asked Program Director B if there was any other information regarding Resident 2's program services and/or ways meet his/her needs. Program Coordinator C reviewed the ISP and stated that was the same ISP that the caregiver's have access to. Program Coordinator C stated that Resident 2 was on a pureed diet and also on a Mediterranean diet and provided Surveyor with general information on a pureed diet and its consistency. Surveyor asked if there was	N 389		

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N 389	Continued From page 14 documentation of individualized care or needs for Resident 2. Program Coordinator C provided Surveyor with Resident 2's "Health Passport" and stated that this sheet goes with the residents when they are sent to the hospital. The health passport identified that Resident 2 was on a pureed diet and that s/he can understand what staff says to him/her and answer with yes or no. On 03/03/3036 at 11:30 a.m., Program Director B stated s/he would look to see if s/he could find Resident 2's older ISP, which had more details about Resident 2's needs and stated Resident 2 has his/her ups and downs. Program Director B stated s/he does not have Resident 2's old ISP.	N 389		
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 record review and interview, the provider did not provide services to manage Resident 1's sexually aggressive behavior while s/he resided at the facility from 11/04/2025 to 01/17/2026. Resident 1 was discharged due to behavior on 01/17/2026. Findings include:	N 433		

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N 433	Continued From page 15 On 02/18/2026, the department received a complaint alleging a resident was sexually assaulted in the facility. On 03/03/2026 Surveyors conducted a complaint investigation. The provider is licensed as a class CNA (non-ambulatory) CBRF able to serve up to 6 residents within the client groups of traumatic brain injury, developmentally disabled, advanced age, and emotionally disturbed/mental illness On 03/06/2026, Surveyor reviewed Resident 1's closed record, that was provided by Area Director A and Program Director B. Resident 1 was admitted to the facility on 11/04/2025 with a diagnosis including Bi-polar, type 2 diabetes and dementia (early stage). On 03/06/2026, Surveyor reviewed Resident 1's November 2025, December 2025 and January 2026 observation notes, which documented: -12/15/2025 "[Resident 1] spent most of [his/her] day in [his/her] room ...[s/he] agreed to taking a shower staff had told [him/er] to get ready for [his/her] shower and to call for staff when [s/he]was ready and [s/he] decided to just take [his/her] clothes off all the way walk out of [his/her] room come to end of hallway close to living room where others clients were completely naked and asked for towels and wash clothes even after staff had told [him/her] to grab [his/her] stuff [s/he] knows where [his/her] towels and wash clothes are and then proceeded to walk naked to the bathroom while staff was telling [him/her] [s/he] cant do that there are other people in this house [his/her] response was yea yea and continued walking into the bathroom got a shower ..."	N 433		

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N 433	Continued From page 16 -12/18/2025 [Resident 1] refused to eat breakfast took [his/her]meds and went outside to smoke a few cigarettes but when [s/he] want (sic) out for a cigarette [s/he] had no pants on and just a depends staff has recently talked to him about this when staff seen [s/he] had no pants on staff said [Resident 1] its cold out and you know you need to wear pants [s/he] responds with ya ya and went back to room ..." -12/29/2025 [Resident 1] asked staff if they wanted to get laid last night. Staff told [him/her] that was inappropriate and [s/he] needs to go to bed. [S/he] also headed towards a client's room on [his/her] side but staff saw [him/her] as [s/he] was standing in the room doorway of the client. [Resident 1] has woken up looking for other clients in the house on the opposite side of the house ..." -12/31/2025 " ...we had a meeting on concerns of [his/her] change in condition came to with taking [him/her] to urgent care to get a full evaluation done to see what is going on with [him/her] as to why [s/he] wont eat is weak falling allot (sic) and sodium levels keep on going low change in behavior and change of medications concerns [him/her] not sleeping we then were at hospital for 9 hours ....released [him/her] to go home ..." -12/31/2025 " ...staff went in to check on [him/her] and empty [his/her] catheter [s/he] was seen trying to satisfy [himself/herself]" -01/17/2026 " ...while staff was on the other side [Resident 1] got out of [his/her] room without staff knowing [s/he] had gotten out of [his/her] room because [s/he] knows how to shut off [his/her] bed alarm staff got done toileting client came over to [his/her] side noticed [his/her] door was open and [s/he] wasn't in [his/her] room staff thought [s/he] had got out to smoke again but then noticed [his/her] chair was still in the house with [his/her] coat went to check bathroom [s/he]	N 433		

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N 433	Continued From page 17	N 433		

wasn't there so staff had checked [Resident 1] room another client in the house that [s/he] has already been caught going into [his/her] room while [s/he] was sleeping when staff got to the door way [s/he] was sitting on the side of [his/her] bed while [s/he] was laying down in [his/her] bed sleeping [s/he] woke [him/her] up when [s/he] had sat down in [his/her] bed [s/he] was still laying down [s/he] was sitting on the bed closer to [his/her] stomach area and [s/he] was laid down kind of wrapped around [his/her] body while[his/her] hand was fondling [his/her] private area and whispering something to [him/her] staff couldn't hear staff had asked what [s/he] was doing [s/he] removed [his/her] hand from [his/her] private area rolled [his/her] eyes grabbed [his/her] catheter and staff told [him/her] to get out of [his/her] room and to go to [his/her] room staff then called supervisor eventually ambulance and police officers had came for the incident staff seen ambulance pull up went to go tell [Resident] to get ready to go to the hospital and [s/he] was masturbating looked at staff while [s/he] finished satisfying [himself/herself] then was sent out to the hospital."

Surveyor noted that the home Resident 1 lived in was coed. Resident 1's bedroom was in a coed hallway.

Surveyor reviewed incident reports from November 2025, December 2025 and January 2026 which documented:
-01/02/2026 "Staff reported that when they went into [Resident's] bedroom to empty [his/her] catheter bag, [Resident] asked, "can you help me go to sleep" while [s/he] was touching [himself/herself] inappropriately. Staff verbally redirected [Resident] and let [him/her] know that it was inappropriate"

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N 433	Continued From page 18 Surveyor reviewed an email from Area Director A with a subject line "follow up email concerns after ER visit", dated 01/01/2026 at 6:42 p.m., the email indicated that "[Resident 4] was talking in [his/her] room saying "[Resident 1] do not do that" the staff opened the door and asked the member what [s/he] was speaking on and [s/he] stated that [s/he] had seen [Resident 1] touch one of [Resident 2]'s private area the day before. The [member] does have Mental Health diagnosis and isn't always accurate on all accounts when relaying information due to [his/her] diagnosis. [S/he] is the only verbal member on that side of the home with [Resident 1]. The other side of the home we have 2 other [members] that are non-verbal and one who is verbal also with Mental Health diagnosis. We are talking with the members who are verbal regarding allegations however, it is challenging due to their diagnosis. This is very concerning given what occurred a few days ago as well as comments to the overnight staff and touching [himself/herself] last night." Surveyor reviewed Resident 1's individual service plan (ISP), dated 12/03/2025 which documented: -Behavior Challenges which require support interventions (Check All that Apply) Verbal aggression was checked, and the behavioral challenges section was left blank Resident 1's ISP did not include behavior management, frequency and approaches the CBRF provided to manage and intervene with Resident 1's sexually aggressive behavior that s/he had been displaying since December 15, 2025. On 03/06/2026, at approximately 2:00 p.m.,	N 433		

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N 433	Continued From page 19 Surveyor shared concerns with Area Director A and Program Director B about Resident 1's sexually aggressive behavior that led to another resident being sexually assaulted on 01/17/2026. Program Director B stated that the staff was trying to keep Resident 1 in line of sight but that the home was often short staffed. Area Director A acknowledged that there have been documented behavior incidents since December 15, 2025. Area Director A stated the provider had a meeting on 12/31/2025 regarding the behavioral concerns and Resident 1 was sent to the hospital for evaluation but was sent home. Area Director A stated that another resident did make an accusation indicating that Resident 1 had assaulted Resident 2 on 12/31/2025, as documented in his/her email. Area Director A said with the diagnosis of that resident it was hard to investigate the allegation and get accurate information. Area Director A acknowledged that Resident 1 did not have an updated behavior management section in the ISP that included sexually aggressive behaviors.	N 433		