STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012491	A. BUILDING: _____ B. WING _____	R 04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREATIVE LIVING ENVIRONMENTS LAYTON C	12320 W LAYTON AVE GREENFIELD, WI 53228

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{N 000}	Initial Comments On 04/14/2026, Surveyor completed a standard survey, verification visit, and 1 complaint investigation at Creative Living Environments Layton Court. As a result, 7 deficiencies were identified, and 1 complaint was unsubstantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 6	{N 000}		
N 191	83.13(3)(d) Posting activity schedule. The CBRF shall post all of the following: Activity schedule as required under s. DHS 83.38(1)(c). This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure an activity schedule was posted in the facility which had potential to affect 6 of 6 residents in the home. Findings include: On 04/13/2026, at 9:15 AM, Surveyor toured the facility. Surveyor did not observe an activity schedule posted in the facility for the duration of the survey. On 04/13/2026, at approximately 10:00 AM, Surveyor interviewed Resident 1. Surveyor inquired if the facility provided activities and/or notified residents of daily activities offered. Resident 1 reported the facility staff "sometimes" offers activities. Resident 1 reported the activity schedule is not posted in the facility.	N 191		

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

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N 191	Continued From page 1 On 04/14/2026, at approximately 11:30 AM, Surveyor interviewed Administrator A. Administrator A confirmed the code requirement. Administrator A did not provide an explanation why activity schedule was not posted.	N 191		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the resident or the resident's legal representative (if applicable), Managed Care Organization (MCO) care management team, or the Licensee/ Administrator signed the individual service plan (ISP), acknowledging their involvement in, understanding of, and agreement with the ISP for 2 of 2 (Resident 1 and Resident 2) residents	N 387		

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N 387	Continued From page 2 reviewed. Findings include: On 04/14/2026, at approximately 10:00 AM, Surveyor reviewed resident records and identified the following: Resident 1 was admitted on 1/30/2023, with diagnosis including bipolar disorder and anxiety disorder. Resident 1 was her/his own person. Resident 1 was enrolled in an MCO care management program. Resident 1's ISP, dated 01/23/2026, was not signed by the resident, MCO care managers, or the administrator/licensee. Resident 2 was admitted on 03/31/2025 with a diagnosis including schizoaffective disorder and obsessive-compulsive disorder. Resident 2's record indicated s/he had a guardian. Resident 2 was enrolled in an MCO care management program. Resident 2's updated ISP, dated 05/08/2025, was not signed by Resident 2's guardian, MCO care managers, or the administrator/licensee. On 04/14/2026, at approximately 11:30 AM, Surveyor interviewed Administrator A. Administrator A confirmed the code requirement. Administrator A did not provide an explanation why Resident 1 and Resident 2's ISPs were unsigned. Administrator A reported s/he would ensure ISPs were signed.	N 387		
N 419	83.37(3)(c) Medication storage: locked cabinet. Administered by facility. The CBRF shall keep medicine cabinets locked and the key available only to personnel identified by the CBRF.	N 419		

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N 419	Continued From page 3 This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure residents' medications were securely stored in 1 of 1 medication closet. The medication closet in the common area of the facility was unlocked. This had the potential to affect 6 of 6 residents. Findings include: On 04/13/2026, at 9:15 AM, Surveyor observed the medication closet in the common area of the facility. The medication closet contained a locking mechanism; the locking mechanism was not engaged. Surveyor opened the medication closet and observed residents scheduled prescription medications. The medication closet was unlocked for the duration of the survey on 04/13/2026. Surveyor observed residents moving freely throughout the facility. On 04/14/2026, at approximately 11:30 AM, Surveyor interviewed Administrator A. Administrator A confirmed the code requirement. Administrator A reported s/he would ensure medications were securely stored at all times.	N 419		
N 490	83.44(2)(b) Toilet and bathing area. All toilet and bathing areas, facilities and fixtures shall be clean and in good working order. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure toilet and bathing areas were clean for 6 of 6 residents. One of 2 resident bathrooms needed cleaning.	N 490		

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N 490	Continued From page 4 Findings include: On 04/13/2026, at approximately 9:15 AM, Surveyor toured the facility observed the following: East Common Resident Bathroom - The wallpaper was peeled off the wall and missing in multiple sections. - The blinds and window coverings were covered in approximately 1/8th inch (in) thick gray substance consistent with dust. - The top of the cabinets in the bathroom was covered in approximately 1/8th in thick gray substance consistent with dust. - The plant in the bathroom was covered in approximately 1/8th in thick gray substances consistent with dust. - The light bulbs and light fixture were covered in approximately 1/8th in thick gray substances consistent with dust. - The floor of the shower contained brown stains and multiple black scuff marks. On 04/14/2026, at approximately 11:30 AM, Surveyor interviewed Administrator A. Administrator A was unaware the east bathroom of the facility needed cleaning.	N 490		
N 507	83.46(1)(f) Combustibles. Combustible materials shall not be placed within 3 feet of any furnace, boiler, water heater, fireplace or other similar equipment. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure combustible materials were not	N 507		

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N 507	Continued From page 5 placed within 3 feet of the furnace. A metal shelving unit which contained combustible items was placed withing 3 feet of the furnace. Findings include: This facility was licensed on 10/10/2008 to serve up to 8 semi-ambulatory residents in the client groups of advanced aged, emotionally disturbed/mental illness, irreversible dementia/Alzheimer's, and physically disabled. On 04/14/2026, at 9:15 AM, Surveyor toured the facility. The basement contained 1 furnace. Surveyor observed a metal shelving unit within 3 feet of the furnace. The shelving unit contained carboard boxes, wooden shelving, and a milk crate with cloth rags. On 04/14/2026, at 11:30 AM, Surveyor interviewed Administrator A. Administrator A confirmed the code requirement. Administrator A was unaware the shelving unit was moved within 3 feet of the furnace. Administrator A reported all materials within 3 feet of the furnace would be moved.	N 507		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may	N 525		

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N 525	Continued From page 6 be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure fire drills were conducted in each quarter of 1 of 2 years (2025). There were no fire drills conducted in the 3rd and 4th quarters of 2025. Fire drill documentation for 2024 and 2025 did not contain total evacuation times. Findings include: This facility was licensed on 10/10/2008 to serve up to 8 semi-ambulatory residents in the client groups of advanced aged, emotionally disturbed/mental illness, irreversible dementia/Alzheimer's, and physically disabled. On 04/14/2026, at 9:45 AM, Surveyor reviewed safety records and identified the following: Fire drills reviewed for 2024 to present by Surveyors did not contain total evacuation times. Three fire drills were conducted in 2025 on 01/31/2025, 02/27/2025, and 05/27/2025. Surveyors did not locate evidence of fire drills conducted in the 3rd and 4th quarters of 2025. On 04/14/2026, at 11:30 AM, Surveyor interviewed Administrator A. Administrator A confirmed the code requirement. Administrator A	N 525		

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N 525	Continued From page 7 confirmed the required quarterly fire drills were not completed in the 3rd and 4th quarters of 2025. Administrator A did not provide explanation why drills were not conducted.	N 525		
N 526	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure tornado, flooding, or other emergency or disaster drills were conducted semi-annually for 2 of 2 years. One tornado, flooding, or other emergency or disaster drill was conducted in 2024. No tornado, flooding, or other emergency or disaster drills were conducted in 2025. Findings include: This facility was licensed on 10/10/2008 to serve up to 8 semi-ambulatory residents in the client groups of advanced aged, emotionally disturbed/mental illness, irreversible dementia/Alzheimer's, and physically disabled. On 04/14/2026, at 9:45 AM, Surveyor reviewed safety records and identified the following: In 2024 one tornado drill was conducted on 04/11/2024. Surveyor did not locate evidence of a second tornado, flooding, or other emergency or disaster drill conducted in 2024. Surveyor did not locate evidence of tornado,	N 526		

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N 526	Continued From page 8 flooding, or other emergency or disaster drills conducted in 2025. On 04/14/2026, at 11:30 AM, Surveyor interviewed Administrator A. Administrator A confirmed the code requirement. Administrator A reported s/he did not find any other drills conducted in 2024 or 2025 when looking for files. Administrator A reported s/he was unsure if the drills were completed.	N 526		