STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014097	A. BUILDING: _____ B. WING _____	C 05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTINGTON PLACE MEMORY CARE 3	3902 EAST ROTAMER ROAD JANESVILLE, WI 53546

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N 000	Initial Comments From 05/13/2026 to 05/18/2026, Surveyor conducted a complaint investigation at Huntington Place Memory Care 3, a CBRF in Janesville. One deficiency was identified. This is a repeat deficiency. See Statement of Deficiency (SOD) FV3E12, dated 02/04/2025, and SOD 98QK11, dated 06/05/2023. The complaint was unsubstantiated. Census: 16	N 000		
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 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 and interview, the provider did not ensure an individual service plan (ISP) was updated when there was a change in condition or need. Resident 1's ISP was not updated to include	N 389		

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

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N 389	Continued From page 1	N 389		

behaviors.

This is a repeat deficiency. See Statement of Deficiency (SOD) FV3E12, dated 02/04/2025, and SOD 98QK11, dated 06/05/2023.

Findings include:

On 05/13/2026 at approximately 11:00 a.m., Surveyor reviewed Resident 1's record. S/he was admitted to the facility on 02/22/2022, with a diagnosis of depression, Alzheimer's disease and type II diabetes. The Individual Service Plan (ISP), dated 11/26/2025, stated that "When [Resident 1] is resistive to cares, the care staff will approach [him/her] on three sperate occasions. Documentation of each attempt and outcome will be documented in a behavior in [his/her] EMR." The ISP did not indicate Resident 1 had any other behavioral concerns or interventions.

At approximately 11:30 a.m., while reviewing progress notes, Surveyor noted that Resident 1 had progress notes that documented the following:

-05/07/2026 5:40 AM " [Resident 1] has been up half the night repeatively (sic) undressing have put [his/her] shirt on bout (sic) 5x did get [him/her] to keep on for alil (sic) while giving [him/her] a snack and has clothes on now. Alot of redirecting throughout the night."
-04/23/2026 9:55 PM "at about 9:15 pm individual became extremely agitated while staff were changing their bedding. and stated they now wanted to be left alone. A few minutes later [Resident 1] came to staff requesting help and asking to speak to their family. At this point [Resident 1] was becoming noticeably more

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agitated still yelling profanities and using vulgar lanquage. [Resident 1's] family was contacted upon their request, once family answered [Resident 1] went back to their room. After a few more minutes, while staff where with another individual, [Resident 1] came out of their room and began to berate another resident. Staff then attempted to redirect [Resident 1] back to their room. And [Resident 1] became more upset and deliberately hit staff with their walker. After that [Resident 1] went back to their room, While staff went to do rounds, [Resident 1] came out of their room again even more irate than before, staff heard [Resident 1] shouting and quickly went to their assistance. [Resident 1] was then found in hallway near the dining room pinning another resident up against the wall with their walker. Staff managed to redirect [Resident 1] away and called their family. While on the phone with their family [Resident 1] began to barricade staff in the nurses station while yelling insults and profanities. Staff attempted to leave the nurses station and [Resident 1] reacted by hitting staff in the face and pushing them again with their walker. After staff made it through [Resident 1] directed their anger toward the other staff in the nurses station and threw the phone at staff because [family] hung up the phone. [Resident 1] then began to swat at staff in the nurses station and yell threats, insults, profanities. The other staff then tried to redirect resident out the way of the nurses station and to a chair where the [Resident 1] began to hit staff in the face repeatedly with their elbows and fist. After this staff where finally able to manage to get the [Resident 1] to sit in a chair until 3rd shift staff came in at 10:00pm."
-04/21/2026 4:40 AM "[Resident 1] refusing to keep a shirt on put one on 3 times took it off and hitting tried to get [him/her] to go in [his/her] room if [s/he] refused to put shirt on refusing that as

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well so leaving [him/her] for now will reapproach again after get other res ready."
-04/16/2026 4:21 AM "[Resident 1] has taken clothes off many times throughout the night but has staying in [his/her] room for most part of it."
-04/14/206 9:27 PM "[Resident 1] was asking multiple times to please keep [his/her] clothes on, every time staff helped [Resident 1[get dressed. [Resident 1] became very aggressive with staff cussing, hitting, yelling etc. [Resident 1] finally left [his/her] clothes on after the 3rd time. "
-03/31/2026 5:40 AM "[Resident 1] was at another res door naked while getting another res dressed started pushing chair outside of [his/her] room undressed was to take [him/her[back in room and put depends and clothes on."
03/31/2026 3:17 AM "[Resident 1] been undressing after clothes put on but staying in [his/her] room had to put clothes back on a few times now."
-03/25/2026 6:01 AM "[Resident 1] refused cares very combative."
-03/24/2026 5:10 AM "Went to check laundry and found [Resident 1] in another res room [room #] with shirt off trying to take pants off went in at walked [Resident 1] to [his/her] room and got [him/her] dressed and gave snack."
-03/22/2026 4:49 AM '[Resident 1] came out of room for the second time without clothing. Staff able to assist with getting clothing on. Staff offered snack of cookie, goldfish crackers and cup of juice. [Resident 1] spilled juice on table and floor, staff mopped floor and wiped down table."
-03/22/2026 4:11 AM "Writer was leaving another resident room from doing rounds when came upon [Resident 1] in the hallway. [Resident 1] did not have any clothing on and holding a pillow up against [him/her]. Writer and staff entered [Resident 1's] room to assist with dressing.

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N 389	Continued From page 4 [Resident 1] was cooperative with putting on a depend. Writer offered a nightgown x2 to wear [Resident 1] refused stating, "No, I don't care." Writer offered a shirt and again [Resident 1] refused stating "I told you no, I do not care." Upon observation of the bathroom, writer and staff found shirt placed in the [Resident 1's] toilet with urine water. Staff removed shirt from toilet and took to laundry." -03/14/2026 4:28 AM "[Resident 1] has been in their room /bed naked all shift, at one point [Resident 1] took off their brief and threw it on the ground. Staff attempted to assist [Resident 1] in getting clothes on and or brief and [Resident 1] became upset each time." On 05/13/2026 at approximately 12:45 p.m., Surveyor interviewed Caregiver B. Caregiver B stated that Resident 1 did have an increase of behaviors but most of them were during the night when s/he was not working. Caregiver B stated that when Resident 1 is refusing or having a hard time, s/he will just try reapproaching him/her 3 different times. On 05/13/026 at approximately 1:15 p.m., Surveyor interviewed Executive Director A and Health & Wellness Dir C. Health & Wellness Dir C acknowledged that the ISP was not updated to include a behavior management section for Resident 1. Executive Director A stated that the facility would begin updating the ISP for Resident 1 with his/her behavioral management needs as soon as possible.	N 389		