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 08/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTONWOOD MANOR ASSISTED LIVING	1450 S MILITARY AVE GREEN BAY, WI 54304

(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 07/29/2026 with additional information gathered through 08/04/2026, Surveyors conducted a verification visit and complaint investigation at Cottonwood Manor Assisted Living. As a result, 2 of 2 complaints were substantiated and 3 new deficiencies were identified. One (1) of 2 previous deficiencies were corrected and 1 was a repeat deficiency. See Statement of Deficiency (SOD) FZS612, dated 01/27/2026. Under statutory provisions of WI Stat. Ch. 50 a $200 revisit fee is being assessed. Census: 28	{N 000}		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on interviews, observation and record review the provider did not follow the Individualized Service Plan (ISP) and implement housekeeping for 1 of 1 resident (Resident 13) reviewed. Findings include: On 06/23/2026, the Department received a complaint alleging concerns with cleanliness of resident rooms and odors. On 07/29/2026, Surveyors conducted a verfication visit and complaint investigation at the facility.	N 388		

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

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N 388	Continued From page 1 At approximately 11:10 AM, Surveyors observed a strong urine-like odor while walking down the hallway on the bedroom suite-side of the facility (near the activities area). Surveyors observed the urine-like odor become stronger near Resident 13's room. Upon entry into Resident 13's room, Surveyors observed his/her floor to have spills that were sticky and covered with debris and dust. Surveyor observed a disposable urinal hanging from the bathroom towel rack that contained approximately 1.5 to 2 inches of dark yellow urine-like liquid. There was also a dark gold color inside the bowl of the toilet and the bathroom floor appeared unclean with debris scattered throughout. On 07/29/2026 at 11:18 AM, Surveyors interviewed Resident 13 who was sitting in his/her wheelchair. S/he reported staff assist him/her with medication administration, laundry, showers and housekeeping. Resident 13 stated housekeeping happens "every so often" and expressed s/he could not recall the last time his/her room was cleaned. S/he stated staff are supposed to clean his/her room every week, but that does not happen. On 07/29/2026 at 11:35 AM, Surveyors interviewed Cleaner T who discussed owning a cleaning business along with Cleaner U. Cleaner T explained being hired to clean the facility hallways, bathrooms and all resident rooms every Wednesday for 5 hours except for Resident 13's room. Cleaner T stated (previous) Executive Director B (ED B) advised them not to clean Resident 13's room because of possible fecal matter on the bathroom floor. Cleaner T recalled that the last time they cleaned Resident 13's room was about 1.5 months ago.	N 388		

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N 388	Continued From page 2 On 07/29/2026 at 12:30 PM, Surveyor reviewed Resident 13's ISP dated 03/24/2026 with diagnoses including benign prostate hyperplasia w/out lower urinary tract symptoms, pulmonary embolism, pressure ulcer of right hip, injury of right foot, pulmonary hypertension, heart disease, anemia in chronic kidney disease, lymphedema and colostomy complication. Resident 13 was admitted to the facility on 08/20/2025. Resident 13's ISP identified the following need: Housekeeping - Resident will have a clean environment in which to reside through the next review. Date initiated 08/20/2025. - Provide housekeeping service weekly and PRN. On 07/29/2026 at approximately 1:15 PM, Surveyors interviewed Executive Director (ED) M who stated s/he was not aware that Cleaner T and Cleaner U were advised not to clean Resident 13's room. ED M stated s/he would ensure Resident 13's room was cleaned immediately and every week.	N 388		
{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	{N 389}		

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{N 389}	Continued From page 3 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 Service Plans (ISPs) were updated to reflect the needs of Resident 11. Resident 11 was noted to display both verbal and/or physical behaviors towards staff and residents. Resident 11's ISP identified his/her tendency to display behaviors, but it did not identify effective interventions to prevent and/or manage his/her behaviors. This is a repeat deficiency. See Statement of Deficiency (SOD) FZS612, dated 01/27/2026. Findings include: On 06/23/2026, the Department received a complaint alleging care concerns. On 07/29/2026, Surveyors conducted a verification visit and complaint investigation at the facility. Surveyors requested a sample of resident records to include the record of Resident 11 from Wellness Director (WD) F and Executive Director (ED) M. On 07/29/2026 at 12:15 PM, Surveyor reviewed Resident 11's record and noted the following: Resident 11 was admitted to the facility on	{N 389}		

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{N 389}	Continued From page 4 10/14/2025 with diagnoses to include hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, diplopia (double vision), osteoarthritis of right hip and bilateral knees, artificial hip joint, hypothyroidism, hypertension, unspecified mood disorder, depression, anxiety, chronic pain, torticollis (condition causing the neck muscles to twist or tilt the head to one side), agoraphobia with panic disorder and traumatic brain injury. Resident 11 had a legal guardian and managed care organization (MCO). Resident 11's ISP, currently in place as of 07/29/2026, identified needs around transfers, toileting, dressing, bathing, safety checks, housekeeping, medication administration and behaviors. The following was noted: *Assistive Devices: "Sit to stand for transfers ... wheelchair." *Mobility: "Fall 2/12/26 intervention: ensure resident fully awake and able to fully participate prior to transfer ... non-ambulatory ... wheelchair is primary mode of transportation ... requires assistance with propelling wheelchair to and from all meals and activities of choice ... call light within reach when in room ... encourage non-slip socks in room ... proper footwear when out of bed ... keep pathways in room clear of clutter encourage participation in activities that will increase strength and mobility." *Toileting: " ... generally takes 1-2 hours when using the toilet ... will ring when needing to go to the bathroom ... staff to assist with transferring on and off toilet ... continent of bladder and bowel ... requires assistance for toilet use ..."	{N 389}		

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{N 389}	Continued From page 5 *Bathing: " ... requires assistance for bathing/showering ... assist with 2 showers a week ... skin integrity: skin check completed during each shower of the week" and report concerns ... *Dressing: " ... complete assist with dressing from 1 staff ... needs assistance with dressing [his/her] upper and lower body." *Wellness/Safety: " ... routine safety checks each shift ..." *Medication/Pharmacy: "Staff performs medication administration ... will receive medication as prescribed by physician ... facility orders medications from pharmacy ..." * Behavior Care: "Will show decreased s/s [signs and symptoms] of anxiety, sadness and/or depression ... will remain free of s/s of distress, symptoms of depression, anxiety or sad mood ... diagnosis: depression, anxiety ... related meds: lorazepam, buspirone, venlafaxine, quetiapine, bupropion, risperidone ... monitor behavior: yelling, crying, repeating self ... monitor for increase in anxiety level. Has PRN [as needed] lorazepam available. Also, try to redirect through conversation and offering of iPad." Review of Resident 11's Progress Notes and a "Follow Up Question Report" from 06/01/2026 to 07/29/2026 documented behaviors, and read in part: (Surveyor note: The "Follow Up Question Report" documented completed care tasks. The "Behavior Monitoring" task reflected "Monitor for increase in anxiety level. Has prn [as needed] lorazepam available. Also, try to redirect through	{N 389}		

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{N 389}	Continued From page 6	{N 389}		

conversation and offering of iPad." Following the behavioral monitoring task, it was noted, "Behavior symptoms. Has the resident exhibited this behavior before" with responses to include, "Yes," "Not applicable," and "None of the above observed" and who documented the task.)

06/04/2026 - Question Report: Behavior symptoms - "Yelling/screaming, abusive language, threatening behavior."

06/08/2026 - Progress Note: "On Sunday June 7th ... had very to no little sleep and was yelling and being combative towards staff members and when staff members was [sic] trying to calm and find solutions the resident was yelling at the staff ... seems to be very confused of what [s/he] really wanted ... staff was trying to help but resident continue [sic] to yell at the staff ..." Author: Caregiver J.

06/09/2026 - Progress Note: "Staff was preparing [his/her] shower, but the resident proceeded to yell at the staff member because staff was taking the caddy to the shower and staff explained to the resident that 'staff is preparing your shower' but the resident wasn't understanding and continued to yell and call staff names." Author: Caregiver J.

06/12/2026 - Question Report: Behavior symptoms - "Yelling/screaming."

06/14/2026 - Progress Note: " ... has had behaviors since staff's shift started at 7:00 PM (06/13/26) ... was in the restroom when staff arrived for shift, staff heard resident banging on walls and screaming ... checked on resident though [s/he] did not press [his/her] pendant ... was yelling at staff about other temporary staff members (agency) [s/he] proceeded to call them

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{N 389}	Continued From page 7	{N 389}		

derogatory names/racial names ... assisted resident with getting off the toilet and back in chair ... 10:00 PM [s/he] was back in restroom ... was screaming and banging [his/her] right arm against the wall ... staff responded quickly ... reminded multiple times [s/he] cannot be doing this and needs to use [his/her] pendant ... declined to get ready for bed ... 11:30 PM ... started again, yelling stating [s/he] wants to go to bed ... staff responded and told [Resident 11] it is not appropriate to keep yelling ... has a call button ... woke up [his/her] neighbor due to screaming which then became a confrontation between [his/herself] and [his/her] neighbor which staff had to redirect ... assisted with getting into the restroom at 11:45 PM and was checked on multiple times until [s/he] finally rang [his/her] pendant alongside with screaming and banging [his/her] hand on the wall in [his/her] restroom ... call light went off for approx. 10-15 minutes due to staff assisting other residents at this time ... rang [his/her] pendant after [s/he] gotten [sic] into bed around 2:45 AM stating [s/he] felt like [s/he] was going to fall off the bed ... staff assisted with a boost ... afterwards [Resident 11] began yelling at staff about [his/her] pajamas not matching, clothes missing ... would not allow staff to turn off [his/her] call light and stated [s/he] will break it before [s/he] allows staff to touch it." Author: Caregiver N.

06/12/2026 - Question Report: Behavior symptoms - "Yelling/screaming."

06/15/2026 - Question Report: Behavior symptoms - "Yelling/screaming. Abusive language."

06/15/2026 - Progress Note: " ... got off the toilet around 3:30 AM, [s/he] then requested to go back

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{N 389}	Continued From page 8 to the bathroom at 4:15 AM ... began to scream at staff ... staff told resident to give staff a few minutes to put laundry in the laundry room (as it was in staff's hands) ... staff got back to resident room ... began to yell at staff again, staff attempted to assist resident ... continued to yell at staff ... redirected ... had no choice but to leave the room of resident due to ongoing screaming behavior around the time of 430-445 AM ..." Author: Caregiver N. 06/15/2026 - Progress Note: " ... yelling and didn't use [his/her] call light and as soon as staff walked in staff said, 'good morning, I'm sorry I was in another room doing cares on a resident and [Resident 11] said 'you're doing this on purpose' ... proceeded to yell ... staff member asked politely 'please stop yelling and cussing at me' and [Resident 11] said 'I don't care I need to go to the bathroom and I don't care about the other residents that needed help.' While staff was helping and doing cares on [him/her] [s/he] continued to have behaviors." Author: Caregiver J. 06/15/2026 - Progress Note: " ... was having behaviors throughout the evening hours. Staff was dealing with an emergency situation and resident was communicated to about the situation, staff told resident that staff will be back ... Emergency services were in the building and [Resident 11] began screaming for EMS to come in and help [him/her] which then led to resident stating [s/he] now had to use the restroom, staff helped resident in the restroom ... began banging on the walls and screaming when [s/he] was finished, staff responded promptly, and resident then told staff [s/he] needed more time ... politely asked [him/her] to use [his/her] pendant or wall call light when [s/he] is finished." Author:	{N 389}		

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{N 389}	Continued From page 9 Caregiver N. 06/16/2026 - Progress Note: " ... up for the whole night, [s/he] was cleaning [his/her] bathroom and organizing [his/her] room, staff checked on [him/her] multiple times ... Around 415 AM resident rang [his/her] call light as staff was in the middle of finishing a care, staff told resident that it would be just a few minutes due to staff doing others personal cares at that time, [s/he] proceeded to call staff liars and yell at staff ... assist with toileting around 5AM, staff asked resident to turn [his/her] pendant off, resident refused and began banging on the wall (at this point [s/he] was on the toilet) staff politely asked resident not to bang on the wall due to neighbors still sleeping, [s/he] said [s/he] does not care and they should be up, since [s/he] is up ... asked resident to turn [his/her] call light off so staff knows when [s/he] is finished ... continued screaming and threw [his/her] toilet paper at staff, and pulled the string in the bathroom (other call light) and stated that staff should just check on [him/her] and [s/he] shouldn't have to pull lights, staff promptly turned the wall call-light off and left the room ... began screaming again, stating [s/he] needed [his/her] toilet paper that was on the floor in [his/her] bedroom due to [him/her] throwing it at staff, staff handed her toilet paper ... as of 5:50AM [his/her] pendant is still on due to refusing to let staff turn it off, and its inside of [his/her] shirt." Author: Caregiver N. 06/16/2026 - Question Report: Behavior symptoms - "Yelling/screaming. Kicking/Hitting, Abusive language, Threatening behavior, Rejection of Care." 06/18/2026 - Question Report: Behavior symptoms - "Yelling/screaming, Abusive	{N 389}		

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{N 389}	Continued From page 10 language, Rejection of Care." 06/18/2026 - Progress Note: " ... rang [his/her] pendant for assistance with toileting around 3:30AM ... told resident to give staff just a few minutes as staff were assisting other residents at that time ... staff helped resident into restroom and told resident to ring [his/her] pendant when [s/he] was ready, around 5:15AM-5:30AM instead of resident only ringing [his/her] pendant [s/he] also was banging on [his/her] bathroom wall, screaming at the top of [his/her] lungs ... staff arrived ... in the middle of the transfer ... [s/he] began stating [s/he] still had to go ... put [him/her] back down onto toilet via lift and told [him/her] to call when [s/he] was ready ... began screaming at staff as staff closed [his/her] door and exited the room, [s/he] then pressed [his/her] pendant again ... entered resident restroom and asked [him/her] why [s/he] was yelling and [s/he] was now ready ... began screaming at staff stating that staff can stay in [his/her] bedroom and wait for [him/her] to fully be finished ... explained to resident that staff also has other cares to attend to ... resident declined to turn off pendant, [s/he] tucked it into [his/her] shirt ... began screaming again, stating [s/he] was finished ... staff assisted ... unable to turn [his/her] pendant off as of 5:48AM due to refusal ... began screaming more ..." Author: Caregiver N. 06/18/2026 - Question Report: Behavior symptoms - "Yelling/screaming, Abusive language." 06/20/2026 - Question Report: There were 2 separate documented behavioral incidents of "Yelling/screaming." 06/21/2026 - Question Report: Behavior	{N 389}		

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{N 389}	Continued From page 11 symptoms - "Yelling/screaming, Abusive language." 06/22/2026 - Question Report: Behavior symptoms - "Yelling/screaming, Abusive language." 06/22/2026 - Progress Note: "Resident wanted toilet paper ... staff came back and resident pushed [his/her] call light, and staff was going to turn it off, but the resident took it away and refused staff to turn off the call light and resident was yelling ... continue [sic] to yell and blame staff members ... staff said 'Please don't yell at me' resident said 'I can yell if I want' the resident continued and staff answered the resident call light in a timely manner." Author: Caregiver J. 06/23/2026 - Question Report: Behavior symptoms - "Yelling/screaming, Abusive language." 06/25/2026 - Question Report: Behavior symptoms - "Yelling/screaming, Abusive language." 06/26/2026 - Question Report: Behavior symptoms - "Yelling/screaming." 06/27/2026 - Question Report: Behavior symptoms - "Yelling/screaming, Abusive language." 06/30/2026 - Question Report: There were 2 separate documented behavioral incidents of "Abusive language" and "Yelling/screaming." 07/01/2026 - Question Report: Behavior symptoms - "Yelling/screaming, Abusive language, Threatening behavior."	{N 389}		

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{N 389}	Continued From page 12 07/02/2026 - Question Report: Behavior symptoms - "Yelling/screaming, Abusive language. Threatening behavior." 07/02/2026 - Progress Note: "Late Entry 07/01/26 ... [Resident 11] was on the toilet ... let [him/her] know that staff would be back to check on [him/her] after med count as [s/he] stated [s/he] was not finished in restroom at this time ... rang [his/her] wall call light shortly after, at the time of [his/her] call light ringing staff had to assist another call light with breathing concerns ... let [him/her] know that staff will be back in just a few moments ... staff arrived ... [Resident 11] was very frustrated that [s/he] had to wait for staff to finish with a emergency concern ... began accusing staff members of leaving [him/her] in restroom for 3 hours ... staff attempted to verbally redirect ... explained to [Resident 11] that staff had only been in the building for staff's portion of shift for a short time ... staff assisted with [Resident 11's] transfer, [s/he] began yelling at staff stating that [his/her] sling has [him/her] leaning ... staff has gotten [him/her] onto [his/her] bed and began adjusting [his/her] pillows/sheets, staff reiterated [his/her] pillows/sheets three different times ... began screaming at staff ... after multiple times of attempting to redirect [his/her] behavior, staff walked out of [his/her] room ... Staff did ask resident if [s/he] would feel better if [s/he] had a PRN [as needed] lorazepam to help calm [him/her] down ... began screaming and throwing things on the floor ... staff went back in by [Resident 11] asking [him/her] to please not scream, as it was late ... [his/her] neighbor came out of [his/her] room and began yelling at [him/her], another resident who was walking down the hallway was also pitching in yelling at [Resident 11] in regard to [him/her] yelling and	{N 389}		

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{N 389}	Continued From page 13 waking them up ... did the best at redirecting all residents involved ... attempted to contact [WD F] with no response ... contacted [Business Office Manager (BOM) P] ... [BOM P] did have a semi-long discussion with [Resident 11] ... about [his/her] behaviors and did end up agreeing/asking for a PRN lorazepam, staff administered ..." Author: Caregiver N. 07/03/2026 - Question Report: Behavior symptoms - "Yelling/screaming." 07/05/2026 - Question Report: Behavior symptoms - "Yelling/screaming." 07/07/2026 - Question Report: Behavior symptoms - "Yelling/screaming." 07/10/2026 - Question Report: There were 3 separate documented behavioral incidents of "Yelling/screaming" and "Yelling/screaming, Rejection of care." 07/12/2026 - Question Report: Behavior symptoms - "Yelling/screaming." 07/14/2026 - Question Report: Behavior symptoms - "Yelling/screaming, Abusive language, Threatening behavior." 07/14/2026 - Progress Note: " ... scheduled shower today ... staff let [Resident 11] know we do not have the shower chair that [s/he] had been using no longer due to it not belonging to us ... became combative asking staff how [s/he] is going to be able to shower properly ... reassured [Resident 11] we would be in there to help ... staff was helping wash ... was complaining that the shower water was getting cold, at this point we were in there for 45 minutes ... [Resident 11] did	{N 389}		

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{N 389}	Continued From page 14	{N 389}		

not like that staff was helping [him/her] ... calling staff members 'worthless' and screaming. While drying off [him/her] was different from, what [s/he] was used to due to the kind of chair [s/he] was in ... staff was talking [him/her] through the whole process ... s/he had to use the bathroom right away, staff then promptly transferred [him/her] onto the toilet, [s/he] began screaming at staff, due to being upset [s/he] couldn't go into [his/her] own restroom ... staff explained ... would need to get [him/her] fully dressed in order to bring [him/her] back to [his/her] room because [s/he] was nude ... began screaming at staff stating [s/he] does not care and that everybody as 'seen me naked before' ... attempted to verbally redirect, but was unsuccessful ... another staff member entered the restroom to calm [Resident 11] down ..." Author: Caregiver N.

07/15/2026 - Question Report: Behavior symptoms - "Yelling/screaming, Abusive language."

07/17/2026 - Question Report: There were 2 separate documented behavioral incidents of "Yelling/screaming" and "Yelling/screaming, Threatening behavior."

07/18/2026 - Question Report: Behavior symptoms - "Yelling/screaming."

07/19/2026 - Question Report: Behavior symptoms - "Yelling/screaming."

07/21/2026 - Question Report: Behavior symptoms - "Yelling/screaming, Threatening behavior."

07/21/2026 - Progress Note: "Resident transferred to restroom ... staff exited restroom to

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{N 389}	Continued From page 15	{N 389}		

let resident have privacy ... resident called and staff entered room to find resident asking where tablet was ... resident rang again shortly after leaving a different staff member entered [sic] and resident yelled at staff to wait but continuously asks for privacy so staff exited room due to resident not being done ... began banging on the wall after 1 minute of call light being pulled ... Went back into room and resident was screaming at all staff. Staff member talked to resident about not being acceptable behavior and waking other residents." Author: Caregiver O.

07/23/2026 - Question Report: Behavior symptoms - "Yelling/screaming, Threatening behavior."

07/24/2026 - Progress Note: " ... placed in restroom to use bathroom, when staff went to deliver pills, resident was on the phone with 911 because '[s/he] should not get [his/herself] off the toilet.' Staff reminded [Resident 11] [s/he] had a call light to be able to notify us ..." Author: Caregiver O.

07/24/2026 - Question Report: Behavior symptoms - "Pinching/scratching/spitting, Rejection of Care."

07/27/2026 - Progress Note: " ... assisted resident with toileting, staff told resident to ring [his/her] pendant when [s/he] was done ... responded promptly when resident rang ... still wiping and told staff to 'hang on a second' during this time another resident was screaming for help ... told [Resident 11] that staff will be back ... staff had to assist another resident in an emergency situation, during the time staff was away ... [s/he] then rang again and began screaming and banging on [his/her] bathroom wall ... staff then

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{N 389}	Continued From page 16 went back to assist [Resident 11], staff explained to [Resident 11] that staff is the only staff here at night and to please have patience when ringing ... became very combative and accusing staff of being a 'liar' staff did not respond to the negative behaviors ... staff was in attempt [sic] to lift [him/her] sit to stand ... [s/he] was looking down to the left ... the strap that does under [his/her] left arm was tight against [his/her] neck, staff told [Resident 11] [s/he] needed to lift [his/her] head up ... [Resident 11's] response to staff was 'yeah I'll just tell them you tried to purposely strange me' ... verbally redirected ... told [him/her] that would never be the case as I am here to help [him/her] ... staff then lifted [him/her] ... staff promptly got [him/her] in bed ... [s/he] did not like the position [s/he] was in, in bed, when staff tried to move [him/her] over [s/he] then began accusing staff of harming [him/her], staff backed up, and told [him/her] to let staff know when [s/he] was comfortable ... staff got [him/her] covered up and exited the room ... resident was still screaming and yelling, threating [sic] staff and purposely throwing [his/her] juice cup towards [his/her] door ... [s/he] then rang [his/her] pendant and when staff arrived [Resident 11] began accusing staff of not wanting to do [his/her] laundry ... [s/he] then said 'oh well aren't they going to do it when I have my shower anyways?' ... staff asked [Resident 11] to please turn [his/her] pendant off, [s/he] responded and said 'no that's something you need to do' ... [Resident 11's] pendant is around [his/her] neck ... staff explained to [Resident 11] that I don't feel comfortable doing that at this time and [s/he] still declined to turn it off stating [s/he] 'wants other people to know how horrible you are.' Author: Caregiver N. 07/27/2026 - Question Report: There were 2 separate documented behavioral incidents of	{N 389}		

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{N 389}	Continued From page 17 "Yelling/screaming, Abusive language, Threatening behavior, Rejection of Care" and "Yelling/screaming, Abusive language." 07/28/2026 - Progress Note: "Resident called on [his/her] pendant ... staff responded at [his/her] door way due to also currently dealing with behaviors from another resident ... asked staff for juice ... told [Resident 11] to please give staff one moment ...while staff was attending to a behavior that was awaking other residents, it took aprox [sic] 27 minutes in another room, when staff arrived back by [Resident 11] [s/he] was on the phone with 911 ... staff explained staff was with another resident and it was just behaviors [Resident 11] was hearing, operator stated that [Resident 11] called and said [s/he] 'needed help and is hearing a [fe/male] scream ... [Resident 11] stated [s/he] would like to use the restroom ... staff transferred [him/her] to the restroom ... staff also had a talk with [Resident 11] and explained to [him/her] that [s/he] cannot call 911 unless there is a real emergency situation that needs assistance ... [Resident 11] then began yelling at staff ... the attempt to verbally redirect did not work ... [s/he] began screaming at staff ..." Author: Author: Caregiver N. 07/28/2026 - Question Report: There were 2 separate documented behavioral incidents of "Yelling/screaming, Abusive language, Threatening behavior, Rejection of Care" and "Yelling/screaming." 07/29/2026 - Question Report: There were 2 separate documented behavioral incidents of "Yelling/screaming, Kicking/hitting, Abusive language" and "Yelling/screaming." On 07/29/2026 at 11:55 AM, Surveyors	{N 389}		

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interviewed Wellness Director (WD) F and Executive Director (ED) M. ED M confirmed Resident 11 has displayed both verbal and physical behaviors towards staff. S/he stated there has been nothing physical towards residents. ED M reported Resident 11 has called 911 on occasion when s/he doesn't get his/her juice in a timely manner and s/he yells and screams. S/he stated Resident 11 "screams for help if [his/her] call light is not answered within minutes" and his/her behaviors occur more at night. ED M acknowledged Resident 11's ISP did not include effective interventions to manage his/her behaviors. ED M reported, "I was going through [his/her] ISP yesterday to determine what interventions will be suitable for [him/her]." ED M stated staff have been advised to redirect and speak calmly to Resident 11. S/he reported, "Staff need to get down to [his/her] level and ask [him/her] what [s/he] needs. Usually it's juice or [s/he] needs to go to the bathroom." ED M stated Resident 11 does not currently have a behavioral support plan, but staff monitor and chart on his/her behaviors daily on every shift.

On 07/30/2026 at 12:17 PM, Surveyor interviewed Power of Attorney (POA) Q who stated Resident 11 has "tremendous anxiety" and significant mental health issues. POA Q reported Resident 11 has issues with constipation and it often takes him/her 1 to 2 hours on the toilet, but this is something they are working on with his/her physician. S/he confirmed Resident 11 is dependent on staff for assistance with cares and "yells out to caregivers" and exhibits behaviors specifically when it comes to toileting.

During an interview with Caregiver N on 07/30/2026 at 3:08 PM, s/he confirmed s/he works NOC shift. S/he stated, "I work alone at

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{N 389}	Continued From page 19	{N 389}		

night and it can be difficult at times with chronic behaviors." Caregiver N reported "[Resident 11] has behaviors, but not every night." Caregiver N reported Resident 11 will stay on the toilet for up to 2 hours and will press his/her pendant when s/he is done. Caregiver N stated when s/he goes in to assist him/her, Resident 11 will say s/he is not done and will ask staff to wait or for more time. Caregiver N stated, "This happens no matter how often we check on [him/her]. [S/he] bangs on the wall and screams if [s/he] wants to get off the toilet." Caregiver N reported there are times Resident 11 forgets to press his/her pendant and "screams at the top of [his/her] lungs" and this wakes up other residents.

On 07/30/2026 at 3:48 PM, Surveyor interviewed Caregiver R who confirmed s/he is a caregiver on NOC shift. S/he stated Resident 11 is "very picky and likes things a certain way." Caregiver R reported s/he also "likes to fib" saying things during cares like "this person punched me" or "no one has changed me in 3 days." Caregiver R stated, "[S/he] will yell, hit the walls and scream. Other residents complain [s/he] wakes them up. I try to redirect [him/her] and change the subject, but it's hard to do when [s/he] is stuck on something." S/he reported, "[Resident 11] has good days and bad days" and discussed s/he will sleep through the night and the next s/he is up for most of the night having behaviors and yelling.

On 08/04/2026 at 10:30 AM, Surveyors interviewed WD F, ED M and Registered Nurse (RN) S. ED M acknowledged Surveyor's concern Resident 11's ISP was not updated to include effective interventions to manage his/her behaviors. S/he stated "We are currently providing redirection with staff on [his/her] behaviors. They need more training on how to

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{N 389}	Continued From page 20 approach [him/her]. We are working on new interventions." ED M also reported Resident 11's cares are taking over an hour to complete, so s/he has plans to "spend more time with [him/her]" and re-evaluate him/her. When Surveyor inquired about Resident 11's PRN Lorazepam, WD F stated s/he has an order for it to be administered twice per day, but at times it is "not effective" and s/he will not take it unless s/he asks for it. WD F reported they also asked for the Lorazepam to be scheduled instead of PRN, but Resident 11 did not want that as s/he states it "feels like we are drugging [him/her]." ED M also stated since Surveyors onsite visit, they have since added another caregiver on night shift due to the level of care needs. The provider did not ensure Resident 11's ISP was updated to reflect his/her needs.	{N 389}		
N 527	83.47(2)(f) Horizontal evacuation. Horizontal evacuation. The CBRF shall have approval from the department before including horizontal evacuation in the emergency and disaster plan. CBRFs using horizontal evacuation shall document the total evacuation time of the fire zone evacuated. This Rule is not met as evidenced by: Based on observation and interview, the provider did not obtain Department approval before implementing the horizontal evacuation in the emergency and disaster plan. The Community-Based Residential Facility (CBRF) residents are evacuated to their rooms which are equipped with fire-rated doors (point of rescue) or moved to the other side of available	N 527		

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N 527	Continued From page 21 fire-rated doors. The provider did not obtain Department approval prior to implementing horizontal evacuation. Findings include: The Community Based Residential Facility (CBRF) is licensed as a class CNA (non-ambulatory) to provide care for the following resident types: physically disabled, developmentally disabled, advanced aged and irreversible dementia/Alzheimer's. On 07/29/2026 at approximately 11:05 AM, Surveyors observed the fire alarm sounding and Maintenance Director (MD) Q directing residents to the activity area on the north side of the building. MD Q stated the building has 2 sets of fire doors used for horizontal evacuation. MD Q explained residents are directed to the opposite side of the building and the other side of the fire doors depending where the fire is in the building. On 07/29/2026 at approximately 12:00 PM, Surveyor interviewed Executive Director (ED) M who confirmed that the provider was practicing horizontal evacuation and was unsure if approval had been requested from the Department. On 08/03/2026, Surveyors reviewed Department records and did not see evidence that a waiver had been approved for the use of horizontal evacuation. On 08/04/2026 at 10:30 AM, Surveyors interviewed ED M, Wellness Director (WD) F and Registered Nurse (RN) S who confirmed they	N 527		

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Y3100	Continued From page 22	Y3100		
Y3100	50.09(1)(f) Resident's Rights In Certain Facilities (f) Physical and emotional privacy in treatment, living arrangements and in caring for personal needs, including, but not limited to: 1. Privacy for visits by spouse or domestic partner. If both spouses or both domestic partners under ch. 770 are residents of the same facility, the spouses or domestic partners shall be permitted to share a room unless medically contraindicated as documented by the resident ' s physician, physician assistant, or advanced practice nurse prescriber in the resident ' s medical record. 2. Privacy concerning health care. Case discussion, consultation, examination and treatment are confidential and shall be conducted discreetly. Persons not directly involved in the resident ' s care shall require the resident ' s permission to authorize their presence. 3. Confidentiality of health and personal records, and the right to approve or refuse their release to any individual outside the facility, except in the case of the resident ' s transfer to another facility or as required by law or 3rd-party payment contracts and except as provided in s. 146.82 (2) and (3).	Y3100		

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Y3100	Continued From page 23	Y3100		

This Rule is not met as evidenced by:
Based on observation, record review and interview, the provider did not ensure Resident 12's right to physical and emotional privacy in his/her living arrangements.

Findings include:

The Community Based Residential Facility (CBRF) is licensed as a class CNA (non-ambulatory) to provide care for the following resident types: physically disabled, developmentally disabled, advanced aged and irreversible dementia/Alzheimer's.

On 06/08/2026, the Department received a complaint alleging staff were entering resident rooms without permission.

On 07/29/2026 at 12:15 PM, Surveyors interviewed Executive Director (ED) M who stated caregivers use a master key to enter resident rooms to do safety checks or enter if they don't get a response after knocking on the resident's door. ED M stated caregivers knock and wait a minute for residents to respond before entering residents' rooms.

On 07/29/2026 at approximately 3:20 PM, Surveyor observed a caregiver knock on Resident 12's door and enter Resident 12's room within 5-10 seconds using the facility master key. Surveyor did not hear an audible response from Resident 12 to enter his/her room.

On 07/29/2026, Surveyor reviewed Resident 12's Individual Service Plan (ISP) dated 04/29/2026 and noted s/he was admitted to the facility on

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COTTONWOOD MANOR ASSISTED LIVING	1450 S MILITARY AVE GREEN BAY, WI 54304

(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
Y3100	Continued From page 24 03/29/2026. Resident 12 was his/her own decision maker and independent with activities of daily living. On 08/03/2026 at 8:51 AM, Surveyor interviewed Resident 12 who discussed caregivers knock at his/her door, wait a few seconds and then use the master key to open his/her bedroom door. Resident 12 stated this happens daily and s/he has expressed to management s/he does not want anyone entering his/her room without his/her permission. Resident 12 stated last week a caregiver knocked and immediately entered his/her room using the master key prior to him/her giving permission. S/he reported s/he was partially undressed from the waist down. Resident 12 described another incident when a caregiver knocked and immediately entered his/her room using the master key, and shouted out his/her name. Resident 12 stated s/he was in the bathroom and just stepped out of the shower when s/he heard the caregiver's voice. Resident 12 expressed being very upset with the provider for not protecting his/her right to privacy in his/her room. On 8/04/2026 at 10:30 AM, Surveyor interviewed ED M who acknowledged Resident 12's right to privacy in his/her room and his/her right to decide when caregivers need to enter his/her room. ED M stated Resident 12's ISP will be updated to reflect the agreed upon plan and caregivers will be informed of the plan.	Y3100		