STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020807	A. BUILDING: _____ B. WING _____	C 02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN EMBERS SENIOR LIVING	2626 FINGER ROAD GREEN BAY, WI 54302

(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 02/11/2026, Surveyor investigated 1 complaint investigation at Autumn Embers Senior Living in Green Bay. One (1) of 1 complaint was substantiated. As a result of the survey, 1 deficiency will be issued. Census: 19	N 000		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not investigate and document an	N 158		

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

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N 158	Continued From page 1	N 158		

allegation of neglect by a caregiver for 1 of 1 (Resident 1) residents reviewed.

A private duty caregiver agency was hired by Resident 1 to provide 1:1 care and supervision. Facility staff found Resident 1 inside a neighbor's house while an employee of the private duty caregiver agency was standing at the end of the driveway. The facility did not conduct an investigation into the incident.

Findings Include:

On 10/24/2025, the department received a complaint regarding allegations of a resident elopement.

On 02/11/2026, Surveyor conducted an onsite investigation. A sample of resident records was reviewed, including the record of Resident 1.

Resident 1 was admitted to the facility on 10/16/2025 with diagnoses to include frontotemporal dementia, asthma and unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. Resident 1's pre-admission assessment dated 10/10/2025 indicated Resident 1 had dementia, sundowners, wanders and likes to busy. Resident 1 was assessed to wander and be an elopement risk. Resident 1 was independent with walking and transfers. Resident 1 passed away on 11/08/2025.

Resident 1's signed admission agreement dated 10/15/2025 indicated Resident 1 would have a "One-on-One Staff Supervision Fee" which would be "charged directly from 3rd party."

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Surveyor reviewed Resident 1's progress notes. The following was noted:
*10/22/2025 at 5:41pm "resident's 1 on 1 caregiver said if [s/he] gets out of the facility gain [s/he] is letting [him/her] run"
*10/22/2025 at 6:33pm "neighbor called facility to let staff know that resident had walked into [his/her] house said that 1 on 1 caregiver walked away from resident and left [him/her] unattended which led to [him/her] walking into [his/her] house, resident then also got into someone else's house [Autumn Ember] staff member helped resident out of the second house because residents 1 on 1 [caregiver agency] caregiver stood at the end of the driveway saying "[expletive] this, [expletive] this"

On 02/11/2026 at 11:00 AM, Surveyor interviewed Guardian D. Guardian D verified s/he was the guardian for Resident 1. Guardian D stated Resident 1 was residing at another facility but due to behaviors and elopement risk, the facility had requested Resident 1 find alternative placement. Guardian D stated Autumn Embers accepted Resident 1 under the condition Resident 1 would have 1 on 1 caregiver upon admission. Guardian D stated s/he contacted with a caregiver agency to provide the 1 on 1 caregiver.

On 02/11/2026 at 9:45 AM, Surveyor interviewed Caregiver C. Caregiver C verified Resident 1 had a 1 on 1 caregiver through a caregiver agency. Caregiver C stated an agency caregiver was always present with Resident 1 and they had a walkie talkie to communicate with facility staff if Resident 1 started to become behavioral. Caregiver C could not recall the date but stated there was one time when Caregiver C went to check on Resident 1 in his/her room and s/he was not there. Caregiver C stated s/he used the

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walkie talkie to call the agency caregiver. The agency caregiver responded that Resident 1 was in a neighbor's house at that time. Caregiver C stated s/he immediately went outside and saw the agency caregiver standing at the end of the neighbor's driveway and noted Resident 1 was in the neighbor's house. Caregiver C stated the agency caregiver stated, "I'm not going in there (neighbor's house)." Caregiver C stated s/he went into the neighbor's house and was able to redirect Resident 1 out of the house and back to the facility. Caregiver C stated the agency caregiver was just letting Resident 1 walk into other houses on the block.

On 02/11/2026 at approximately 9:30 AM, Surveyor interviewed Executive Director A and Previous Wellness Director B. Previous Wellness Director B stated s/he was the Wellness Director at the facility at the time of the incident. Executive Director A stated upon admission Resident 1 had a 1 on 1 caregiver through a private caregiver agency due to having significant behaviors at Resident 1's past facility. Executive Director A stated Resident 1's guardian found the caregiving agency and hired them. Previous Wellness Director B stated staff called him/her when Resident 1 was found in the neighbor's house. Previous Wellness Director B stated s/he lives about 2 minutes away so immediately walked over to the facility and by that time Resident 1 was back at the facility. Previous Wellness Director B stated s/he did talk with the people who lived in the house. Surveyor requested to see the incident report or investigation into the incident. Previous Wellness Director B stated s/he did not think there was an investigation into the incident but staff did make a progress note.

On 02/11/2026 at approximately 2:30 PM,

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N 158	Continued From page 4 Surveyor called Executive Director A. Executive Director A verified the facility did not have an investigation into the allegation of neglect by the agency caregiver. Executive Director A stated s/he did report the caregiver to the caregiver agency and the caregiver never came back to the facility, however, the facility did not conduct an investigation into the incident. Executive Director A was unaware of the the agency's caregiver involved in the incident.	N 158		