STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018807	A. BUILDING: _____ B. WING _____	09/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANNON AT MENOMONEE FALLS	W 180 N7890 TOWN HALL RD MENOMONEE FALLS, WI 53051

(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
U 000	INITIAL COMMENTS On 09/14/2026, Surveyor conducted a monitoring visit at The Arboretum. One deficiency was identified. Census: 41	U 000		
U 268	89.34(17) TENANT RIGHTS Rights of tenants. A tenant of a residential care apartment complex shall have all the rights listed in this section. These rights in no way limit or restrict any other rights of the individual under the U.S. Constitution, civil rights legislation or any other applicable statute, rule or regulation. Tenant rights are all of the following: (17) SAFE ENVIRONMENT. To a safe environment in which to live. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure a safe environment in which to live. Findings include: On 09/14/2026 at 10:16 AM, Surveyor toured the provider's kitchen and loading dock area with Culinary Director B. Culinary Director B confirmed the facility had a fire on 06/20/2026. Culinary Director B reported the fire started in a dumpster containing cardboard right outside the loading dock. Culinary Director B showed the Surveyor the exterior damage the fire caused. Through the exit of the loading dock, Surveyor observed a	U 268		

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

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U 268	Continued From page 1 large area of siding removed and replaced with heavy black plastic sheeting. While outside, Surveyor noticed near the C-wing exit, a large area of what appeared to be a powdery black dusting covering the siding approximately 9 feet wide and at least by 18 feet high (Photo 1). Surveyor questioned if the black substance was soot from the fire damage. Culinary Director B reported s/he thought the black like substance was coming from the boiler exhaust vent directly below. Surveyor questioned how long the substance had been present or if it was observed prior to the fire at the facility. Culinary Director B did not provide an answer to either question. On 09/15/2026, Surveyor reviewed a fire report dated 06/20/2026. The following was documented: "M98 was notified that units were dispatched to reports of a minor outdoor dumpster fire at the [provider name] ...Upon arrival crew immediately noticed a column of black smoke coming from the C-side of the building. Upon approach, crew witnessed a dumpster that was on the exterior of the structures loading dock fully engulfed in flames, with flames having already spread to nearby structures and the main building s exterior. M98 reported a first-in, and advised B99 and all incoming units of their findings." On 09/14/2026 at 10:24 AM, Surveyor toured the facility. The following was observed: 1) The C-wing back emergency exit door had extensive rust damage at the bottom, and the entire bottom plate was barely hanging and needed to be replaced. The emergency exit door could not be secured, allowing for a potential security risk (Photo 2).	U 268		

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U 268	Continued From page 2 2) The D-wing back emergency exit door was heavily coated in green algae and black mildew like substance staining towards the bottom. The door's wooden trim was covered in the same substances leading up to the door's handle. The emergency exit door could not be secured, allowing for a potential security risk (Photo 3). Culinary Director B reported s/he had been working at the facility for 3 years and the C and D-wing exits had never been secured. Culinary Director B acknowledged this could lead to concerns with anyone being able to enter the facility. 3) Once inside the C-wing exit, Surveyor observed a large triangular piece of drywall near the ceiling that was peeling downwards. On the landing below, Surveyor observed a plastic bucket used to catch the water as it drips from the ceiling. Surveyor observed the bucket had a few inches of water inside (Photo 4). Culinary Director B reported the roof directly above the C-wing exit was a flat roof, did not have the right pitch, and when it rains hard, water leaks into the building. Culinary Director B reported the leaking water had been going on for over 3 months. 4) Inside the dining room/activity space, Surveyor observed two holes in the drywall ceiling. The first hole had an irregular shape with drywall peeling away from side to side, leaving jagged edges, and a visible opening approximately 12 inches wide by 6 inches in length at the bottom. The second hole was near a sprinkler head and was approximately the size of a baseball (Photo 5.) 5) Inside the basement, Surveyor observed the resident storage area. The storage area door was propped open by a small rectangular bin that had been collecting water from a pipe directly above	U 268		

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U 268	Continued From page 3 (Photo 6). The hallway directly outside the resident storage area, had many ceiling tiles missing and many ceiling tiles appeared to have water damage. Surveyor observed a large garbage can in the middle of the hallway that was used to catch leaking water from the pipes above. The garbage can had several inches of water at the bottom. In the same hallway, Surveyor observed an additional 5-gallon bucket placed in the walkway to catch leaking water from the pipes above (Photo 7.) On 09/16/2026 at 2:00 PM, Surveyor interviewed and shared findings with Interim Executive Director A and Regional Director C. Both staff acknowledged an understanding of the above concerns. Interim Executive Director A reported Management Company D took over this community on 09/01/2026 and was addressing environmental concerns. Regional Director C reported the provider had their capital project team complete a walk through the facility and had identified many areas that required attention. Regional Director C stated the provider would address the above concerns.	U 268		