STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	410293	A. BUILDING: _____ B. WING _____	C 10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLVIEW	W9484 COUNTY RD JJ HORTONVILLE, WI 54944

(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 10/20/2025, with information gathered through 10/22/2025, Surveyors conducted a standard survey and 1 complaint investigation at Dellview in Hortonville. One (1) of 1 complaint was substantiated. As a result of the survey, 2 deficiencies were issued. Census: 8	N 000		
N 348	83.32(3)(d) Rights of Residents: Free from mistreatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from mistreatment. Be free from physical, sexual and mental abuse and neglect, and from financial exploitation and misappropriation of property. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 (Resident 1) resident reviewed were free from sexual abuse. Resident 1 was sexually assaulted by Caregiver C. Findings Include: On 06/24/2025, the department received an "Misconduct Incident Report." The report stated, "On June 21st, 2025 at approximately 3:10 PM,	N 348		

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

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N 348	Continued From page 1 [Resident 1] asked to speak to the staff in private. Once they were in a private area, [Resident 1] informed the staff member that [Resident 1] had [performed a sexual act] with the [fe/male] staff member [Caregiver C] who worked overnight because [s/he] had asked [him/her] to and offered to pay [him/her]. The staff member who allegedly asked [Resident 1] for sexual favors worked from 11 PM on June 20th 2025 until 7 AM on June 21st, 2025. No other staff members were present during this time. The [fe/male] staff member is not a direct employee of Brotoloc North but works for a temp agency that Brotoloc North is contracted with called [name of staffing agency]...The staff member assured [Resident 1] that [Resident 1] did nothing wrong, and that [s/he] did the right thing by informing the staff." The report continued, "The staff member contacted management about the incident. A member of management came to Dell View and spoke to [Resident 1]. [Resident 1] relayed the events to management. The staff member on shift and the management member compared the information they were told by [Resident 1] and found that there were no deviations in the story. Law enforcement was then called to investigate the incident. An officer from Outagamie County Sheriff's Department arrived and took a statement from [Resident 1] and filed a report. The officer as given contact information for [name of staffing agency.] Brotoloc North management also contacted [name of staffing agency] and informed the co-owner that an allegation was made against one of their staff members and that the staff member would not be allowed back to Brotoloc North until the investigation was completed. Brotoloc North is also completing a Client Rights Investigation." Additional information provided in the report indicated, "...on June 24th, 2025, the detectives provided an	N 348		

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N 348	Continued From page 2	N 348		

update that the accused staff member was taken into custody."

On 07/07/2025, the department received a complaint regarding abuse allegations.

On 07/09/2025, the department obtained a police report regarding the above incident. The report detailed the officers investigation with a conclusion to arrest Caregiver C on the following charges: 1. Wis. (Wisconsin) State Statute 940.225(2)(c) - second degree sexual assault of a person who suffers from a mental illness or deficiency which renders that person temporarily or permanently incapable of appraising the person's conduct, and the defendant knows of such condition. 2. Wis. State Statute 940.225(2)(j) - Second degree Sexual Assault by an employee, or nonclient resident of an entity, as defined in s. 48.685(1)(b) or 50.065(1)(c), and has sexual contact or sexual intercourse with a client of the entity. Per Wisconsin Circuit Court Access website, as of 10/21/2025, Caregiver C's case was still open.

On 10/20/2025, Surveyor conducted an onsite visit to the facility. Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 12/17/2009 with diagnoses to include mood disorder with depressive features, bipolar, agoraphobia panic disorder, hypothyroidism and diabetes mellitus type 2. Resident 1's record indicated Resident 1 is under guardianship since 02/09/2022. Resident 1's ISP (Individualized Service Plan) indicated Resident 1 is independent with all ADLs (activities of daily living), can communicate his/her wants and needs however, Resident 1 "has experienced some brain damage as a result of hypoglycemic episodes, which has impacted [his/her] cognitive development.

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[His/Her] current level of functioning is not age-appropriate. While [s/he] is still intelligent and demonstrates strong memorization skills, [his/her] overall cognitive and emotional maturity is more consistent with that of an older adolescent." Additionally, the ISP stated Resident 1 "is a social person and enjoys interacting with others. [Resident 1] is a kind individual and does not like upsetting others by saying "no", therefore [s/he] can be
easily manipulated or taken advantage of."

On 10/20/2025 at approximately 12:15 PM, Surveyor interviewed Resident 1. Resident 1 verified the incident noted in the report above. Resident 1 stated s/he was scared to tell someone but knew s/he needed to let someone know. Resident 1 indicated s/he did perform a sexual act with Caregiver C. Resident 1 stated that if Caregiver C had come back to work the next night the plan was to have sexual intercourse. Resident 1 indicated s/he was very anxious about Caregiver C coming back to work and that is why s/he decided to tell a staff member about what had happened. Resident 1 indicated s/he is doing good at the facility and has support from the staff and other residents. Resident 1 says s/he stays busy by crocheting, reading and helping others around the home. Resident 1 stated s/he is going to counseling sessions to talk about the incident with the next one scheduled for the end of the month.

On 10/20/2025 at 12:30 PM, Surveyor interviewed Regional Director B and Program Manager A. Regional Director B verified s/he was the one who submitted the above report to the department. Regional Director B indicated once management was made aware of the incident, the police were called and have been handling it.

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N 348	Continued From page 4 Regional Director B stated they did terminate employment for one of the staff members for not following facility policy and notifying management immediately upon finding out about the incident. Additionally, Regional Director B stated management and staff have been providing support to Resident 1 and each other during this time as it was upsetting to everyone. In summary, on 06/21/2025, Resident 1 reported s/he performed a sexual act on Caregiver C because Caregiver C asked him/her to and offered to pay him/her. Once reported to staff, staff called management and management contacted the police department. A police investigation was conducted. Caregiver C was arrested and charges are pending for second degree sexual assault.	N 348		
N 666	83.59(7)(a) Emergency egress lighting provided All exit passageways and stairways shall be provided with emergency egress lighting with a stand-by power source. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure all exit passageways and stairways were clearly identified with emergency egress lighting with a stand-by power source. Five (5) of 5 exits identified on the fire evacuation map were not clearly identified at the door with emergency egress lighting with a stand-by power source. Findings Include:	N 666		

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N 666	Continued From page 5 On 10/20/2025 at approximately 11:00 AM, Surveyor conducted a tour of the home with Program Manager A. During the tour, Surveyor observed the fire evacuation map on the wall. Surveyor identified 5 exit passageways (entryway on main floor, exit door near office on main floor, exit door between bedroom #4 and #5, exit door in living, exit door in basement out to patio) on the map. Throughout the tour, Surveyor observed the 5 exit passageways did not have emergency egress lighting above or near the door indicating they were exit doors. Surveyor did not observe any other exit passageways throughout the home. At approximately 12:15 PM, Surveyor interviewed Program Manager A and Regional Director B regarding the exit passageway signage. Regional Director B indicated s/he was unaware of why there were no emergency exit signs above or near the exit passageways. Regional Director B stated the facility changed classification a few years ago and maybe that had something to do with it.	N 666		