STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015048	A. BUILDING: _____ B. WING _____	C 04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGES AT CEDAR RUN THE	6090 SCENIC DR WEST BEND, WI 53095

(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 04/14/2026 with information gathered through 04/15/2026, Surveyor conducted a standard survey and complaint investigation at The Cottages at Cedar Run, a Community-Based Residential Facility (CBRF) in West Bend, WI. One deficiency identified. Complaint unsubstantiated. Census: 59	N 000		
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 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 assess resident's needs, abilities, and physical and mental condition for 2 of 2 residents (Resident 1 and Resident 2) reviewed when there was a change in needs, abilities or condition. Resident 1 had a total of 9 falls from 02/04/2026-04/08/2026 and had no assessments. Resident 2 exhibited new behaviors a total of 3	N 381		

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

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N 381	Continued From page 1	N 381		

times from 02/23/2026-04/13/2026 and had no assessment.

Findings include:

On 04/14/2026, Surveyor reviewed Resident 1 and Resident 2's records and identified the following:

Resident 1
-Resident 1 was admitted to the provider's facility on 08/18/2025.
-Resident 1 had a total of 9 falls with no assessment regarding his/her falls.
-Resident 1's comprehensive assessments dated 09/23/2025 indicated the following: Skin status: Skin intact: No. Right elbow, 3 open areas, wound care and dressing change adjusted weekly. Falls risk: 1 or more falls in last 12 months. Health and Care Needs: 7 falls since admission. Safety: Some risk is inherent. Situations or condition which put tenant at risk of injury or harm. Increased risk of falls."
-Resident 1's Fall Tool dated 02/04/2026 at 1:30 AM stated the following: "Resident's position when found: Sitting with back against bed. Resident found in apartment. Type of injury: Skin tear."
-Resident 1's Fall Tool dated 02/09/2026 at 4:50 AM stated the following: "Resident found sitting on bottom facing bathroom. Resident found in apartment. Type of injury: bleeding and swelling."
-Resident 1's Fall Tool dated 02/11/2026 at 1:07 PM stated the following: "Resident said nothing, was attempting to stand from table, laying on left side in dining room. Type of injury: Skin tear x 2."
-Resident 1's Fall Tool dated 02/13/2026 at 1:00 AM stated the following: "Resident sitting on

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N 381	Continued From page 2	N 381		

buttocks on floor next to bed in apartment. Type of injury: bleeding, cut skin tear."
-Resident 1's Fall Tool dated 03/11/2026 at 3:00 AM stated the following: "Resident walking out of bathroom, sitting on floor in bathroom. Type of injury: bleeding, cut skin tear, skin tear."
-Resident 1's Fall Tool dated 03/22/2026 at 9:00 AM stated the following: "Laying flat on floor in apartment. Type of injury: bleeding."
-Resident 1's Fall Tool dated 03/28/2026 at 10:50 AM stated the following: "Sitting on bottom, as if [s/he] slipped out of bed in apartment."
-Resident 1's Fall Tool dated 03/29/2026 at 10:20 AM stated the following: "Trying to transfer by [him/herself], was found on bottom in sitting position leaning against night stand. Type of injury: Abrasion."
-Resident 1's Fall Tool dated 04/08/2026 at 9:30 AM stated the following: "Resident trying to stand and turn, found on butt sitting up in dining room."

-Resident 1's most recent ISP dated 03/18/2026 indicated the following: "Special instructions: Difficulty for [him/her] to form words. Can answer yes/no questions, point, use gestures. Requires reminders for safety. Is impulsive with walking and making quick movements. 15-minute checks. Keep water within reach and encourage/prompt [him/her] to drink it on checks. Toileting: Every 2 hours including noc shift-specific times for nocs: 1130, 130, 330, 530. Health monitoring: vitals: monthly set."

Resident 2
-Resident 2 was admitted to the provider's facility on 05/30/2025.
-Resident 2's comprehensive assessments dated 07/14/2025 indicated the following: "Mental and Emotional Health: Behavioral Symptoms, No behavior symptoms."

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N 381	Continued From page 3 -Resident 2 exhibited new behaviors 3 times that needed staff intervention from 02/23/2026-04/13/2026. -Resident 2's ISP dated 02/23/2026 indicated the following: "SUPERVISION at all times. Noc shift to be on 30 min checks. Keep physically and visually distanced from #215, #212 and #206." -Resident 2's progress notes dated 02/23/2026: "Intervention supervision at all times. Care plan updated." -Resident 2's ISP dated 03/30/2026 indicated the following: "when resident is in common areas with other residents present, outside of activities, staff is to remain within arms length of the resident to ensure resident interaction with other residents remains positive at all times. NOC shift to be on 30 min checks. Keep physically and visually distanced from #215, #212 and #206."]-Resident 2's progress notes dated 03/30/2026: "Talked with POA about the incident with another resident. [S/he] stated, oh boy, again. Reassured [POA] that we were updating care plan and that a staff member will be staying arms length away from mom while in common areas. Updated special instructions to read "when resident is in common areas with other residents present, outside of activities, staff is to remain within arm's length of resident to ensure resident interaction with other residents remains positive at all times. [POA] noted [s/he] understood and knows [s/he] can't remember what happens or who was just there to visit with [him/her]." -Resident 2's comprehensive assessments dated 04/13/2026 indicated the following: "Mental and Emotional Health: Behavioral Symptoms, No behavior symptoms." -Resident 2's ISP dated 04/13/2026 indicated the following: "when resident is in common areas	N 381		

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N 381	Continued From page 4 with other residents present, outside of activities, staff is to remain within arms length of the resident to ensure resident interaction with other residents remains positive at all times. NOC shift to be on 30 min checks. Keep physically and visually distanced from #215, #212 and #206." On 04/14/2026 at approximately 12:30 PM, Surveyor interviewed Administrator A. Administrator A stated Resident 1 did have multiple falls but when s/he fell, a progress note was completed, Resident 1's Power of Attorney (POA) was notified and the individual service plan (ISP) was updated. Administrator A stated Resident 2 is not usually an aggressive person but it is hard for him/her to know his/her surroundings by getting too close to other residents and being inside their "bubble" which sometimes has lead to the physical altercations between other residents and why staff are to be at arms lengths at all times. Administrator A acknowledged care plans were updated for Resident 1 and Resident 2 regarding the cares but they did not conduct an assessment regarding Resident 1's falls or Resident 2's behaviors. Administrator A stated they are currently working on a better system for their assessments and care plans to coincide better and be more specific to each resident's needs moving forward.	N 381		