STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018879	A. BUILDING: _____ B. WING _____	C 06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIORITY PLACE LLC	8726 WEST MILL ROAD MILWAUKEE, WI 53225

(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 06/04/2026 with information collection through 06/12/2026, Surveyors completed a complaint investigation at Priority Place. As a result, 1 deficiency was identified. The complaint was substantiated. Census: 21	N 000		
N 426	83.38(1)(b) Supervision. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident's highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Supervision. The CBRF shall provide supervision appropriate to the resident's needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure appropriate supervision for 1 of 1 resident (Resident 1). Resident 1 had a history of elopement and eloped from the facility approximately 3 times in April 2026, 6 times in May 2026, and 2 times in June 2026. Findings include: On 05/18/2026, The Department received a complaint alleging supervision concerns for residents. The provider is licensed as a Class CNA (Non-	N 426		

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

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N 426	Continued From page 1 Ambulatory) community based residential facility to provide services for up to 24 residents who may be physically disabled, correctional clients, emotionally disturbed/mental illness, irreversible Dementia/Alzheimer's, public funding, terminally ill, alcohol/drug dependent, advanced aged, traumatic brain injury, and developmentally disabled. On 06/04/2026, at approximately 10:00 AM, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 02/16/2026. Resident 1 had a diagnosis of Huntington's disease and repeated falls. Resident 1 had a legal guardian, a protective placement order, and a managed care organization (MCO). Resident 1's Individual Service Plan (ISP), updated 06/04/2026, indicated Resident 1 had elopement/exit seeking behaviors. Resident 1 walked with a walker. The goal for Resident 1 indicated Resident 1 "would remain safe within the facility and elopement episodes will decrease." The ISP indicated interventions of verbal redirection, close supervision during periods of agitation, facility staff to follow elopement procedures when Resident 1 leaves without authorization, notify management and responsible party of incidents, document behaviors and triggers and interventions. Licensee A implemented the elopement procedure after Resident 1 eloped 3 times. There were no new interventions implemented when the elopement procedure was put in place for Resident 1. Resident 1 did not have 1:1 services in place. On 06/04/2026, at approximately 11:00 AM, Surveyor reviewed Resident 1's progress notes. Resident 1 eloped from the facility on 05/01/2026,	N 426		

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N 426	Continued From page 2 05/02/2026, 05/08/2026, 05/18/2026, 05/25/2026, 05/31/2026, 06/01/2026, and 06/02/2026. Resident 1 did not have 1:1 services in place. The facility protocol was to call the Milwaukee Police Department when verbal redirection did not work for Resident 1. Resident 1 often eloped to his/her guardian's house and would sometimes get on the Milwaukee County Transit bus. On 06/04/2026, at approximately 11:45 AM, Surveyor reviewed all of Resident 1's elopement incident reports. The report included elopement dates of 04/17/2026, 04/18/2026 and 04/21/2026. The incident report dated Tuesday 04/21/2026, indicated Resident 1 eloped from the facility and declined to return to the facility with the verbal redirection of the facility staff. Resident 1 was returned to the facility with the assistance of law enforcement. The report indicated Resident 1 had a behavioral history of elopements, verbal aggression, and physical aggression towards facility staff. The report indicated Resident 1's behaviors impacted the facility staff ability to safely supervise the resident in a non-secured environment. The facility protocol for Resident 1 indicated staff were to contact Resident 1's guardian, managed care organization case manager, and law enforcement to assist with Resident 1's safe return to the facility. On 06/04/2026, at approximately 11:55 AM, Surveyor reviewed a 30-day notice to discharge Resident 1. The notice was dated 02/25/2026 and indicated the provider was unable to support Resident 1's need for supervision and behavioral support. On 06/05/2026, at approximately 2:20 PM, Surveyor requested documentation via email from Supervisor B regarding additional support request	N 426		

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N 426	Continued From page 3	N 426		

such as 1:1 services for Resident 1. Supervisor B indicated Licensee A did not have documentation reflecting request for additional support for Resident 1.

On 06/12/2026, at approximately 1:00 PM, Surveyor reviewed text messages sent from Supervisor B via email to the Surveyor on 06/08/2026. The text messages indicated conversations taken place between Case Manager C and Supervisor B. The text messages expressed concern for Resident 1's elopement behaviors and the status on alternate housing request for Resident 1. Supervisor B also requested Case Manager C to conduct a behavior assessment, elopement assessment, and a smoking assessment for Resident 1 on 06/03/2026 via text message.

On 06/04/2026, at approximately 12:15 PM, Surveyor interviewed Licensee A. Licensee A confirmed Resident 1 did not have dedicated staff to ensure s/he did not elope from the facility. Licensee A reported s/he requested additional support from Resident 1's MCO and was not provided the support. Licensee A reported s/he gave Resident 1 a 30-day notice to move as the facility was unable to meet Resident 1's supervision and behavior needs. Licensee A reported Resident 1 was difficult to redirect and sometimes would become verbally and physically aggressive. Surveyor informed Licensee A of his/her responsibility as a provider to ensure for the safety of Resident 1 and a to put an effective intervention in place to support Resident 1's supervision and behavioral needs.

On 06/04/2026, at approximately 12:30 PM, Surveyor interviewed Supervisor B. Supervisor B reported s/he asked the MCO for additional

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N 426	Continued From page 4 support staff and was not provided the additional support staff. Supervisor B reported Resident 1 does not listen to anyone and s/he was unsure of how to fully support Resident 1 when s/he eloped from the facility. Supervisor B reported Resident 1 is a safety risk for him/herself and Resident 1 should have 1:1 services in place. Supervisor B reported Licensee A has tried verbal redirection with Resident 1 in addition to buying Resident 1 items (candy, soda, cigarettes) which s/he requested to keep him/her from eloping. This intervention was not added to the ISP. The above-mentioned approach does not always work, and Resident 1 was reported to become aggressive physically and to elope. Supervisor B reported Resident 1 attended a doctor's appointment in May 2026. Supervisor B requested a clinical evaluation of Resident 1's mental health and a medication review from Resident 1's physician. The request was not honored, and no medication changes were done to assist with Resident 1's behaviors.	N 426		