STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525069	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maplewood Center	8615 W Beloit Rd West Allis, WI 53227

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of the facility's policy, the facility failed to ensure that injuries of unknown origin were reported to the state agency for one of one sampled resident (Resident (R) 1) out of a total sample of 18 residents. This failure had the potential to result in unidentified abuse, incomplete investigations, and the continuation of unidentified injuries. Findings include: Review of R1's Resident Face Sheet, located in the electronic medical record (EMR) under the Resident tab, revealed an admission date of 09/18/25 with a diagnosis of Parkinsonism. Review of R1's Care Plan, located in the EMR's Resident Assessment Instrument (RAI) tab, revealed a Problem Start Date: 08/18/25 with the Category: ADLs [Activities of Daily Living] Functional Status Potential ADLs: I have impaired mobility related to weakness, falls, Parkinsons. An Approach Start Date: 02/10/26 stated, Gait/Ambulation: limited assist x2 [assist of two staff] with 2ww [wheeled walker], gait belt, and wc [wheelchair] follow. Another approach with a start date of 02/10/26 indicated, Transfer status: limited assist of 1 with gait belt and 2WW. Review of R1's significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/26/26, located in the EMR under the RAI tab, revealed R1 had a Brief Interview for Mental Status (BIMS) score of eight out of 15, which indicated moderate cognitive impairment. The assessment indicated R1 required partial/moderate assistance for chair/bed-to-chair transfers, toilet transfers, and transitioning from sitting to standing. Review of a Resident Progress Note dated 03/27/26 at 11:30 AM, located in the EMR under the Resident tab, stated, Writer was called to [room number of R1] by the unit nurse to discuss a new skin issue that was first found by the [name of hospice agency] nurse. Per the unit nurse there was a laceration to the resident's R [right] lower leg. Writer arrived to [room number of R1] and found the resident in her broda [specialized wheelchair] chair. She was calm and appeared not to be in any distress. Writer instructed the unit nurse to notify the provider . Upon inspection of the wound/laceration to the resident's R calf, the writer noticed that there was no active bleeding. The laceration measured 4 cm [centimeters] x [by] 3 cm. The laceration was in a J shape. The surrounding skin was bruised and noticed to be thin and fragile. The resident at the time didn't complain of pain. The unit CNA [certified nursing assistant] and hospice nurse placed a hoyer [mechanical lift] sling underneath the resident to transfer her to bed. Per the hospice nurse, she got the okay to send the resident out to the hospital for an evaluation . Review of an Event Report dated 03/27/26, located in the resident's EMR under the Resident tab, (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed by Licensed Practical Nurse (LPN) 1 at 4:37 PM, revealed the section titled DESCRIPTION documented a Right posterior calf wound. In the section titled PHYSICAL OBSERVATION the following was documented: Type of Injury: Laceration. Location and Size of Skin Tear/Laceration: Right Posterior calf wound. Depth of Skin Tear/Laceration: Deep. Blood Loss-Note Amount and Control: Controlled Bleeding. Wound Edges: Irregular. Activity During Skin Tear/Laceration Occurrence: Unknown. In the INTERVENTIONS – Immediate measures taken section of the report, Other – Sent to the Hospital was checked. Review of a Resident Progress Note dated 03/28/26 at 10:59 PM, located in the EMR under the Resident tab, revealed, Pt [patient] Sustained Skin Tear To L [left] Lat [lateral] Leg during assisted transfer. Area measured 1.8 x 3.9 cm, exposed adipose [fat] tissue w/ [with] md [moderate] bleeding. Pt. AO [Alert and Oriented] @ [at] baseline, no distress S/sx [signs or symptoms] . Review of an Event Report dated 03/28/26, located in the resident's EMR under the Resident tab, completed by LPN4 at 9:02 PM, revealed the section titled DESCRIPTION documented a S/T [skin tear] to the later [lateral] L shin. In the section titled PHYSICAL OBSERVATION the Type of Injury selected was a Skin Tear. The Location and Size of Skin Tear/Laceration was 2.1 x 1.5 L lateral shin. For the Depth of Skin Tear/Laceration, Deep was selected. Wound Edges was marked as Irregular. The facility's Incident Investigation Summary for R1, provided by the facility, revealed the following Investigative Findings: Both incidents involved different staff members; Re-enactments of both transfers were completed with involved staff to assess technique and potential contributing factors; A thorough environmental review of the resident's room and equipment was conducted, including the bed, frame, and surrounding areas; While the bed frame was considered as a potential contributing factor, this was deemed unlikely due to the presence of an air mattress overlay; As a precaution, maintenance conducted a facility-wide audit of bed frames and removed exposed bolts used for positioning rails; At the time of both incidents, the resident was wearing long pants, and there was minimal blood noted on clothing or bedding, making it difficult to determine the exact mechanism of injury. There was also no cuts or holes in the pants found at either time; Despite comprehensive review, the specific cause of the lacerations could not be determined. The investigation concluded, Based on the investigation findings, the injuries are considered inconclusive in origin, with the resident's significant skin fragility/skin failure and overall clinical decline being major contributing factors. There is no evidence to support that the injuries were intentional, and no abuse or neglect is suspected. An interview was conducted with the Administrator on 05/21/26 at 5:30 PM. The Administrator was asked if the instances where R1 received injuries of unknown origin were reported to the state agency. The Administrator stated that the injuries were not reported because they could not determine what caused the injuries. Review of the facility's policy titled, Administration Policy and Procedure with Subject: Abuse, Neglect, Exploitation, Misappropriate and Injuries of Unknown Origin, revised April 2026, revealed an Alleged Violation is defined as . a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified, could be an indication of noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property. The policy section titled Reporting/Response stated, The facility will: i. Report all alleged violations (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: 1. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or 2. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. b) The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, record review, and interviews, the facility failed to ensure two of seven sampled residents (Resident (R) 3 and R11) reviewed for falls were left in a safe position while staff stepped away from the resident's bedside, resulting in R3 and R11 falling from the bed and sustaining injuries. In addition, the facility failed to ensure that staff were aware of R1's change in mode of transfer to ensure safe transfers. Findings include: 1. Review of R3's Resident Face Sheet, located in the electronic medical record (EMR) under the Resident tab, revealed an admission date of 09/27/24 with diagnoses of Parkinson's disease without dyskinesia and dementia. Review of R3's Care Plan, located in the EMR under the Resident Assessment Instrument (RAI) tab, revealed a category of Falls which stated, [R3] has potential for falls related to Parkinson's, freq [frequent] falls, anemia, weakness. An approach, dated 05/13/25, stated, Frequent checks for safety and toileting needs; low bed with floor mat next to it while the resident remains in bed. Review of R3's quarterly Minimum Data Set (MDS), located in the EMR under the RAI tab with an Assessment Reference Date (ARD) of 10/13/25, revealed R3 had a Brief Interview for Mental Status (BIMS) score of four out of 15, indicating R3 was severely cognitively impaired. R3 was dependent on staff for chair/bed-to-chair transfers. Review of R3's John Hopkins Fall Risk assessment, completed on 10/23/25, located in the EMR under the Resident tab under Observations, revealed a score of 8, which indicated she was a moderate fall risk. On 12/21/25, the facility submitted a report titled ALLEGED NURSING HOME RESIDENT MISTREATMENT, NEGLECT, AND ABUSE REPORT to the state agency at 2:11 PM under allegation type: Other: Reportable incident that is not misconduct related. R3's name was listed as the person affected, and Certified Nursing Assistant (CNA) 5 was listed as the accused person. The report indicated the incident occurred on 12/21/25 at approximately 8:20 AM. The Brief Summary of Incident revealed, The aide was in residents room cleaning up the resident and got the resident dressed. Aide reported she left the room to get assist to transfer resident out of bed. Resident was heard by the unit nurse calling out. The nurse went to the room and found the resident on the floor. Resident was sent out to ER [Emergency Room]. The aide was sent home pending investigation of the fall. RN [Registered Nurse] Supervisor attempted to get results from ER several times, however due to ER volume wasn't able to get results until 1:17 PM. Resident was found to have a Nondisplaced Right Femur fracture. Upon initial investigation the bed position may have been a contributing factor of the injury, hence staff education initiated on leaving beds in appropriate height when leaving a room. A house wide audit was also done to ensure all beds in appropriate height. During an interview on 05/19/26 at 1:26 PM, CNA5 stated she cared for R3 every time she was at the facility. CNA5 stated that R3 was total care for all aspects of care and utilized a Hoyer (mechanical) lift with two people assisting for transfers. CNA5 reported at the time of R3's fall, she took care of R3 so much, she just knew the care that she needed and knew there was a care plan somewhere. CNA5 stated she believed R3 was a fall risk. CNA5 reported that on the day of the fall, she dressed R3 and (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	asked another CNA to help with the Hoyer lift. CNA5 said while she was waiting for the other CNA, she heard another resident across the hallway yelling for help. She said she knew that resident was also a fall risk so she left the room to check on the other resident, and when she was returning, she heard R3 yelling from across the hall. CNA5 said she forgot to lower the bed down to the floor, and R3 had fallen out of bed. CNA5 said she was sent home after the incident and when she returned, she received training on where to locate the care plan. During an interview on 05/20/26 at 11:30 AM, Licensed Practical Nurse (LPN) 2 stated she was the nurse that was working when R3 fell from her bed. LPN2 stated she was at the medication cart doing the medication pass and heard someone yelling out for help. LPN2 stated she went down to see what was going on and noticed R3's bed was high, with the top of the mattress approximately three feet from the floor, and R3 was not in it. LPN2 stated she saw R3 on the floor, laying on her left arm. LPN2 said there was a fall mat in place and R3 was laying on it. The CNA was in the room adjacent (across the hall). LPN2 said they did not move the resident, immediately notified the DON (Director of Nursing), and called 911. LPN2 stated that there was staff training on bed heights following the fall. During an interview on 05/20/26 at 4:00 PM, the DON explained the steps taken to investigate the incident and the actions taken after the incident occurred to include staff training regarding falls and bed heights, the location of the care cards for instruction on care needs, and a house-wide review of bed heights for safety. 2. Review of R11's Resident Face Sheet, located in the EMR under the Resident tab, revealed an admission date of 06/18/24 with diagnoses of chronic combined systolic (congestive) and diastolic (congestive) heart failure, chronic kidney disease, stage 3 unspecified, and Alzheimer's disease, unspecified. Review of R11's annual MDS assessment with an ARD of 03/02/26, located in the EMR under the RAI tab, indicated R1 had a BIMS score of zero out of 15, indicating R11 was severely cognitively impaired. The assessment indicated R11 was dependent on staff for chair/bed-to-chair transfers, rolling left and right in bed, toilet hygiene, personal hygiene, and dressing. Review of R11's Care Plan located in the EMR under the RAI tab revealed, [R11] has potential for falls related to impaired mobility, weakness and impulsiveness. Approaches, dated 11/26/24, were to Recline Broda [specialized wheelchair] back when not eating for comfort and safety and Resident cares completed at the start of shift. Pool noodle when in bed to help define edge of bed. The care plan did not include approaches for the resident's bed to be in the low position with a mat beside the bed. Review of R11's John Hopkins Fall Risk assessment, completed on 12/17/25, located in the EMR under the Resident tab under Observations, revealed a score of 13, which indicated R11 was a high fall risk. During an observation on 05/18/26 at 3:20 PM, R11 was seated in the common area of the unit on which she resided in a Broda chair. R11 was observed to have stitches across her forehead with yellowish bruising on her forehead and down below her eyes. When asked what happened to R11, CNA11 stated she was off for a few days and when she came back, R11 had fallen. During an interview on 05/19/26 at 8:40 AM, LPN3 stated R11 fell about a week ago from her bed. When asked if the bed was in a high or low position at the time of the fall, LPN3 demonstrated that (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	the bed was at about her hip's height. During an interview on 05/19/26 at 8:43 AM, CNA10 stated that she was assigned to R11 the day of the fall, on 05/12/26. While providing care for R11, CNA10 stepped away to go to the bathroom to wet a face towel, and when she was going back to the resident's bedside, R11 was rolling onto the floor. When asked what the position of the bed was at the time of the resident's fall, CNA10 demonstrated it was at the height of her hip. CNA10 said she met with the DON and RN supervisor and went over what took place. During an interview with the DON on 05/20/26 at 2:30 PM, the DON was asked about the investigation that was conducted for R11's fall. The DON said that the CNA was providing cares in bed. The DON said that the CNA went to the bathroom to wet a towel to clean R11's face, and R11 was too close to the edge of the bed. The DON stated that it was an unfortunate mishap. On 05/21/26 at 10:15 AM, CNA10 was asked to go to R11's room and demonstrate the height of the bed at the time of the fall. CNA10 lifted the bed to the height she recalled it was at when she left the resident to go to the bathroom and stated the height was at a normal working height for providing cares. The height of the bed was described as being over two feet from the floor to the top of the mattress. CNA10 stated that the RN supervisor came in and took pictures to see how high the bed was. CNA10 explained that R11 was not in the middle of the bed but further to the left side of the bed, demonstrating where the resident's left shoulder was by pointing to the mattress, approximately six inches from the edge of the mattress. CNA10 said the floor mat was not in position by the bed because she was still providing cares when she left the resident to go to the resident's bathroom. During an interview on 05/20/26 at 10:22 AM, RN1, the first-floor supervisor on the AM (morning) shift, confirmed she took pictures of the height of the bed on her supervisor phone when R11 fell. RN1 shared two pictures taken on 05/21/26 at 7:36 AM (per date and time on the iPhone). RN1 described one of the pictures as the CNA standing beside the bed to show the height of the bed when R11 fell. The other picture was described by RN1 as a picture of the bed height and the body of the resident, without a picture of R11's face, still lying on the floor after the fall. A mat was not on the floor beside the bed. The bed was observed to be in a high position, greater than two feet off the floor in the pictures. An observation was made on 05/21/26 at 12:30 PM with CNA10, the Administrator, the DON, RN1, and the Director of Buildings and Grounds (DOBG) present in the room of R11. CNA10 was asked to place the bed in the position at the height when the resident fell from the bed. CNA10 raised the bed using the remote. The DOBG measured from the floor to the top of the mattress with the measurement being 30 inches. CNA10 was asked to show the distance of R11's left shoulder to the edge of the bed when she left R11 to wet the towel. The distance where CNA10 showed the resident's left shoulder to be to the edge of the bed measured 8 inches per measurement by the DOBG. When the pictures taken by RN1 were mentioned at the end of the observation, RN1 stated she deleted the pictures. During an observation of the care card located inside R11's closet door on 05/21/26 at 2:00 PM it was revealed that the care card did not include any information about the resident's risk for falls or that the bed was to be at a low position. The latest date for any interventions for R11's care to be provided was 03/29/26, which was prior to the R11's fall. 3. Review of R1's Resident Face Sheet located in the EMR under the Resident tab, revealed an admission date of 09/18/25 with a diagnosis of Parkinsonism. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of R1's significant change MDS with an ARD of 02/26/26 revealed R1 had a BIMS score of eight out of 15, which indicated moderate cognitive impairment. The assessment indicated R1 required partial/moderate assistance for chair/bed-to-chair transfers, toilet transfers, and transitioning from sitting to standing. Review of R1's Care Plan, provided by the Administrator, revealed a problem area, I have impaired mobility related to weakness, falls, Parkinsons. An approach, dated 03/22/26, was for the resident to be transferred utilizing the Hoyer lift and the assistance of two staff. R1's care card, located in her closet during her stay, was unavailable since the resident was no longer in the facility. Review of the facility's investigation into R1's injury of unknown origin on 03/28/26, provided by the facility, revealed that CNA2 deviated from the care plan by transferring R1 by herself. The resident's care plan reflected a change in R1's transfer status; effective 03/22/26, staff were to utilize a Hoyer lift. The facility was unable to determine that the improper transfer caused any injury to R1. During an interview on 05/20/26 at 11:31 AM, CNA2 stated R1 was a one person assist to the toilet but could not be left unattended on the toilet. CNA2 stated R1 was a fall risk but after she had COVID, R1 declined. She had been able to stand and pivot but was not able to walk independently. When asked about her transfer of R1 on 03/28/26, CNA2 stated she transferred R1 from the chair to the bed by herself. CNA stated that once she got R1 from the chair to the bed using a one person assist, the resident didn't say anything. When CNA2 started to undress R1, she noticed an open area on the resident's left leg. CNA2 stated she went straight to the nurse to report it. CNA2 said R1 was still a one person assist in the computer but not on paper at that time. CNA2 clarified the paper was the care card. CNA2 said they were taught to look in the computer because the paper card wasn't always updated. CNA2 said the computer was not updated until after the incident. CNA2 said that she assumed R1 was a one person assist until it was changed in the computer but that the facility said she (CNA2) had not properly transferred R1. During an interview with the Administrator on 05/21/26 at 3:30 PM, the Administrator verified that CNA2 improperly transferred R1 on 03/28/26. The care plan reflected it was updated on 03/22/26 to add in the Hoyer lift for R1's transfers.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and policy review, the facility failed to ensure one of two residents (Resident (R) 2), during one of three opportunities for the provision of incontinence care, received incontinence care in a manner that prevented cross-contamination from a dirty area to a clean area. This failure had to the potential to result in urinary tract infections. Findings include: Review of the Resident Face Sheet located in the electronic medical record (EMR) under the Resident tab revealed R2 was admitted to the facility on [DATE] with diagnoses which included chronic diastolic (congestive) heart failure, chronic kidney failure, stage 3b, fibromyalgia, overactive bladder, and a history of urinary tract infections. R2's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/19/26, located in the EMR under the Resident Assessment Instrument (RAI) tab, revealed R2 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R2 was cognitively intact. This assessment also indicated that R2 was dependent on staff for toileting hygiene, was frequently incontinent of urine, and utilized an external catheter. During an observation on 05/19/26 at 10:10 AM, Certified Nursing Assistant (CNA) 6 provided incontinence and perineal care (peri-care) for R2. After providing incontinence care by cleaning the right and left labia in a downward motion, changing the position of the washcloth for each side and cleaning down the middle of the labia, the CNA was observed to use a dry washcloth to dry in between the resident's labia in an up and down motion from the front to the back and then from the back to the front. The resident turned on her right side for the CNA to clean and dry her buttocks. The resident turned onto her back and the CNA again provided perineal care for R2, again using a washcloth to clean the labia in a front to back manner. However, to dry the resident's labia, a dry cloth was used, with the aide drying between the labia in an up and down motion. During an interview on 05/19/26 at 10:35 AM, CNA6 was notified of the surveyor's observations. CNA6 denied she had used the up and down motion during the drying of the resident on both observations of peri-care. The facility's policy titled, Perineal Care of the Female Resident, reviewed May 2020, revealed the following under the section Implementation: Separate the resident's labia with one hand and wash the other using gentle downward strokes from the front to the back of the perineum to prevent intestinal organism from contaminating the urethra or vagina. Avoid the area around the anus, and use a clean washcloth for each stroke by folding each used section inward. This method prevents the spread of contaminated secretions or discharge. Pat the area dry with a bath towel because moisture can cause skin irritation and discomfort.