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{N 000}	Initial Comments On 01/26/2026 with additional information gathered through 01/27/2026, Surveyor conducted a verification visit and complaint investigation at Cottonwood Manor Assisted Living. As a result, 1 of 1 complaints was substantiated and 1 new deficiency was identified. Two (2) of 3 previous deficiencies were corrected and 1 was a repeat deficiency. See Statement of Deficiency (SOD) FZS611, dated 09/12/2025. Under statutory provisions of WI Stat. Ch. 50 a $200 revisit fee is being assessed. Census: 30	{N 000}		
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, observation and interview, the provider did not ensure Individual	N 389		

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

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N 389	Continued From page 1 Service Plans (ISPs) were updated to reflect the needs of Resident 10. Resident 10 was visually impaired, displayed both verbal and physical behaviors towards staff and residents and tended to refuse care. Resident 10's ISP did not include information about his/her visual impairment needs or identify effective interventions to prevent and/or manage behaviors or refusals of care. Findings include: On 09/29/2025, the Department received a complaint alleging concerns with resident care. On 01/26/2026, Surveyor conducted a verification visit and complaint investigation at the facility. On 01/26/2026 at 9:15 AM, Surveyor requested Resident 10's record to include his/her face sheet, ISP, progress notes, incident reports, medication administration record (MAR) and physician orders from Wellness Director (WD) F. On 01/26/2026 at 9:30 AM, Surveyor interviewed Resident 10 who reported, "I am legally blind. I can see shadows." Resident 10 stated, "Staff have put laundry and garbage bags in the hallway. I've tripped over it before because I can't see very well." Resident 10 proceeded to show Surveyor devices including a handheld magnifying glass and a tabletop magnifying reader s/he utilizes to assist him/her. Resident 10 reported s/he is independent with activities of daily living and uses a cane to ambulate as needed. S/he stated, "I do everything on my own. I don't need help." While speaking with Resident 10, Surveyor	N 389		

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observed crumbs, wrappers and other debris scattered on the floor, a garbage can full of garbage, broken vinyl blinds, a broken blue recliner chair and a white sprinkled substance resembling salt on the floor near his/her refrigerator. Surveyor also observed staining in Resident 10's bathroom sink, debris on the floor and around the toilet, an unclean white bath towel hanging on the wall and no toilet paper roll on the wall. When Surveyor asked Resident 10 when the last time his/her room was cleaned, s/he stated, "They don't clean for me anymore. They never ask. It's been a month. I clean everything myself." Resident 10 also expressed concerns about the food and stated, "It's never hot enough and they are always out of something. They were out of eggs this morning. I like fried eggs and they didn't have any." S/he also stated, "I can't have corn, spicy foods or chips. Corn gets caught in my throat and they still serve it to me."

On 01/26/2026 at 12:53 PM, Surveyor observed as Resident 10 was provided a lunch meal by Dietary Aide (DA) E. DA E set Resident 10's plate down on the table in front of him/her and walked away without explaining what was on his/her plate. Surveyor inquired with Resident 10 about his/her plate of food and s/he stated, "I can't eat noodles and it's greasy." Surveyor explained there was pork tenderloin, stuffing, broccoli and gravy on his/her plate.

On 01/26/2026 at 1:15 PM, Surveyor reviewed Resident 10's record and noted the following:

Resident 10 was admitted to the facility on 09/06/2024 with diagnoses to include type 2 diabetes with diabetic retinopathy with macular edema, dementia, Alzheimer's Disease, unspecified psychosis, stage 3 chronic kidney

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disease, osteoarthritis, asthma, cardiomyopathy, alcohol abuse, congestive heart failure, history of falls, difficulty walking, obstructive sleep apnea and hyperlipidemia. Resident 10 had a legal guardian and was protectively placed.

Resident 10's ISP, signed 09/10/2025, identified needs around frequent safety checks, medication management, housekeeping, behaviors and meals. The ISP did not include information about his/her visual impairment needs or identify effective interventions to prevent and/or manage behaviors or refusals of care. The following was noted:

*Assistive Devices: "Wears glasses routinely."

*Personal Safety: "Frequent safety checks ... will receive monitoring to ensure safety ... will be kept safe with dignity and respect ... staff notified of personal safety risk (elopement risk) and will provide resident with guidance or redirection as needed."

*Nutrition/Eating: "Provide meal three times daily and snacks ... will be offered choices in menu, with escorts, and meal assistance as requested or needed to promote quality of life ..."

*Mobility: "Fall intervention: Staff to make sure no water is on floor ... ambulates independently ... ambulates with assist with cane, but sometimes leaves cane in room and walks without one ... transfers self independently ... call light within reach when in room ... keep pathways in room clear of clutter ... will maintain ability to ambulate and transfer independently ... will demonstrate ability to use assistive device safely and consistently ..."

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N 389	Continued From page 4 *Wellness/Safety: "One time bed safety check/assistance per night ... light on, check at night ... wellness and safety choices and needs will be met with privacy and dignity ..." *Mental Status: "[Resident 10] demonstrates harmful behavior to self, others and/or their environment ... redirect as needed ... new lock for [his/her] door ... staff is to knock and wait for resident to answer the door before entering ...resident requires frequent behavior monitoring ... can become agitated easily and become aggressive ... verbally aggressive, demanding, uncooperative, and disruptive ... will be assisted by staff/family in making individualized choices for health and personal care ... will demonstrate orientation to person, time and place ... will maintain current level of cognitive function ..." *Medication/Pharmacy: "Staff performs medication administration ... will receive medication as prescribed by physician and will have access to them either independently or by assistance from staff ..." *Housekeeping: "Provide housekeeping service weekly and prn (as needed) ... provide laundry service weekly and prn ... pick up trash daily ... daily bed making ... pick up trash and check apartment daily to prevent clutter ... will have a clean environment ... bed will be made daily ... trash will be removed daily ..." *Behavior Care: " ... history of yelling at staff when [his/her] plate is not hot. Staff is to warm plate prior to putting food on and serving ... punched another resident in the face on 09.28.25 ... issued a 30 day notice due to physical behaviors ... aggression, irritable, yelling, throwing items ... ensure positive interaction and	N 389		

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appropriate behaviors as needed ... observe for and immediately report to the clinical/wellness supervisor or executive director any signs or symptoms of resident posing a danger to self and/or others ... behavior monitoring ... safety will be maintained ... elopement risk and will not leave community unattended ..."

Review of Resident 10's Progress Notes and Incident Reports from 09/01/2025 to 01/26/2026 documented behaviors and refusals, and read in part:

09/28/2025 - Incident Report:
Resident-to-Resident altercation in the dining room. " ... 9:00 am [Resident 10] was yelling in the dining room yelling at staff about the food not being warm enough. [Unknown Resident] yelled at [Resident 10] to "knock it off" and [Resident 10] got upset and charged at [Unknown Resident]. [Unknown Resident] fell to the floor and [Resident 10] had [sic] punched [Unknown Resident] in the face. Staff intervened and for [sic] [Resident 10] off of [Unknown Resident]. [Resident 10] grabbed [his/her] sunglasses and belongings and left the dining room. Staff then called WD [sic] to report the incident. WD instructed staff to call 911 due to [Unknown Resident] being hit is [sic] face ... [Resident 10] obtained a battery citation ... [Resident 10] is to eat in room or before/after all residents are out of dining room ..." Author: Wellness Director (WD) G.

09/29/2025 - Progress Note: "ED [sic] was asked to go to [Resident 10's] room so [s/he] could talk to [him/her]. ED went and [Resident 10] screamed at ED about the food and how [s/he] tells the staff to overcook the food, ED told [him/her] that was not true and that [s/he] doesn't cook the food or make the menu ... [Resident 10]

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was screaming at ED and staff could hear so staff member [Caregiver H] knocked on door and came in to see if I needed help. [Resident 10] got very agitated and stormed at the door and I motioned for the staff member to leave, and [Resident 10] kicked the door close [sic] and proceeded to scream at me ... told [Resident 10] repeatedly to please not scream at me. I than [sic] left ..." WD G.

09/29/2025 - Progress Note: Physician requested for Resident 10 to go to the emergency room to be evaluated "for [his/her] hand swollen from punching a resident in the face the day prior ... [Resident 10] refused to be seen ... said if [s/he] is to be seen [s/he] wants to hear from them ... states [s/he] will call them on [his/her] own." Author: WD G.

09/29/2025 - Progress Note: " ... writer went into resident's room to deliver [Resident 10] [his/her] lunch. [Resident 10] informed writer that [his/her] room has not been cleaned. Writer offered to clean [Resident 10's] room and [Resident 10] stated [s/he] did not want anyone to clean [his/her] room and that [s/he] would clean it [him/herself] ... Author: WD G.

10/01/2025 - Progress Note: "[Resident 10] was in [another resident's room] messing with [his/her] belongings and took [his/her] television out of [his/her] room and making a lot of noise and waking up other residents from sleep by yelling at staff calling staff names when staff let [him/her] know that [s/he] was not able to be in [another resident's room] taking belongings that was not [his/her]." Author: WD G.

10/02/2025 - Progress Note: "[Resident 10] comes down to dinner after everyone is done

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eating, [s/he] wants [his/her] plate and food to be hot, we warm [his/her] plate up so it's hot almost burning are [sic] hands. Gave [him/her] the plate of food and [s/he] said it wasn't hot enough ... rewarmed it two more times ... third time [s/he] talked to a staff member saying it wasn't hot enough even after we touched the plate and it was hot. [S/he] then brought [his/her] plate back into the kitchen wand [sic] threw [his/her] food on the floor and counter than came into another staff's face and said "I want my food to be hot" then walked away mad. This has happened many times and almost every day for every meal. Residents and staff are getting scared of [him/her] that's why [s/he's] eating after everyone is gone out of the dining room." Author: Medication Aide (MA) I.

10/03/2025 - Progress Note: " ... [Resident 10] came down for breakfast and right away [Resident 10] started yelling/cussing with abusive/threatening behavior towards another resident." Author: Caregiver J.

10/07/2025 - Progress Note: "Follow up to altercation. [Resident 10] is upset ... continues to yell at staff and other residents. [Resident 10] is coming to dining room. Staff is sitting in dining room for all meals while resident is present." Author: WD G.

10/10/2025 - Progress Note: " ... writer received a text from the night staff informing writer that the med keys to one of the carts were missing ... PM [sic] shift informed night staff that the keys were in the med cart before leaving at 10:00 pm last night. PM staff came to building to attempt to look for missing keys. Writer also came to building to search for missing keys ... not able to find them ... ED came to building and looked at the security

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cameras in the med room. ED saw [Resident 10] on camera taking the med keys between 2:40 am and 2:45 am ... [Resident 10] stated [s/he] didn't have them ... informed [Resident 10] that we saw [him/her] take the keys on camera. [Resident 10] stated the keys were in the beauty shop. WC [sic] and writer turned around to leave [Resident 10's] room and [Resident 10] pulled the keys out of [his/her] pocket and threw the med keys on the table ..." Author: WD G.

10/10/2025 - Progress Note: "[Resident 10] requested ED to come to [his/her] room so [s/he] could talk to [him/her]. ED had WD and WC stand outside the room just in case something happened. [Resident 10] demanded money from ED, ED stated that [s/he] can't give [him/her] money ... stated only guardian can get money. [Resident 10] stated that [s/he] will flip this building upside down, destroy the camera system so we can't know it was [him/her]. [Resident 10] stated [s/he] can get into any room in this building. [S/he] stated taking the med keys is just the beginning of what [s/he] can do to me." Author: WD G.

10/19/2025 - Progress Note: "[Resident 10] was upset with the food that [s/he] had for lunch and decided to throw [his/her] food across the dining room." Author: Caregiver J.

11/06/2025 - Progress Note: "[Resident 10] came out of [his/her] room for breakfast. Staff mopped one side of the dining room hallway on suite side due to residents going down for meal. [Resident 10] had an issue with half the floor being wet and attempted to hit staff with [his/her] cane. [S/he] then had attitude yelling, cursing and being very disrespectful as [s/he] walked away stating, "I did it on purpose and that [s/he] is going to sue the

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company for mopping half the floor." Author: Wellness Coordinator (WC) K.

11/24/2025 - Progress Note: "[Resident 10] kicked another resident's laundry basket that was full of clothes that was sitting in the hallway outside their room all over the floor." Author: WC K.

12/08/2025 - Progress Note: " ... [Resident 10] set the fire alarms off ... put [his/her] magnifying glass in the microwave ... stated that [s/he] was trying to get the air bubbles out of the glass part. ED and firemen told [him/her] this cannot be done. Fireman opened [Resident 10's] windows and side doors to vent the area ... [Resident 10] screamed at the fireman that [s/he] didn't want [his/her] windows opened." Author: WD G.

01/23/2026 - Progress Note: "[Resident 10] was walking up and down hallways ... [s/he] purposely knocked a cup of coffee off the ledge making it fall to the floor and spill/make mess. When [Resident 10] was asked why [s/he] did that [s/he] just stated, "I'm blind, it shouldn't be there" ... didn't offer to clean it up and just walked away." Author: WC K.

Review of a document titled "Notice of Discharge and Termination of Tenancy - Imminent Risk of Harm to Other Residents and Violation of Community Rules," issued by Executive Director (ED) B on 09/25/2025 to Guardian L reflected Resident 10 was issued a 30-day discharge notice. The document read in part: "[Resident 10] has had more than several incidents where [s/he] has thrown and broken plates ... hitting staff, pulling there [sic] hair, pushing them ... incidents with other residents hitting them ... This behavior has placed other residents and staff at imminent

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risk of harm to their safety and/or health ... this behavior is not acceptable ..."

Review of "Housekeeping Duties" checklists provided by ED B reflected resident rooms are cleaned weekly on Tuesday, Wednesday or Thursday, and once completed staff sign off indicating what resident rooms were cleaned and/or if they were refused. Room cleaning consisted of vacuuming; sweeping and mopping bathroom and kitchen floors; cleaning showers, sinks, toilets and mirrors; light dusting; and garbage removal and bag replacement. Surveyor reviewed the weekly checklists from 12/31/2025 to 01/19/2026 which reflected Resident 10's room was scheduled to be cleaned every Thursday and there were 4 documented refusals.

During an interview with Caregiver J on 01/26/2026 at 9:20 AM, s/he stated Resident 10 does not like help from staff and does everything on his/her own. Caregiver J reported, "We assist with laundry as needed, but [s/he] doesn't like it. We also try to clean when [s/he's] not here as [s/he] will refuse." Caregiver J stated Resident 10 gets mad often about the temperature of his/her food and will throw food and spill drinks. S/he confirmed Resident 10 has gotten both verbally and physically aggressive towards staff and residents. Caregiver J recalled when Resident 10 hit another resident in the face and also pulled a staff member's hair.

On 01/26/2026 at 10:20 AM, Surveyor interviewed Executive Director (ED) B who reported Resident 10 was issued a 30-day discharge notice on 09/25/2025 due to behaviors. S/he stated they are continuing to work with other providers and have had numerous assessments for alternative placement. ED B stated Resident

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N 389	Continued From page 11 10 requires no assistance with activities of daily living aside from medication management. S/he stated Resident 10 will refuse medication "once in a great while" and housekeeping is a "hit or miss." ED B reported Resident 10 has accused previous housekeeping staff of stealing items from his/her room, but it was investigated by police and unfounded. S/he stated there have been several incidents where Resident 10 has become physical with both staff and residents including hitting a staff member and a resident. On 01/26/2026 at 10:55 AM, Surveyor interviewed Family D who reported, "[Resident 10] is blind and sees shadows." S/he stated s/he visits often and has observed the medication cart sitting in the hallway and wet floors on multiple occasions. Family D reported, "This is concerning and a tripping hazard for [Resident 10]." Family D discussed a recent incident where Resident 10 was served corn and when they asked staff for a substitution was told they did not have anything else prepared. Family D reported, "The staff told us there was a sign posted saying they need to know a head of time, but [Resident 10] is blind and needs help." On 01/26/2026 at 12:15 PM, Surveyor interviewed Dietary Aide (DA) E who reported Resident 10 likes his/her plate hot, so s/he "sanitizes" the plate in the dishwasher three times before putting food on it and serving it. DA E stated the plates are too big for the microwave, so they use the dishwasher but most of the time it still is not hot enough for Resident 10. DA E also verified Resident 10 did not get fried eggs this morning as they did not have any. S/he confirmed they will be receiving eggs in their upcoming grocery order scheduled for 01/28/2026.	N 389		

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(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 389	Continued From page 12 On 01/26/2026 at 3:25 PM, Surveyor interviewed Wellness Coordinator (WC) K who stated Resident 10 can be "irritable, belligerent and grumpy." S/he reported his/her door is always locked making it difficult for staff to do things for him/her. WC K reported Resident 10 often refuses housekeeping and medications. WC K stated, "Staff try and do a quick clean when [s/he] goes down to eat, but [s/he] never wants anyone in his/her room." S/he reported when staff administer medications, "[Resident 10] will refuse to give back [his/her] inhaler and nasal spray, so it's often left in [his/her] room. When [s/he] takes [his/her] pills, [s/he] doesn't want staff to stay and watch [him/her] like we are supposed to. We go in and just give [him/her] [his/her] medications and that is it. [S/he] wants to take them [him/herself]." WC K also discussed Resident 10 likes his/her food "hot, hot" and "if you don't bring a hot plate, [s/he] will throw it." S/he reported, "Staff are threatened by [him/her] because of [his/her] behaviors. [S/he] picks and chooses who [s/he] is going to have behaviors with." On 01/26/2026 at 2:25 PM and 4:07 PM, Surveyor interviewed ED B and WD F. Surveyor reviewed Resident 10's ISP with ED B and WD F. ED B confirmed they do not have a behavioral support plan or behavioral monitoring in place for Resident 10. ED B also acknowledged there are no additional interventions listed to prevent and/or manage his/her behaviors. ED B confirmed Resident 10 refuses housekeeping services and this is not reflected in his/her ISP. Surveyor inquired about the "frequent safety checks" and WD F confirmed staff conduct one safety check each shift. When Surveyor asked if Resident 10's ISP identified s/he had a vision impairment, WD F stated, "It should be listed under "assistive devices" or "personal safety," but I do not see it."	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015625	A. BUILDING: _____ B. WING _____	R-C 01/27/2026

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N 389	Continued From page 13 On 01/27/2026 at 11:10 AM, Surveyor interviewed Guardian L who stated Resident 10 was diagnosed legally blind about 6 to 7 years ago and had his/her driver's license revoked because of his/her vision problems. S/he reported Resident 10 "can get around fine and can see basic figures and shadows." Guardian L stated Resident 10 often refuses care and likes to be independent. S/he reported, "[Resident 10] does not like to be told what to do. [S/he] gets agitated with staff and can be intimidating when [s/he] wants to be." Guardian L discussed that Resident 10 has "a lot of problems with eating and coughs a lot." S/he reported the temperature of food has always been an issue for Resident 10 and it may be "more of a sensory thing." Guardian L stated Resident 10 has behaviors and continues to be physically aggressive with staff and residents. Guardian L reported, "There was an incident last week I believe where [s/he] chest bumped a resident and another time where [s/he] punched a resident in the face." S/he reported they received a 30-day discharge notice from the facility due to Resident 10's continued behavior and are actively looking for alternative placement. On 01/27/2026 at 4:00 PM, Surveyor interviewed ED B and WD F. Surveyor discussed the concern Resident 10's ISP was not updated to reflect his/her needs related to visual impairment or include effective interventions to prevent and/or manage behaviors, or refusals of care. ED B and WD F acknowledged Surveyor's concern and stated they will update Resident 10's ISP to reflect his/her needs. WD F stated they have a plan to be more "present during mealtimes" and will start telling Resident 10 daily what is on the menu and if s/he wants to know what is on his/her plate. ED B also reported that since Surveyor's	N 389		

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N 389	Continued From page 14 visit, Resident 10 stole a laptop off the medication cart, broke a table and broke into the lock box that controls the heat and air conditioning. The provider did not ensure Resident 10's ISP was updated to reflect his/her needs.	N 389		
{N 481}	83.43(1) Environment safe, clean, and comfortable 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. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a living environment that was safe, clean and homelike. This is a repeat deficiency. See Statement of Deficiency (SOD) FZS611, dated 09/12/2025. Findings include: On 09/29/2025, the Department received a complaint alleging concerns with cleanliness of resident rooms and odors. On 01/26/2026, Surveyor conducted a verification visit and complaint investigation at the facility. On 01/26/2026 at 9:25 AM, while walking into the bedroom suite-side of the facility, Surveyor noted a strong order of urine.	{N 481}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{N 481}	Continued From page 15 On 01/26/2026 at 9:30 AM, Surveyor interviewed Resident 10 who expressed there is a "urine smell" whenever s/he opens his/her bedroom door into the hallway. On 01/26/2026 at 10:55 AM, Surveyor interviewed Family Member A who reported s/he visits weekly and stated, "The urine smell is horrible." On 01/26/2026 at 12:05 PM, Surveyor noted a strong odor of urine emanating from Resident 9's room. Surveyor observed laminate flooring in the kitchenette and bathroom areas, and carpeting in the living room and bedroom. Surveyor was unable to confirm where the urine-like odor was coming from. On 01/26/2026 at 4:05 PM, Surveyor interviewed Executive Director (ED) B who acknowledged Surveyor's concern. S/he stated s/he would look into the concern and also discussed they have plans to replace older flooring throughout the building. On 01/27/2026 at 4:00 PM, Surveyor interviewed ED B and Wellness Director (WD) F. ED B reported s/he verified the odor of urine coming from Resident 9's room was due to an old, soiled wheelchair cushion and soiled clothing in his/her closet. ED B stated s/he found out Resident 9 was having accidents in his/her clothes and would take them off and hang them in his/her closet. S/he stated the cushion and the soiled clothing have been removed.	{N 481}		