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	05/01/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 20483 Based on observation and interview the facility did not ensure a safe, clean, comfortable, and homelike environment for 5 (R34, R105, R78, R73, & R38) of 6 residents. The base of R34, R105, R78, R73, & R38's tube feeding poles were observed with dried feedings on multiple days. Findings include: Surveyor requested facility policy regarding cleaning resident equipment. Surveyor was provided with the facility's policy titled Wheelchair and [NAME] Cleaning and Maintenance reviewed 4/25. This policy does not address resident's tube feeding poles. No other policy was provided. On 4/21/25, at 11:40 a.m., Surveyor asked Housekeeping Aide (HA)-GG, who was working on the vent unit, if she is responsible for cleaning resident's tube feeding poles. HA-GG replied ya but we just started this vent unit. Surveyor asked when they started cleaning the vent unit. HA-GG informed Surveyor a month ago and explained those poles were on SunnyView 2. HA-GG stated I'll start cleaning its all stuck on there. Surveyor asked HA-GG in the last month has she cleaned any of the tube feeding poles. HA-GG replied no, to be honest with you, I'm really not sure if it's my job or the CNAs (Certified Nursing Assistants). I would think it would be mine, technically they are suppose to clean and we go after them. On 4/22/25, at 8:46 a.m., Surveyor asked Registered Nurse (RN) Supervisor-AA who is responsible for cleaning resident's tube feeding poles. RN Supervisor-AA replied housekeeping but all staff can do it. On 4/22/25 at 8:51 AM Administrator-A was interviewed and indicated housekeeping is responsible for cleaning gastrostomy tube feeding poles. 1.) On 4/15/25, at 3:16 p.m. Surveyor observed R34's tube feeding pole has multiple areas of dried feeding on the base of the pole. On 4/16/25, at 9:50 a.m., Surveyor observed R34's tube feeding is not running. The base of the tube feeding pole has splattered dried feeding on three of the four legs of the tube feeding pole. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/17/25, at 1:12 p.m. Surveyor observed the base of R34's tube feeding pole continues to have multiple dried feeding on three of the four legs. On 4/21/25, at 11:45 a.m. Surveyor observed the base of R34's tube feeding pole continues to have multiple areas of dried feeding on three of the four legs. Surveyor noted on one of the legs there is a clump of what appears to be R34's tube feeding. 2.) On 4/16/25, at 9:38 a.m., Surveyor observed R105's tube feeding of Isosource 1.5 is running at 60 ml/hr (milliliter per hour). Surveyor observed the base of R105's tube feeding pole has multiple areas of dried feeding covering approximately two thirds of the legs on two of the four legs. On 4/17/25, at 1:07 p.m. Surveyor observed the base of R105's tube feeding pole has multiple areas of dried feeding on three of the four legs. On 4/21/25, at 11:42 a.m. Surveyor observed the base of R105's tube feeding pole has multiple areas of dried feeding on three of the four legs with one of the legs of the tube feeding pole has half of the leg covered with dried feeding. 3.) On 4/16/25, at 9:42 a.m., Surveyor observed the base of R78's tube feeding pole has multiple areas with dried feeding. On 4/17/25, at 1:11 p.m. Surveyor observed the base of R78's tube feeding pole has dried feeding on all four legs of the base. Surveyor noted three of the four legs are 75% covered with dried feeding. On 4/21/25, at 11:43 a.m., Surveyor observed the base of R78's tube feeding pole continues to have dried feeding on all four legs. Surveyor noted three of the four legs continue to be over 75% covered with dried feeding. 4.) On 4/17/25, at 1:04 p.m. Surveyor observed the base of R73's tube feeding pole has dried splattered feedings on two of the four legs. On 4/21/25, at 11:39 a.m. Surveyor observed the base of R73's tube feeding pole continues to have dried splattered feedings. On 4/21/25, at 3:14 p.m. during the end of the day meeting with Previous Nursing Home Administrator (NHA)-C, NHA-A, and Director Clinical Operations-D were informed the base of R34, R105, R78, R73 tube feeding poles were dirty with dried feedings on multiple days. No information was provided to Surveyor as to why these tube feeding poles were not being cleaned. 22692 5.) On 4/16/25 at 10:32 AM, R38's gastronomy tube pole was observed to be covered with what appeared to be dry gastrostomy feeding solution on the pole and base. On 4/17/25 at 8:32 AM, R38's gastrostomy tube pole was observed to be covered with what appeared to be dry feeding solution on the pole and base. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/21/25 at 10:32 AM, R38's gastrostomy tube pole was observed to be covered with what appeared to be dry feeding solution on the pole and base. Family member-LLLL was in the room during the observation and indicated the gastrostomy tube pole has been like that for months. Family member-LLLL indicated it is hard to raise or lower the pole because it sticks because of all the dried feeding solution on it. The above findings were shared with Former Administrator-C and Director of Nurses (DON)-B on 4/22/25. Additional information was requested if available as to why R38's gastrostomy feeding pole was dirty for the above observations. None was provided.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 2.) R414 was admitted to the facility on [DATE]. Diagnoses includes pleural effusion (fluid accumulates between lungs & chest wall), acute respiratory distress, malignant neoplasm (cancer) of unspecified ovary, anxiety disorder, and depression. The hospital assessment/plan not dated under recommendations documents (1) Pleurx (drainage catheter) placed -Drain daily -Up to 1L drainage -Bedside nurse to complete self education for patient and patient's son -Interventional Pulm (pulmonary) f/u (follow up) as outpatient. (2) Neoadjuvant therapy (treatment given before the main treatment) for metastic ovarian cancer per Gyn/Onc (Gynecology/Oncology). R414's pre admit note dated 3/20/25, at 1:28 p.m., written by Director of Admissions/ Licensed Practical Nurse (LPN)-FF for admission diagnosis document R (right) pleural effusion. For PICC (peripherally inserted central line catheter) documents R brachial double lumen. Under notes documents R side chest tube-hospital sending back up Pleurx kit, NO chemo planned while in rehab. R414's admission note dated 3/20/25, at 4:00 p.m., written by Licensed Practical Nurse (LPN)-PPP documents Skin assessment:: Per Supervisor, BUE (bilateral upper extremity) bruising, Dressing R side. Devices/equipment (dentures, catheters, IVs (intravenous), CPAP (continuous positive airway pressure) etc):: Double lumen PICC RUE (right upper extremity), Bilateral HA (hearing aids). Bowel/Bladder continence:: Continent of bowel, Continent of bladder. Admission Transfer Status:: 1 assist. Other assessment details:: General diet, Bilateral Ovarian CA (cancer), Dressing R side s/p (status post) Pleurx. R414's nurses note dated 3/20/25, at 11:10 p.m., written by Registered Nurse (RN)-X documents Pt (patient) is 77y/o (year old) Female recently diag (diagnosis) w/ (with) ovarian CA following Gyn Onc clinic visit. Admit to [Hospital initials] w/ Resp (respiratory) Distress S/sx (signs/symptoms) 2/2 (secondary to) pleural effusion. Pt arrived to facility via ambulance transport s/ family present. s/p pleurex placement, pressure Drgs (dressing) seen to R (right) flank covered w/ (with) cl (clear) Drsg (dressing). LCTA (lungs clear to auscultation), O2/sat (oxygen saturations) 994 sic (94)%RA (room air). Denied SOB (shortness of breath), no accessory muscle use, Res (respirations) 18reg. Pt AOX3 (alert orientated times three), mood/affect appropriate. Decision Yes, Code Full, consent obtained. Abd (abdomen) round, soft, active BS (bowel sounds), LBM (last bowel movement) 3/20, soft stool x1 (times one). No expressed pain/disc (discomfort) during assessment. Skin: scattered Iv site bruises BUE, DL mid-line R cephalic w/ sm (small) pooled of blood to insertion site. Flushed w/ NS (with normal saline) 10cc (cubic centimeters), patency confirmed. Excoriations to Bil (bilateral) groin, inner thighs, peri-areas and buttocks. Tx (treatment) initiated. 2+ Bil ankle edema, education provided on extre sic (extra) elevation. AVS (after visit summary) verified w/ Provider [Name] faxed/confirmed w/ pharmacy. Orientation to Rm (room), call light & bed functions provided. Hand off rpt (report) to incoming Noc (night) staff. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R414's nurses note dated 3/21/25, at 12:51 p.m., written by LPN-JJ documents writer called into residents room by CNA (Certified Nursing Assistant) and therapy dept. (department) to meet w/ (with) resident and son. Son demonstrated cares for chest tube drainage and site care. Writer observed site; no inflammation or drainage present. There are approx. (approximately) 4 stitches present on pt's (patients) right side (mid intercostal) bra line holding chest tune in place. Pt uses padding underneath tubing and gauze w/ tegaderm on top for protective measures. Dressing must be removed prior to draining tube into PLEUR -X drainage vacuum bottle. Writer and son remove 1L (liter) of fluids. Drainage can be held if pt experiences pain. R414's SNF (skilled nursing facility) Initial Visit note dated 3/21/25 written by APNP (Advanced Practice Nurse Prescriber)-RRR under history of present illness documents Patient is a [AGE] year-old female with past significant medical history of rheumatoid arthritis, dyslipidemia (abnormal levels of fatty components in blood stream), GERD (gastroesophageal reflux disease), anxiety, insomnia, depression, osteopenia, CVA (cerebrovascular accident), ovarian mass, was seen at gynecology clinic on 3/6/2025 at [hospital name] found to have bilateral complex cystic solid adnexal (the space in female pelvic region) masses large right pleural effusion. Patient was admitted to hospital, CA (cancer antigen)125 was greater than 6000, patient did briefly require intubation due to acute respiratory distress shortly after CT (computed tomography) PE (pleural effusion) was obtained right-sided chest tube was placed was able to be extubated chest tube continued to have large output ranging from 600 to 1000 cc/day. Cytology of pleural effusion returned adenocarcinoma of m?llerian sic (mullerian) origin. Patient was also treated for suspected pneumonia with Rocephin. Patient did have cardiac stress test with normal myocardial perfusion, PICC line was placed, for anticipation of potential chemotherapy. Patient was started on carboplatin/paclitaxel on 3/14/2025. Due to increased CT output interventional radiology placed Pleurx drain. Patient was discharged in medically stable condition on 3/20/2025 and transferred to Village Manor Park for SAR (subacute rehab). Under assessment and plan includes documentation of * J90 - Pleural effusion, not elsewhere classified *: Monitor respiratory status, Pleurx care per hospital orders. R414's nurses note dated 3/22/25, at 2:46 p.m., written by LPN-SSS documents Res (Resident) left the building with the her son -AMA (against medical advice). Writer received report that this res was upset in regards to a drain/treatment. Day shift nurse stated to writer that she did not see any order in regards to a drain/treatment. Stated that she looked in the orders and didn't see any orders listed or charting. Writer did review orders and was reviewing DC (discharge) summary when staff nurse approached writer to state that this resident left the grounds. Res did not voice any concerns/complaints with writer before leaving. On duty RN made aware. R414's nurses note dated 3/22/25, at 5:54 p.m., written by RN Supervisor-QQ documents Writer received a call from [Hospital Name] ER social worker inquiring if supplies were sent with resident on admission. Supplies noted in room. Resident will be staying at hospital and not returning at this time. [Name] NP aware. COO (Chief Operating Officer) aware. Surveyor reviewed R414's physician orders and was unable to locate a physician order for the care of R414's right chest tube and PICC line. Surveyor reviewed R414's care plans and noted two care plans were developed. The ADL (activities daily living)/Mobility care plan with a start date of 3/20/25 and a Nutritional Status: I am at nutritional risk care plan with a start date of 3/21/25. The facility did not develop a baseline care plan for R414's right chest tube and PICC line. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/21/25, at 3:49 p.m., Surveyor informed RN-X Surveyor didn't see any order for the chest tube. RN-X informed Surveyor the hospital discharge had home health for the Pleurx. RN-X informed Surveyor she was not clear if home care or they were doing the chest tube. RN-X indicated she was off the next day, spoke with the night shift and ask them in the morning to clarify this. RN-X informed Surveyor this was not passed on and stated that was missed. Surveyor asked RN-X who starts the baseline care plans. RN-X informed Surveyor their infection control nurse or if RN-OOO is working she will help out. On 4/16/24, at 3:37 p.m., Surveyor read LPN-PPP her admission note for R414 dated 3/20/25 at 4:00 p.m. LPN-PPP informed Surveyor she only puts orders in if the supervisor ask. Surveyor asked LPN-PPP if she put R414's orders in. LPN-PPP replied no. Surveyor asked LPN-PPP if R414 had a chest tube. LPN-PPP replied yes and there was an issue with getting the equipment. LPN-PPP informed Surveyor she didn't lift the dressing but the supervisor said there was a tube under and the patient told her that it needed to be drained. Surveyor asked who would of put orders in the chest tube and PICC line. LPN-PPP replied first name of RN-X. LPN-PPP informed Surveyor the hospital didn't send the supplies for the chest tube so the son brought in one from home. LPN-PPP informed Surveyor she told RN Supervisor-AA that RN-X was suppose to put the order in but didn't. On 4/21/25, at 10:50 a.m., Surveyor asked RN Supervisor-QQ who develops baseline care plans. RN Supervisor-QQ informed Surveyor would think either MDS (minimum data set) or the nurse. RN Supervisor-QQ then stated the night shift supervisor usually starts the baseline care plan. Surveyor asked RN Supervisor-QQ if a resident has a chest tube would you expect a care plan be developed. RN Supervisor-QQ replied yes. On 4/21/25, at 11:28 a.m. Surveyor asked LPN-JJ if she remembers R414. LPN-JJ replied that's the lady with the chest tube. LPN-JJ explained R414 wasn't her patient but she was called into the room by a CNA (Certified Nursing Assistant) and therapy asking if she could meet with R414's son on how to drain the chest tube. LPN-JJ explained R414's son showed her how to drain the chest tube. LPN-JJ informed Surveyor the device was kind of big so possibly may need 2 people to drain it. LPN-JJ informed Surveyor the son wanted to make sure the chest tube was being drained as it was done the night before R414 was admitted and R414's son said it is drained one time a day. On 4/22/25, at 8:32 a.m., Surveyor informed RN Supervisor-AA Surveyor didn't see any orders for R414's chest tube & PICC line and asked RN Supervisor-AA if he knew anything about this. RN Supervisor-AA replied no. RN Supervisor-AA explained R414 was admitted on his day off and he had an appointment the next day so he came in late. Surveyor asked RN Supervisor-AA who is responsible for R414's baseline care plans. RN Supervisor-AA informed Surveyor the supervisor for the shift when R414 came in. On 4/22/25, at 11:32 a.m., Surveyor informed Director of Nursing (DON)-B there are no orders for the care of R414's chest tube and PICC line when she was a resident at the facility and there are no baseline care plans for the chest tube or PICC line. DON-B informed Surveyor after the 21st (3/21) she went on vacation and when she came back she heard of the situation. DON-B informed Surveyor she had a meeting with the supervisors as to why orders weren't transcribed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/24/25, at 8:50 a.m., Surveyor asked Director of Admissions (DOA)/Licensed Practical Nurse (LPN)-FF to explain the facility's admission process. DOA/LPN-FF explained she reviews the referrals and has red, yellow, and green system to determine if yes they can come in or no. DOA/LPN-FF explained wounds go their wound care nurse and DON-B to make sure they can accommodate. Any denials go to Nursing Home Administrator (NHA) for approval. DOA/LPN-FF explained if she has any questions or if haven't done something prior she would go to DON-B to make sure they are able to take care of the resident. Surveyor asked about R414. DOA/LPN-FF informed Surveyor she reviewed her referral and noted R414 had a Pleurx. DOA/LPN-FF indicated she verified with the social worker in the hospital she had a Pleurx and was confident that they would be able to manage R414. DOA/LPN-FF explained she checked with central supply to see if they had any kits in house or had to be ordered. DOA/LPN-FF explained R414 was going to be admitted Thursday afternoon and asked the hospital for a back up kit and let central supply know R414 will be coming in. Surveyor asked DOA/LPN-FF who enters the orders after a resident is admitted . DOA/LPN-FF explained she takes the AVS (after visit summary) and enters all the medication orders for the nurses. The supervisor checks behind and inputs in other orders such as the Pleurx, wound orders, anything above the medications. Surveyor verified with DOA/LPN-FF she only enters the medication orders and the supervisor or who ever is doing the admission would input the other orders. DOA/LPN-FF replied yes. DOA/LPN-FF stated just the meds I'm suppose to be entering. Surveyor asked DOA/LPN-FF if they have admitted any other residents with chest tubes. DOA/LPN-FF informed Surveyor there was a lady not soon before R414 who had a chest tube but she was on hospice and passed away. No additional information was provided to Surveyor as to why there no physician orders for the care of R414's chest tube and PICC line and why there was no baseline care plan for R414's chest tube & PICC line. 50700 Based on interview and record review, the facility did not ensure residents received treatment and care in accordance with professional standards of practice for 2 (R514, R414) of 23 sampled residents reviewed for a change of condition or care to inserted medical devices. *R514 had 9 documented bowel movements in the month of April in 2025, that were documented as bright red or tarry and black. The bowel movements were not documented in a nursing progress note and there was no update to R514's physician, which had care planned interventions for R514's anticoagulation medication. *R414 did not have a physician order for the care of a chest tube or Peripherally Inserted Central Catheter (PICC) line, there was also not a baseline care plan for the care of the chest tube or the PICC line. Findings include: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Notification of Changes revised: 2/2025 documents: POLICY: it is the policy of this facility that changes in a resident's condition or treatment are immediately shared with the residents and/or the resident's representative, according to their authority, and reported to the attending physician or delegate. Nurses and other care staff are educated to identify changes in a resident status and define changes that require notification of the resident and/or their representative, and the resident's physician, to ensure the best outcome of care for the resident. PROCEDURE: 2. The nurse will notify the resident, resident's physician and the resident's representatives for non-immediate changes of condition on the shift the change occurs unless otherwise directed by the physician. 3. Document the notification and record any new orders in the resident's medical record in the EMAR. 1.) R514 was admitted to the facility on [DATE] and has diagnoses of permanent atrial fibrillation, diverticulitis of large intestines, enterocolitis due to clostridium difficile, long-term use of anticoagulants. R514's Admission Minimum Data Set (MDS) assessment, dated 3/28/2025, had a Brief Interview Mental Score (BIMS) of 00, which indicates R514 is severely cognitively impaired. Under section B (hearing and sight) it documents a 2, which indicates that R514 sometimes is understood/understands. R514's care plan for blood thinner, dated 3/25/2025 documents: If side effects are noted, a nurse note should reflect this issue with immediate follow up notification to the physician via phone call. Monitor for presence or absence of active bleeding such as hematuria, petechiae, bruising, bloody stools, or nosebleeds at least daily, every shift: day, evening and night. R514's current order for Eliquis is: Eliquis 5 milligram tablet, take orally for blood clot prevention, twice a day. There were 9 documented bowel movements that were either marked as bright red in color or tarry black in color, there is no progress note of assessment or physician update with any of the documented bowel movements. 1- 4/4/2025 large, bright red and brown for color 2- 4/5/2025 large, bright red and brown for color 3- 4/10/2025 large, bright red and brown for color 4- 4/14/2025 large, bright red and brown for color 5- 4/15/2025 medium, tarry/black for color 6- 4/15/2025 large, bright red and brown for color 7- 4/19/2025 large, bright red and brown and tarry black for color 8- 4/21/2025 large, bright red and brown for color 9- 4/22/2025 large, bright red and brown for color (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/23/2025, at 10:58 AM, Surveyor interviewed certified nursing assistant (CNA)-GGGG, who described documented bowel movement for R514 on 4/22/2025 with the appearance of oatmeal but red and brown in color, stated blood appeared to be in it. CNA-GGGG stated this was reported to licensed practical nurse (LPN)-HHHH on 4/22/2025. On 4/23/2025, at 9:59 AM, Surveyor interviewed LPN-II, who stated R514 was not being monitored for red or black color in bowel movements. LPN-II indicated that nothing was documented on the 24-hour board from last night, there was no update from the nurse on shift report. LPN-II stated that if there was a report of red or black color found in R514's bowel movement, it should be reported to the nurse, so the nurse can observe. Surveyor and LPN-II looked back on the 24-hour board from 4/10/2025 to current and no mention of red or black color in bowel movements were documented. LPN-II indicated that the cna staff should be telling the nurses about any bleeding observed. On 4/23/2025, at 10:16 AM, Surveyor informed Registered Nurse (RN) supervisor-QQ, that it is documented in R514's bowel documentation that R514 is having bright red and tarry black color noted in the bowel movements. RN Supervisor-QQ indicated that RN Supervisor-QQ is adding orders to monitor for bleeding to R514's orders. On 4/23/2025, at 10:30 AM, Surveyor informed Director of Nursing (DON)-B, of concern with documented bowel movements that are marked as bright red or tarry black in color, DON-B stated it is on the care plan to monitor this. Surveyor informed DON-B the concern of it being reported to the nursing staff is what surveyor is informing DON-B of. Surveyor informed DON-B that RN Supervisor-QQ stated that she will be adding orders for monitoring. On 4/23/2025, at 2:24 PM, Surveyor interviewed LPN-HHHH, who informed surveyor that LPN-HHHH was not updated about any stool at all for R514. LPN-HHHH stated that if it was reported that black or red color was observed then LPN-HHHH would have updated the supervisor, called a MD, assessed and completed a full workup for R514. On 4/23/2025, at 2:39 PM, Surveyor interviewed LPN-II, who stated the floor nurses do not go over the CNA documentation as they do not have time to review this. LPN-II stated that RN Supervisor-QQ might be the one to ask about who goes over this documentation. On 4/23/2025, at 2:56 PM, Surveyor interviewed APNP-JJJJ, who indicated being updated one time, verbally a couple of days ago that a small amount of blood in R514's stool was noted. APNP-JJJJ stated to be watching R514's labs closely due to number of loose stools R514 was experiencing. APNP-JJJJ stated staff should be telling APNP-JJJJ about any bleeding, and if notified, APNP-JJJJ would check hemoglobin and order labs for R514. APNP-JJJJ indicated at the time of the interview that no one asked APNP-JJJJ to see R514 related to bloody stools. On 4/24/2025, at 8:10 AM, Surveyor interviewed RN Supervisor-QQ, who stated that RN Supervisor-QQ does not go over the CNA documentation to look at what they are charting. RN Supervisor-QQ indicated that they will look to make sure it's being done but no one looks over what is being documented. (continued on next page)

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	05/01/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/24/2025, at 12:02 PM, Surveyor interviewed DON-B, who indicated that clinical staff should be going over what the CNA's are documenting. Surveyor informed DON-B of staff interview with LPN-II stating that they don't do that and don't have time to do that. Surveyor also informed DON-B of interview with RN Supervisor-QQ as well stating that no one reviews what is charted but that its just reviewed that something is being documented. Surveyor explained to DON-B that as of now the facility has no documented assessment completed for the documented 9 discolored bowel movements from R514, there is changes of condition with this resident being documented by CNA staff and no assessment or medical professional update occurring after. DON-B stated that APNP-JJJJ is the one that goes over the bowel movements and would see if there was a concern. Surveyor informed DON-B that during interview with APNP-JJJJ that 9 discolored bowel movements of red or black were not reported to APNP-JJJJ. On 4/24/2025, at 12:38 PM, Surveyor interviewed APNP-JJJJ, who indicated she can review bowel movements but just the size and amount but no other descriptors like color. APNP-JJJJ stated that APNP-JJJJ expectations is for staff to update APNP-JJJJ on any bloody stools. APNP-JJJJ indicated not having time to go through all that information and that what she is doing with reviewing is in addition to staff updates and not to replace updates. On 4/24/2025, at 12:43 PM, Surveyor informed NHA (CEO)-A, DON-B, and Director of clinical operations-D, of the concern with R514's change of condition with 9 documented bowel movements that were either documented as bright red, or tarry black in color not being assessed or reported to physician as care plan indicates. Surveyor also explained that the care plan also documents that a progress note should be placed with any side effects to blood thinner medication. No additional information was provided.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49845 Based on observation, interviews, and record review, the facility did not ensure residents with hearing impairment received proper treatment and assistive devices including arrangements for an audiology (ear doctor) for 2 of 3 (R3 and R614) residents reviewed for hearing. * Staff was observed not using communication devices to communicate with R3. R3 did not have an audiology consult for assess R3's hearing ability. * Surveyor observed R614 without R614's hearing aids on 4/15, 4/16, & 4/17/25. R614 has a Physician's order and Care Plan directing daily placement of R614's hearing aids because of R614's hearing deficits. The facility failed to ensure R614's right to communicate and interact with R614's environment in a comfortable and dignified manner. Findings include: 1.) R3 was admitted to the facility on [DATE] with diagnoses which include unspecified hearing loss of unspecified ear and multiple unrelated diagnoses. R3's Significant Change Annual Minimum Data Set (MDS), dated [DATE], documents R3 has a brief Interview for Mental Status (BIMS) score of 06, indicating R3 has moderately impaired cognition. R3 does not have behaviors or rejection of care, does not exhibit wandering behaviors, has moderate difficulty with hearing ability. R3's Annual MDS, dated [DATE], documents R3 has a BIMS score of 09, indicating R3 has moderately impaired cognition. R3 does not exhibit behaviors or rejection of care and has adequate hearing ability. On 04/15/2025, at 09:50 AM, Surveyor attempted to speak with R3. Surveyor noted R3 was very hard of hearing and was unable to hold a conversation due to being unable to hear the Surveyor. Surveyor reviewed R3's document, titled Care Plan with a start date of 12/03/2024; which documents, R3 has disturbed sensory perception Auditory. Approaches include, adjust tone and speak directly, call light within reach, explore technology such as amplifiers, modifiers for telephones and services for hearing impaired, provide assistance with communication devices, provide verbal cueing and reorientation if indicated, reduce/minimize environmental noise, speak to resident's unaffected ear and repeat/rephrase if necessary. Surveyor reviewed R3's Electronic Health Record (EHR) and noted the following order, may be seen by dentist/ podiatrist/ psychologist/ psychiatrist/ audiologist/ optometrist/ wound. Surveyor was unable to locate an audiology consult in R3's EHR. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/16/2025, at 08:09 AM, Surveyor observed LPN-FFFF loudly communicating with R3. R3 was observed to have troubles hearing LPN-FFFF by asking LPN-FFFF to repeat what LPN-FFFF said, and R3 saying huh. Surveyor asked LPN-FFFF how staff communicates with R3 when R3 has troubles hearing staff, LPN-FFFF indicated that they will speak loudly in R3's ear. Surveyor asked LPN-FFFF if R3 uses hearing aids, LPN-FFFF indicated that R3 does not have hearing aids or hearing device. On 04/17/2025, at 03:29 PM, Surveyor requested R3's audiology consult from the Facility. Surveyor noted a progress note, dated 04/18/2025, at 02:42 PM, written by SW-MM documenting, met with resident regarding request for hearing test. Resident is agreeable to having a referral for a hearing test. SW sent referral to Home Hearing Aid Services for a hearing test to be scheduled for resident. On 04/21/2025, at 10:42 AM, Surveyor asked DON-B regarding R3's audiology consult. DON-B indicated DON-B will look into that and has spoken to R3 about it. On 04/22/2025, at 09:28 AM, Surveyor interviewed SW-MM. SW-MM indicated R3 does not want to use a pocket talker. SW-MM indicated that R3 had hearing aids, but R3 insisted on having them in R3's room, which R3 has since misplaced the hearing aids on multiple occasions and does not want staff helping locate them. SW-MM was unaware of the last time R3 had R3's hearing aids and indicated R3 will be evaluated by audiology for hearing aids. On 04/22/2025, at 10:48 AM, The Facility informed Surveyor there is no policy for hearing devices. On 04/22/2025, at 03:26 PM, Surveyor informed the Facility of the concerns regarding R3 not being evaluated by audiology and not using alternative methods of communication for R3 to ensure R3 could hear staff efficiently. No further information provided at time of write up. 51016 2.) R614 was admitted on [DATE] with diagnoses that included: Cognitive Communication Deficit and Alzheimer's Disease. R614's MDS (Minimum Data Set) assessment with an assessment reference date of 3/31/25 documents: Section C cognitive patterns a BIMS (Brief Interview for Mental Status) score of 6, indicating severe impairment of cognition for R614. Section B Hearing, Speech and Vision documents R614's ability to hear as moderate difficulty (speaker has to increase volume and speak distinctly). Section B Hearing, Speech and Vision documents R614's hearing aid or other hearing appliance used as yes. R614's Physician's Order dated 3/29/25, at 05:49 PM, documents: Right hearing aide {SIC}: Nurse to ensure HA (hearing aid) is in place in the AM and off @ HS (hour of sleep) and return back to designated container in medication cart. Frequency: twice a day. Special Instructions: Hearing Impairment. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R614's April 2025 Medication Administration Record (MAR) documents: Right hearing aide {SIC}: Nurse to ensure HA (hearing aid) is in place in the AM and off @ HS (hour of sleep) and return back to designated container in medication cart. Surveyor noted the MAR has been signed out as completed every morning and evening shift since R614's return from the hospital on 4/11/25. R614's CNA assignment sheet dated 4-17-25 Section titled Communication documents: 1. check that hearing aid(s) is clean, functioning, and properly placed. Store hearing aid(s) in safe location when not in use. R614's Care Plan titled: Communication, R614 has potential for receptive and expressive language barriers due to Alzheimer's dementia, cognitive losses, hearing loss, slurred speech. Start date: 4/6/2025. R614's Approach section documents: 1. Approach start date 4/6/25, Ask simple yes or no questions. 2. Approach start date 4/6/25, Check that hearing aid(s) is clean, functioning, and properly placed. Store hearing aid(s) in a safe location when not in use. 3. Approach start date 4/6/25 Encourage and assist (R614) to sit at the front on any activity to enhance (R614's) enjoyment. 4. Approach start date 4/6/25, Face (R614) when speaking. 5. Approach start date 4/6/25, Obtain (R614's) attention before speaking. 6. Approach start date 4/6/25, Provide quiet, non-hurried environment free of background noises and distractions. 7. Approach start date 4/6/25, Audiologist/Speech Language pathologist/Speech Therapist PRN. Follow recommendations PRN. 8. Approach start date 4/6/25, Repeat phrases as needed. Rephrase if necessary. 9. Approach start date 4/6/25, Speak clearly and adjust tone as needed. R614's Nursing note dated 4/9/25, at 9:52 PM, documents: Patient still in hospital Family picked up right hearing aid today at 1615. Family asked that he please have hearing aid while he's awake and states that she is aware that he sometimes takes them out but will keep an eye out. R614's Nursing note dated 04/11/2025, at 9:32 PM, documents: Patient was readmitted today around suppertime. He came from (name of hospital) . His left hearing aid is in the med cart narc box. This is the only hearing aid he came with from the hospital. Family said she has the other 2 hearing aids . R614's Nursing note dated 04/14/2025, at 05:59 AM, documents: Monitoring readmission. Resident alert per baseline, needs anticipated by staff. Appears to be readjusting well, HOH (hard of hearing). Hearing aids in narc cart . On 4/15/25, at 12:15 PM, Surveyor observed that R614 was up and dressed and had no hearing aid present in either ear. Surveyor attempted to speak to R614. R614 looked at Surveyor and did not answer Surveyor's questions. On 4/15/25, at 330 PM, Surveyor observed that R614 was dressed lying on bed and did not have a hearing aid in either ear. Surveyor did observe a pocket talker with headphone attachment on R614's bedside table. (continued on next page)

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	525069	A. Building B. Wing	05/01/2025

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/16/25, at 07:48 AM, Surveyor interviewed R614. Surveyor asked R614 about the location of R614's hearing aids. R614 pointed to his right ear and then put both hands up and mouthed to Surveyor I don't know. On 04/16/25, at 07:49 AM, Surveyor interviewed Medication Technician (MT)-AAA. As the Surveyor exited R614's room, MT-AAA was passing meds on the unit. MT-AAA informed the Surveyor he (R614) is nonverbal. Surveyor informed MT-AAA that the Surveyor was able to understand R614. Surveyor asked MT-AAA maybe R614 needs hearing appliances and may be hard of hearing. Surveyor asked MT-AAA if R614 had hearing aids. MT-AAA informed Surveyor that MT-AAA didn't know if R614 had hearing aids. MT-AAA informed Surveyor MT-AAA just started working here recently. Surveyor asked MT-AAA where would staff find information about a resident's hearing aids. MT-AAA informed Surveyor that MT-AAA could look that up in the computer. Surveyor asked MT-AAA what made MT-AAA think R614 was nonverbal. MT-AAA informed Surveyor R614 doesn't talk to MT-AAA when MT-AAA speaks to R614. Surveyor informed MT-AAA that R614 mouthed to the Surveyor that R614 doesn't know where R614's hearing aids are. MT-AAA informed Surveyor that MT-AAA doesn't know if R614 has hearing aids, because R614 doesn't really speak much to MT-AAA. On 04/16/25, at 07:52 AM Surveyor interviewed Register Nurse Supervisor (RN)-QQ. Surveyor asked RN-QQ if R614 had hearing aids, but RN -QQ was on the way to a meeting and would get back to the Surveyor about the hearing aids. On 04/17/2, at 09:30 AM, Surveyor interviewed R614 who was in bed fully clothed. Surveyor asked R614 if R614 needed anything. R614 informed Surveyor that R614 had not eaten yet and repeated go get me something. On 04/17/25. at 09:33 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-W. Surveyor informed CNA-W that the Surveyor tried to speak to R614, and it seemed R614 couldn't hear the Surveyor very well. Surveyor asked CNA-W if R614 had hearing aids or was the pocket talker on the table next to him used instead of hearing aids. CNA-W informed the Surveyor that CNA-W hadn't been over on this unit in a month. CNA-W informed the Surveyor that CNA-W didn't really know if R614 had hearing aids. Surveyor asked where CNA-W could look to find out about hearing aids. CNA-W informed Surveyor CNA-W would look at the care plan or find out in report. Surveyor asked CNA-W where the care plan is located. CNA-W informed Surveyor it is in the matrix computer program. CNA-W informed Surveyor that CNA-W was not sure if the pocket talker on the table was R614's hearing aid or not. CNA-W walked away from the Surveyor. On 04/17/25, at 09:41 AM, Surveyor observed Director of Dietary-SS brought a food tray for R614. Director of Dietary-SS kept knocking asking R614 to come in with the food tray. Surveyor informed Director of Dietary-SS that R614 didn't have R614's hearing aids on and likely could not here the knocking. (continued on next page)

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	525069	A. Building B. Wing	05/01/2025

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/17/25, at 09:47 AM, Surveyor interviewed Activities Therapist (AT)-ZZ. Surveyor asked AT-ZZ what AT-ZZ's role on the unit was. AT-ZZ informed Surveyor that AT-ZZ is the activities person. Surveyor asked AT-ZZ if AT-ZZ works with R614 routinely. AT-ZZ informed Surveyor that AT-ZZ worked with R614 at R614's previous residence. AT-ZZ informed Surveyor not as much since R614 came to this facility. Surveyor asked AT-ZZ if AT-ZZ thought R614's hearing problems created any problems for R614's participation in activities. AT-ZZ informed Surveyor it may partly be affected by R614's hearing but R614 frequently wants to stay in bed during this initial adjustment period. Surveyor asked AT-ZZ where the R614's hearing aids were located. AT-ZZ informed Surveyor It is a pocket talker. AT-ZZ informed Surveyor that AT-ZZ didn't believe R614 has a hearing aid. AT-ZZ informed Surveyor R614 mostly uses the pocket talker when R614's family is here. AT-ZZ informed the Surveyor some residents just do not like using the pocket talker. Surveyor asked AT-ZZ if R614 had a hearing aid besides the pocket talker on the bedside table and where would staff find that information. AT-ZZ informed the Surveyor AT-ZZ was not aware of any hearing aid for R614. AT-ZZ informed Surveyor that AT-ZZ spends a lot of time with R614 on a one-to-one basis because AT-ZZ knows R614 well from the previous assisted living facility. On 04/17/25, at 09:51 AM, Surveyor observed that R614 had no hearing aids in R614's ears. CNA-O was trying to talk R614 into sitting up while eating in bed. CNA-O informed Surveyor that R614 had wheeled back independently from the dining room and transfer independently back into R614's bed. CNA-O informed the Surveyor R614 doesn't want to sit up to eat and needs to sit up to be safe. Surveyor observed CNA-O had to use an elevated volume during the conversation with R614. Surveyor has observed that the pocket talker has not been used with any interactions with R614 so far. On 04/17/25, at 09:51 AM, Surveyor interviewed CNA-O. Surveyor asked CNA-O if R614 used a hearing aid and not the pocket talker on R614 bedside table. CNA-O informed the Surveyor that CNA-O believed the pocket talker on his table was R614 hearing device. Surveyor asked CNA-O if CNA-O was aware there were hearing aids noted in R614's care plan. CNA-O informed Surveyor CNA-O believed R614's hearing device (pocket talker) was on R614's bed table. On 04/17/25, at 09:55 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-II. Surveyor asked LPN-II if LPN-II if R614 had a hearing aide. LPN-II informed Surveyor that LPN-II didn't know if R614 had a hearing aid. LPN-II informed Surveyor that R614 hears LPN-II just fine. CNA-O then informed LPN-II that R614 has the pocket talker which R614 takes off and doesn't like to wear. Surveyor asked both LPN-II and CNA-O if R614 had a hearing aid for R614's ear along with the pocket talker. CNA-O informed Surveyor CNA-O wasn't aware of any other hearing devices. Surveyor asked where would staff find out about R614's hearing concerns or appliances. LPN-II informed the Surveyor that R614 has no hearing aids that LPN-II was aware of. LPN-II informed Surveyor that R614 hears LPN-II just fine every time LPN-II speaks to R614. On 04/21/25, at 09:12 AM, Observed a hearing aid in R614's right ear. Surveyor asked R614 if R614 had a hearing in today. R614 informed Surveyor yes pointed to R614's right ear. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/21/25, at 11:58 AM, Surveyor informed Nursing Home Administrator (NHA)-C that Surveyor observed that R614 had not been provided R614's hearing aids from 4/15/25 through 4/17/25 as directed by R614's physician's orders and Care Plan. Surveyor informed NHA-C while interviewing staff many were not aware of R614 having hear aids. Surveyor informed NHA-A that staff knew where to find the information and that the hearing aids were in the medication administration record, care plan, and R614 had a physician's order for R614's hearing aids. Surveyor informed the NHA-C that 4/21/25 was the first day the Surveyor observed that R614 had a hearing aid in R614's ear. Surveyor informed NHA-C the other concern was the staff had no knowledge that R614 had hearing aids. Surveyor informed NHA-C that nursing charting indicated that family wanted the hearing aids placed daily. Surveyor informed NHA-A that one staff member believed the resident was nonverbal because R614 didn't speak to her. NHA-C informed the Surveyor that the resident had a short hospital stay and staff may not have remembered. Surveyor asked NHA-C if NHA-C felt that the staff should at least check the medication administration record, physician's orders, families wishes and care plan especially when all this documentation is very clear about R614's having hearing aids placed daily. NHA-C asked the Surveyor if the issue is staff didn't know about R614's hearing aids or that they were not placed in R614's ear. Surveyor asked NHA-C if NHA-C felt it was critical to make sure a resident had hearing appliances in so a resident can communicate. NHA-C answered yes, a resident should have their hearing appliances placed. Surveyor asked NHA-C if NHA-C thought staff should know the care plan and follow the physician's orders for R614's hearing aids. NHA-C informed Surveyor yes, they should know to check the orders and the care plan. Surveyor informed NHA the issue is the facility staff didn't assure that R614 had his hearing appliances to ensure that R614 could communicate appropriately in a comfortable and dignified manner. Surveyor informed NHA-C staff didn't try in the 3 days of Surveyor observations and interviews to find out if R614 had hearing aids even after the Surveyor inquired frequently about R614's hearing. Surveyor told NHA-C that staff told the Surveyor the facility provided a packet talker, telling the Surveyor it was the only hearing appliance R614 had despite hearing aids being on the CNA care cards, care plan, physician's orders and on R614's MAR. Surveyor informed NHA-C that the pocket talker was never observed being used for R614 by Surveyor. NHA-C informed the Surveyor the staff should have looked in the care plan and made sure the resident had hearing aids placed rather than just raising their voices when they speak to R614.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on observation, interview, and record review, the facility did not ensure that residents with a pressure injury or at risk for pressure injuries received necessary treatment and services, consistent with professional standards of practice, to prevent the development of pressure injuries and to promote healing for 3 (R78, R100, and R11) of 4 residents reviewed for pressure injuries. * R78 was originally admitted to the facility on [DATE] with multiple pressure injuries. On 2/23/25, R78 was discharged to the hospital and was readmitted on [DATE]. Upon readmission, the facility did not comprehensively assess R78's pressure injuries until 3/13/25 during wound rounds,7 days later. Multiple observations were made of R78's feet/heels resting directly on the air mattress and not being offloaded. On 4/17/25, during wound rounds with Wound Nurse Registered Nurse (RN)-EE, Certified Nursing Assistant/Care Coordinator (CNA/CC)-P and Wound Physician-JJJJ Surveyor observed a pressure injury on R78's right lateral foot. The facility was unaware of this area until it was brought to their attention by Surveyor and two DTIs (deep tissue injuries) were observed on R78's right lateral foot. R78's weight is 200 pounds. R78's air mattress was set at 330, 700, 260, and 460 pounds. R78 is being cited at a scope/severity level of G actual harm isolated. * R100's heels were not being offloaded and R100's at risk for skin breakdown care plan does not include an approach to offload R100's heels. * R11 was hospitalized from 12/8/24 to 12/10/24. There was not a comprehensive assessment of R11's Stage 4 sacral pressure injury until two days after readmission on 12/12/24. R11 was hospitalized on [DATE] to 3/25/25. There was not a comprehensive assessment of R11's Stage 4 sacral pressure injury until two days after readmission on 3/27/25. Findings include: The facility's policy titled, Pressure Sore Prevention and Treatment, reviewed 4/25 documents under policy: Each resident will be assessed routinely during cares to prevent breakdown. If wound is present, monitor and assess wound with each dressing change and measure and document progress weekly. Documented under Procedure is: 3a. At a minimum, all residents at risk for pressure sore development or that receive active treatment for pressure sores will have an an appropriate pressure relief/reduction support surface while in and out of bed. Each resident will be assessed on an individual basis according to need, b. residents at risk must be repositioned and turned per individual schedule. c. Use positioning devices to relieve pressure and to prevent direct skin to skin contact as assessed on an individual need. Positioning devices include but are not limited to: *Boots, *Pillows, *Splints, *Wedges,*PTIOT (physical therapy/occupational therapy) Recommendations. K. The resident's refusal of treatment or non-compliance with preventive measures must be documented in the resident's medical record. The resident and legal representative will be notified and educated to the risks associated with not complying with preventative measures. The Care Plan will also be updated to reflect non-compliance and alternative interventions will be considered for residents with positioning needs caused by contractures that promote pressure areas. (continued on next page)

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	525069	A. Building B. Wing	05/01/2025

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	1.) R78 was originally admitted to the facility on [DATE] with multiple pressure injuries. R78's diagnoses includes Chronic respiratory failure, Quadriplegia (paralysis of all four limbs), Dependence on respirator (ventilator), Atrial fibrillation (irregular & rapid heart beat), Congestive heart failure (heart doesn't pump enough blood to meet the body's needs), Anxiety disorder, and Diabetes mellitus. R78's pressure ulcer/injury CAA (care area assessment) dated 8/13/24 documents under description of problem: CAA triggered due to resident noted to have multiple pressure areas present upon admit, see wound care notes. Documented under causes and contributing factors: [R78's first name] readmitted to the facility following a hospitalization for [NAME] (ventilator associated pneumonia), MDRO (multidrug resistant organism). Other diagnoses include but are not limited to acute and chronic respiratory failure, resident is vent and trach dependent. [R78's first name] is NPO (nothing by mouth) and receives enteral feedings and has a colostomy and indwelling Foley in place. [R78's first name] was noted to have a hx (history) of MVA (motor vehicle accident) in 2021 and is quadriplegic and was admitted with multiple pressure areas that are being monitored by the wound care team for healing. Goal is for [R78's first name] to remain LTC (long term care) at this time. R78's current Impaired Skin Integrity care plan with a start date of 1/2/25 documents the following approaches: Address pain, as needed, to promote resident comfort, and to encourage adherence to interventions to maintain skin integrity. Start date 1/2/25 & edited 4/13/25. Air mattress to bed. Check placement, function and set to proper firmness every shift. Start date 1/2/25 & edited 4/13/25. Apply lotion to arms and legs every AM (morning), HS (hour sleep) and PRN (as needed). Start date 1/2/25 & edited 4/13/25. Assess for presence of risk factors. Treat, reduce, eliminate risk factors to extent possible. Start date 1/2/25 & edited 4/13/25. Encourage physical activity, mobility and range of motion to maximum potential. Start date 1/2/25 & edited 4/13/25. Moisture management - insure abdominal, groin, & chest folds are cleaned & thoroughly dried, twice daily, with AM/PM (morning/evening) cares. Start date 1/2/25 & edited 4/13/25. Monitor skin daily with cares, during baths, and weekly. MD (medical doctor) update if indicated. Start date 1/2/25 & edited 4/13/25. Monitor wounds for S&S (signs and symptoms) of infection. Start date 1/2/25 & edited 4/13/25. Nurse will assess skin - upon admission, weekly on scheduled bath days, prn (as needed). Abnormalities will be documented in chart, and reported to primary physician & wound team for f/u (follow up). Start date 1/2/25 & edited 4/13/25. Turn resident q (every) 1-2 hours. Start date 1/2/25 & edited 4/13/25. Use fluidizer positioner or pillows on legs as appropriate. Keep feet and heels elevated at all times. Monitor calves and call MD/NP (medical doctor/nurse practitioner) if unable to avoid new pressure areas to calves/while attempting to position feet/heels off bed. Start date 1/2/25 & edited 4/17/25. Utilize draw sheet, when available, to minimize risk of friction/shear. Encourage side to side positioning when in bed. Start date 1/2/25 & edited 4/13/25. Wound assessment/measurement performed weekly by wound team. If resident unavailable, assessment to be completed at earliest availability. Start date 1/2/25 & edited 4/13/25. Wound treatments to be performed by nursing, as ordered by MD/NP. Nursing to monitor integrity of drsgs (dressings), with each encounter, and replace drsgs if soiled, loose, or missing. Start date 1/2/25 & edited 4/13/25. R78's Braden assessment dated [DATE] has a score of 10 which indicates high risk for pressure injury development. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R78's quarterly MDS (minimum data set) with an assessment reference date of 3/10/25 assesses R78 for speech clarity as no speech. R78 has short and long term memory problems and is severely impaired for cognitive skills for daily decision making. R78 is assessed as not having any behavior including refusal of cares. R78 is assessed as being dependent for toileting hygiene, roll left and right and chair/bed to transfers. R78 has an indwelling urinary catheter and colostomy. R78 is at risk for pressure injuries and is assessed as having two Stage 4 pressure injuries which were present on admission, 2 unstageable pressure injuries which were present on admission and a diabetic ulcer. R78 receives oxygen, suctioning, trach care, and ventilator services. On 2/23/25, R78 was discharged to the hospital for a change of condition. R78 was readmitted on [DATE]. R78's Braden assessment dated [DATE] has a score of 10 which indicates high risk for pressure injury development. R78's nurses note dated 3/6/25 at 5:46 p.m. written by Registered Nurse (RN)-IIII documents: Resident arrived to facility via: Ambulance At this time: 04:20 PM. From (hospital name or other description): hosp (hospital). Their arrival condition was: Stable. Their admitting diagnoses are: osteomyelitis (bone infection). Other relevant diagnoses include: on vent. Mental Status: alert. Behavior (wandering, agitation, resists care): no. Skin assessment: has woulds sic (wounds) midback, sacral, right lower leg Devices/equipment (dentures, catheters, IVs (intravenous), CPAP (continuous positive airway pressure), etc): Foley, TF(tube feeding), IV pic (peripherally inserted central catheter) right upper arm, vent. Bowel/Bladder continence: Incontinent of bowel. Admission Transfer Status: admitted . Other assessment details. R78's nurses note dated 3/7/25 at 3:06 a.m. written by RN-OOO documents: PAD (post admission) #1 Osteomyelitis/IV ABT (antibiotic) x 2 (times two) for sepsis/wounds. Alert. No SOB (shortness of breath) or cough noted. On vent without difficulties. S/s (signs/symptoms) of pain relieved by APAP (acetaminophen). No adverse reactions. No temp. (temperature). No s/s of infection or infiltration. GJ tube running without difficulties. Foley flowing with yellow urine. Dressings C/D/I (clean/dry/intact). Will monitor. R78's nursing note dated 3/13/25 at 4:26 p.m. documents: STAGE 4 PRESSURE WOUND SACRUM FULL THICKNESS Etiology (quality) Pressure MDS 3.0 Stage 4 Duration > (greater) 1059 days Objective Healing/Maintain Healing Wound Size (L x W x D) (length times width times depth): 3 x 1.5 x 2 cm (centimeter) Surface Area: 4.50 cm ^2 (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Exudate: Moderate Serous Slough: 10 % Granulation tissue: 90 % Wound progress: Improved evidenced by decreased surface area DRESSING TREATMENT PLAN Primary Dressing(s) Sodium hypochlorite solution (dakins) apply once daily for 30 days: 1/2 strength cleanse; Alginate calcium apply once daily for 30 days; Blastx apply once daily for 30 days Secondary Dressing(s) Gauze island w/ bdr (with border) apply once daily for 30 day STAGE 4 PRESSURE WOUND OF THE RIGHT ISCHIUM FULL THICKNESS Etiology (quality) Pressure MDS 3.0 Stage 4 Duration > 456 days Objective Healing/Maintain Healing Wound Size (L x W x D): 2.5 x 2.5 x 3 cm Surface Area: 6.25 cm Exudate: Moderate Serous Granulation tissue: 100 % Epibole present within the wound margins. Wound progress: Improved evidenced by decreased surface area EXPANDED EVALUATION PERFORMED The progress of this wound and the context surrounding the progress were considered in greater detail today. Impaired nutritional status discussed with patient, family, nursing staff, and/or dietitian. Reviewed off-loading surfaces and discussed surfaces care plan. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	DRESSING TREATMENT PLAN Primary Dressing(s) Sodium hypochlorite solution (dakins) apply once daily for 30 days: 1/2 strength cleanse; Alginate calcium apply once daily for 30 days; Blastx apply once daily for 30 days Secondary Dressing(s) Gauze island w/ bdr apply once daily for 30 days UNSTAGEABLE (DUE TO NECROSIS) OF THE LEFT ISCHIUM FULL THICKNESS Etiology (quality) Pressure MDS 3.0 Stage Unstageable Necrosis Duration > 50 days Objective Healing/Maintain Healing Wound Size (L x W x D): 5 x 2.5 x 0.2 cm Surface Area: 12.50 cm Exudate: Moderate Serous Thick adherent devitalized necrotic tissue: 80 % Granulation tissue: 20 % Wound progress: Improved evidenced by decreased depth, decreased surface area DRESSING TREATMENT PLAN Primary Dressing(s) Sodium hypochlorite solution (dakins) apply once daily for 30 days: 1/2 strength cleanse; Alginate calcium apply once daily for 30 days; Blastx apply once daily for 30 days Secondary Dressing(s) (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Gauze island w/ bdr apply once daily for 30 days UNSTAGEABLE (DUE TO NECROSIS) OF THE RIGHT, POSTERIOR SHOULDER FULL THICKNESS Etiology (quality) Pressure MDS 3.0 Stage Unstageable Necrosis Duration > 36 days Objective Healing/Maintain Healing Wound Size (L x W x D): 1.5 x 4 x 0.1 cm Surface Area: 6.00 cm Cluster Wound open ulceration area of 4.80 cm Exudate: Moderate Serous Thick adherent devitalized necrotic tissue: 30 % Granulation tissue: 50 % Skin: Intact normal color 20 % Wound progress: Improved evidenced by decreased surface area DRESSING TREATMENT PLAN Primary Dressing(s) Sodium hypochlorite solution (dakins) apply once daily for 30 days: 1/2 strength cleanse; Alginate calcium apply once daily for 30 days; Blastx apply once daily for 30 days Secondary Dressing(s) Gauze island w/ bdr apply once daily for 30 days DIABETIC WOUND OF THE LEFT, PLANTAR, FIRST TOE FULL THICKNESS Etiology (quality) Diabetic Duration > 1 days (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Objective Healing/Maintain Healing Wound Size (L x W x D): 1 x 1 x 0.1 cm Surface Area: 1.00 cm ^2 Exudate: Light Serous Granulation tissue: 100 % DRESSING TREATMENT PLAN Primary Dressing(s) Xeroform gauze apply once daily for 30 days Secondary Dressing(s) Gauze island w/ bdr apply once daily for 30 days Surveyor was unable to locate a comprehensive assessment of R78's pressure injuries until 3/13/25. On 4/22/25, at 3:32 p.m., Surveyor asked Wound RN-EE who is responsible for comprehensively assessing resident's skin when they are readmitted from the hospital. Wound RN-EE informed Surveyor the nurse taking that resident and if not an RN the supervisor is responsible for doing the assessment when the resident comes back. Usually they like to do skin checks with two people unless it's an RN. They will verify orders with the NP or MD. On 4/22/25, at 3:40 p.m., Surveyor informed Wound Care RN-EE R78 was hospitalized on [DATE] and readmitted on [DATE]. Surveyor informed Wound Care RN-EE Surveyor noted a comprehensive wound assessment on 3/13/25, one week after R78's readmission and asked if there is an assessment prior to 3/13/25. Wound RN-EE informed Surveyor she will look into this and get back to Surveyor. On 4/23/25, at 10:05 a.m., Surveyor asked Wound Care RN-EE if she was able to locate a comprehensive pressure injury assessment prior to 3/13/25. Wound Care RN-EE informed Surveyor she wasn't able to find it and asked [first name] of Director of Nursing (DON)-B to look into for Surveyor. Wound Care RN-EE informed Surveyor he probably came in on the evening shift so we probably didn't see him until the following week unfortunately. On 4/23/25, at 12:35 p.m. DON-B provided Surveyor with a copy of R78's nurses notes dated 3/6/25 at 5:46 p.m. and 3/7/25 at 3:06 a.m. Surveyor informed DON-B these notes are not a comprehensive assessment of R78's pressure injuries. Surveyor informed DON-B there wasn't a comprehensive assessment of R78's pressure injuries until R78 was seen on wound rounds on 3/13/25. Surveyor asked DON-B if there should be a comprehensive assessment after R78 was admitted . DON-B responded correct. The facility did not comprehensively assess R78's pressure injuries until 7 days after R78 was readmitted . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R78's Braden assessment dated [DATE] has a score of 12 which indicates high risk for pressure injury development. R78's weight on 4/4/25 was 201 pounds and on 4/18/25 was 200 pounds. On 4/15/25, at 10:28 a.m., Surveyor observed R78 in bed on the right side with the head of the bed elevated and a wedge under R78's left upper side. R78's tube feeding of Isosource 1.5 is running at 65 ml (milliliter) per hour and R78 is on a ventilator. Surveyor observed R78 has bare feet and R78's heels are resting directly on the mattress. R78's feet and heels are not being offloaded. Surveyor observed the Medline air mattress is set at 330 pounds. On 4/15/25, at 11:32 a.m. Surveyor observed R78 continues to be on the right side with the head of the bed elevated. R78's heels are resting directly on the mattress and R78's heels/feet are not being offloaded. Surveyor observed R78 air mattress continue to be set at 330 pounds. On 4/15/25, at 1:37 p.m. Surveyor observed R78 in bed on his back with the head of the bed elevated. There is a folded blanket under R78's left arm and R78's heels are resting directly on the air mattress. R78's feet/heels are not being offloaded. On 4/15/25, at 3:14 p.m., Surveyor observed R78 in bed on his back with the head of the bed elevated. Surveyor observed R78's continues to have bare feet with R78's heels resting directly on the mattress. R78's feet/heels are not being offloaded. On 4/16/25, at 7:05 a.m., Surveyor observed R78 in bed on his back with the head of the bed elevated. Surveyor observed R78's heels are resting directly on the mattress and R78's heels/feet are not being offloaded. On 4/16/25, at 9:42 a.m., Surveyor observed R78 in bed towards the left side with the head of the bed elevated. R78's tube feeding of Isosource 1.5 is running at 65 ml/hr (hour). There is a pillow under R78's upper right side and a folded blanket under R78's left arm. Surveyor observed R78's legs are not covered with bedding and observed R78's heels are resting directly on the mattress. Surveyor observed R78's feet/heels are not being offloaded. On 4/17/25, at 7:11 a.m., Surveyor observed R78 awake in bed on his back with the head of the bed elevated. Surveyor observed there is a pillow under R78's lower legs. Surveyor observed R78's left heel is resting directly on the mattress and the right heel is being offloaded. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 4/17/25, from 8:38 a.m. to 8:56 a.m., Surveyor observed wound rounds with Wound RN-EE, Wound Physician-JJJJ, and CNA/CC-P for R78's right ischium Stage 4, left ischium Unstageable, sacrum stage 4, and right posterior thigh unstageable DTI (deep tissue injury). Wound RN-EE informed Surveyor all of R78's pressure injuries are community acquired and he has been in and out of the facility multiple times. Surveyor observed at the start of this observation R78's air mattress was set at 700 pounds. During this observation at 8:49 a.m. Surveyor observed a pressure injury on the lateral side of R78's right foot near the pinky toe. Surveyor observed during this observation neither Wound RN-EE or Wound Physician-JJJJ assessed R78's feet. After R78's treatments were completed at 8:56 a.m. Wound RN-EE & CNA/CC-P positioned R78 up in bed and rolled R78 on the left side placing a pillow under R78's right side. Surveyor observed R78's heels were not offloaded and the lateral side of R78's right foot is resting directly on the mattress. At 8:59 a.m. Wound RN-EE informed Surveyor she knows [first name] of DON-B ordered fluidizer for R78 and R78 was covered with a sheet. At 9:02 a.m. Surveyor observed CNA/CC-P placed a pillow under R78's lower legs. Surveyor observed R78's left heel is now being offloaded but the lateral side of R78's right foot is resting directly on the air mattress. CNA/CC-P then adjusted the weight for the air mattress to 260 pounds. Surveyor noted R78's weight is 200 pounds. On 4/17/25, at 1:09 p.m., Surveyor observed R78 in bed on the right side with the head of the bed elevated. There is a pillow under R78's upper left side. Surveyor observed R78's heels/feet are not being offloaded. Surveyor reviewed R78's medical record and was unable to locate any documentation regarding any pressure injuries on R78's right foot. On 4/17/25, at 4:14 p.m., Surveyor asked Wound RN-EE if she could come with Surveyor to look at R78's feet. Wound RN-EE informed Surveyor she usually checks feet during wound rounds but didn't this morning. Wound RN-EE placed PPE (personal protective equipment) on and Surveyor and Wound RN-EE entered R78's room. Surveyor observed R78's heels/feet are not being offloaded. Surveyor asked Wound RN-EE to look at R78's right foot. Wound RN-EE raised R78 right foot off the mattress and Surveyor showed her the pressure injury on the lateral side of R78's right foot near the pinky toe. Wound RN-EE stated, oh yes that's a DTI (deep tissue injury). Surveyor and Wound RN-EE then observed a second DTI on the lateral side. Wound RN-EE stated he's prone, doesn't take much. Wound RN-EE informed Surveyor she will call name of Wound Physician-JJJJ, measure and get a treatment tonight. Wound RN-EE again informed Surveyor she usually looks at residents feet but didn't today and thanked Surveyor. The nurses note dated 4/17/25, at 7:20 p.m., written by Wound RN-EE documents Wound care nurse visit - Post wound care visit with [Wound Physician-JJJJ's name], New pressure areas noted to outer aspect of right foot. Distal DTI on foot near right 5th toe is purple non-blanchable Unstageable DTI, measures 2.2 cm (centimeters) x (times) 1 cm. Resident denies pain with palpation. Proximal DTI lateral aspect of mid foot measures 0.8 x 1.2 cm, depth is unmeasurable (sic), Purple nonblanchable area. resident denies pain with palpation. Contacted [Wound Physician-JJJJ's name] and [APNP-RRR's name] re orders. Skin prep to area daily. Updated floor staff related to off-loading with pillows. Orders updated. On 4/21/25, at 7:17 a.m., Surveyor observed R78 in bed on his back with the head of the bed elevated. R78's heels are not being offloaded and the lateral side of R78's right foot is resting directly on the mattress. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 4/21/25, at 10:38 a.m., Surveyor asked CNA/CC-P what they are doing to prevent pressure injuries from developing on R78's feet/heels. CNA/CC-P informed Surveyor they used to have fluidizer pillow under but when R78 would go to the hospital he would not return with them so they are using a pillow. Surveyor informed CNA/CC-P Surveyor didn't observe anything for offloading R78's heels/feet. CNA/CC-P stated to be honest I didn't have a pillow under there today. On 4/22/25, at 8:39 a.m., Surveyor asked RN Supervisor-AA what is the facility to prevent pressure injuries from developing on R78's feet/heels. RN Supervisor-AA informed Surveyor they should elevate R78's heels. RN Supervisor-AA explained R78 used to have offloading boots but they were causing him to breakdown on his calves. RN Supervisor-AA informed Surveyor they should be using pillows or fluidizer on. Surveyor asked RN Supervisor-AA when staff are doing cares on R78 should they be looking at his feet. RN Supervisor-AA replied yes. On 4/22/25, at 9:08 a.m., Surveyor asked RN Supervisor-AA how should a resident's air mattress be set at. RN Supervisor-AA informed Surveyor it is based on the resident's weight and they can ask the resident if they want it soft or firmer. Surveyor informed RN Supervisor-AA of the observations of R78's feet/heels not being offloaded and the air mattress not set at R78's weight of 200 pounds. On 4/22/25, at 9:12 a.m., Surveyor observed R78's mattress is set at 460 pounds. Surveyor observed R78 on the right side with a wedge and pillow under R78's left side and a blanket under R78's left arm. There is a pillow under R78's lower legs and both of R78's heels are being offloaded. On 4/23/25, at 12:35 p.m., Surveyor informed DON-B of the observations of R78's air mattress not being set according to R78's weight, the multiple observations of R78's feet/heels not being offloaded and Surveyor observed pressure injury on R78's right lateral foot which the facility was not aware of until it was brought to their attention by the Surveyor. 2.) R100's diagnoses includes chronic respiratory failure, dependence on respirator (ventilator), Encephalopathy (general brain dysfunction characterized by alteration in brain function or structure), Quadriplegia (paralysis of all four limbs), and Guillain-Barre syndrome (rare neurological disorder where the body's immune system attacks the peripheral nervous system). R100's admission MDS (minimum data set) with an assessment reference date of 2/12/25 has a BIMS (brief interview mental status) score of 15 which indicates cognitively intact. Speech clarity is assessed as no speech. For functional limitation in range for motion R100 is assessed as having upper extremity and lower extremity impairments on both sides. Toileting hygiene & roll left and right are assessed as being dependent and chair/bed to chair transfer was not attempted due to medical conditions or safety concerns. R100 has an indwelling catheter and is occasionally incontinent of bowel. R100 is at risk for pressure injury development and is assessed as not having any pressure injuries. R100 is checked as receiving oxygen, suctioning, trach care and ventilator. R100's pressure injury CAA (care area assessment) dated 2/19/25 under analysis of findings documents This CAA triggers as resident is at risk for pressure injuries. Resident had botulism and ended up on a trach/vent and now is quadriplegic. Resident cannot feel pressure due to paralysis. Resident is also incontinent of stool. Stoma to trach site, g (gastrostomy)-tube site also must be monitored for s/s of infection. Barrier cream used to protect skin, trach care per RT, nursing cleans G tube site. Pressure reducing mattress on the bed. Resident is on a turning program and does ask to be repositioned. (continued on next page)

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	05/01/2025

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R100's care plan I am at risk for skin breakdown r/t (related to) immobility with a start date of 2/12/25 & edited 4/13/25 documents approaches of Avoid shearing my skin during positioning, transferring, and turning with a start date of 2/12/25 & edited 4/13/25. Handle me with care during direct care with a start date of 2/12/25 and edited 4/13/25. I was offered air mattress but chooses regular mattress after risk/benefit discussion with me and my husband/POA (power of attorney) with a start date of 2/12/25 & edited 4/13/25. Manage pain using pharmacological and nonpharmacological techniques with a start date of 2/12/25 and edited 4/13/25. Measure and record description of area (e.g. location, size (length, width, and depth), color, surrounding skin, presence/absence of drainage, presence/absence of pain, presence/absence of signs of healing) with a start date of 2/12/25 and edited 4/13/25. Monitor and report signs of localized infection (localized swelling, redness, pain or tenderness, heat at the infected area, purulent drainage, loss of function) with a start date of 2/12/25 and edited 4/13/25. Treat area following physician orders with a start date of 2/12/25 and edited 4/13/25. Use mechanical devices with care (e.g., lifts, wheelchairs, bedside tables, restraints, etc) with a start date of 2/12/25 and edited 4/13/25. Utilize the following preventative skin interventions based on Braden score of 13 or more: with a start date of 2/12/25 and edited 4/13/25. Surveyor noted no approaches regarding offloading heels and how often R100 should be repositioned. R100's Certified Nursing Assistant care plan under problem category for skin has a start date of 2/12/25 and under approach description documents I was offered air mattress but chooses regular mattress after risk/benefit discussion with me and my husband/POA. R100's Braden assessment dated [DATE] has a score of 12. A score of 10-12 equals high risk. On 4/15/25, at 11:37 a.m. Surveyor observed Certified Nursing Assistant (CNA)/Care Coordinator (CC)-P and CNA-CC in R100's room. CNA/CC-P asked R100 if she was ready and R100's bedding was removed. Surveyor observed there are pillows under R100's lower legs but R100's heels are resting directly on the mattress and are not being offloaded. On 4/16/25, at 7:10 a.m., Surveyor observed R100 in bed on her back with eyes closed and appears to be sleeping. There is a pillow along R100's left and right upper side and pillows under R100's lower legs. R100's right heel is resting directly on the mattress and the left heel is resting on the pillow. R100's heels are not being offloaded. On 4/16/25, at 9:55 a.m., Surveyor observed R100 in bed with the head of the bed elevated and a visitor by the bedside. There is a pillow under R100's upper left and right side and a pillow under each lower leg. Surveyor observed R100's heels are not being offloaded. On 4/17/25, at 7:19 a.m., Surveyor observed R100 awake in bed on her back with the head of the bed elevated. Surveyor observed there is a pillow under each lower leg. R100's heels are resting directly on the mattress and are not being offloaded. On 4/17/25, at 9:16 a.m. Surveyor observed R100 continues to be in bed on her back with the head of the bed elevated. R100's heels continue to be on the mattress and are not being offloaded. (continued on next page)

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	525069	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 4/21/25, at 7:21 a.m., Surveyor observed R100 in bed with her eyes closed and the head of the bed elevated. There is a pillow under R100's right shoulder and under R100's left upper side. There is a pillow under each of R100's lower legs. Surveyor observed R100's heels are resting directly on the pillow and are not being offloaded. On 4/21/25, at 10:32 a.m., Surveyor observed R100 continues to be in the same position as the previous observation with R100's heels resting directly on the pillows. R100's husband informed Surveyor he repositioned his wife last night before he left and this is the way I left her which tells me they didn't change or reposition her. On 4/21/25, at 10:37 a.m. Surveyor asked CNA/CC-P what is being done so R100 doesn't develop pressure injuries on her heels. CNA/CC-P informed Surveyor R100 doesn't like boots and she wants her pillows a certain way. On 4/21/25, at 11:52 a.m., Surveyor observed R100 sitting in a Broda chair in R100's room. Surveyor asked R100 if staff offloads her heels. R100 started to mouth her words but Surveyor was unable to understand what R100 was mouthing and asked R100 to write on the white board. R100 wrote no when my feet hurt I have them or my family change the position. Surveyor asked R100 if she would let staff position her heels so they were hanging off the pillows. R100 mouthed yes. On 4/21/25, at 12:00 p.m., Surveyor asked Licensed Practical Nurse (LPN)-MMM how they are preventing pressure injuries from developing on R100's heels. LPN-MMM informed Surveyor normally try to put pillows under to try to float her legs. On 4/22/25, at 8:34 a.m., Surveyor asked Registered Nurse (RN) Supervisor-AA what the facility is doing to prevent pressure injuries from developing on R100's heels. RN Supervisor-AA informed Surveyor they should be floating her feet so her heals aren't touching either the pillows or blankets. RN Supervisor-AA informed Surveyor he can't specifically say if R100 has refused boots. Surveyor informed RN Supervisor-AA of the observations of R100's heels not being offloaded and R100's care plan doesn't address offloading heels nor is there any documentation that R100 refuses to have her heels offloaded. On 4/22/25, at 9:01 a.m., Surveyor observed R100 in bed on her right side. Surveyor observed there are pillows under R100's legs and R100's heels are being offloaded. Surveyor noted this is the first observation where R100's heels are being offloaded. On 4/22/25, at 11:22 a.m., Surveyor informed Director of Nursing (DON)-B of R100 at high risk of developing pressure injuries, the observations of R100's heels not being offloaded, and care plan does not have any approaches regarding R100's heels. 47094 3.) R11 was initially admitted to the facility on [DATE] and has diagnoses that include chronic stage 4 pressure injury at the sacral area, dementia, chronic kidney disease stage 3, type 2 diabetes mellitus, major depressive disorder, weakness, history of myocardial infarctions and transient cerebral ischemic attacks. (continued on next page)

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	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Actual harm Residents Affected - Few	R11's quarterly minimum data set (MDS) dated [DATE] indicated R11 had moderately impaired cognition with a Brief Interview of Mental Status (BIMS) score of 12 and the facility assessed R11 needing extensive assist with repositioning with 2 staff members and total assist with 2 staff members for toileting hygiene and transferred using a Hoyer lift with 2 staff members. R11 is incontinent of bowel

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	525069	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on observation, interview, and record review the facility did not ensure 1 (R100) of 3 residents with limited range of motion receive appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Range of motion was not provided to R100 during two personal care observations per R100's plan of care. Findings include: The facility's policy titled, Range of Motion and reviewed 4/25 under policy documents Therapeutic care will be provided to assist residents in maintaining ADL's (activities daily living) and to prevent contractures and maintain the flexibility needed to perform self-cares and maintain mobility. Under the section General Information includes documentation of 4. Move each joint through its range of motion about 5 to 10 repetitions or as tolerated by residents when resistance is felt. R100 was admitted to the facility on [DATE] with diagnoses which include chronic respiratory failure, dependence on respirator (ventilator), Encephalopathy (general brain dysfunction characterized by alteration in brain function or structure), Quadriplegia (paralysis of all four limbs), and Guillain-Barre syndrome (rare neurological disorder where the body's immune system attacks the peripheral nervous system). R100's admission MDS (minimum data set) with an assessment reference date of 2/12/25 has a BIMS (brief interview mental status) score of 15 which indicates cognitively intact. For functional limitation in range for motion R100 is assessed as having upper extremity and lower extremity impairments on both sides. R100's ADL (activities daily living) CAA (care area assessment) dated 2/19/25 under analysis of findings documents This CAA triggers as resident is dependent for all activities of daily living. Resident somehow developed botulism and become paralyzed and is now on a vent with trach. She does not get up by choice as she says that she is too fatigued. Is working in OT/PT (occupational therapy/physical therapy) to gain strength and endurance. R100's ADLs Functional Status/Rehabilitation Potential ADLs care plan with a start date of 2/12/25 includes an approach with a start date of 2/12/25 & edited 4/13/25 of Assist resident with upper and lower body range of motion exercises with cares and encourage resident to participate as able. R100's Certified Nursing Assistant (CNA) care card includes an approach with a start date of 2/12/25 of Assist resident with upper and lower body range of motion exercises with cares and encourage resident to participate as able. On 4/15/25, at 10:16 a.m., Surveyor asked R100 if staff washed her up today. R100 shook her head no. Surveyor asked R100 permission to observe staff wash her up. R100 mouthed yes, please. (continued on next page)

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	525069	A. Building B. Wing	05/01/2025

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/15/25, at 11:03 a.m. Surveyor asked Certified Nursing Assistant (CNA)/Care Coordinator (CC)-P if she has done R100's morning cares today. CNA/CC-P she is going to lunch and then will be doing R100. Surveyor informed CNA/CC-P Surveyor would like to go with her when she does cares. CNA/CC-P then informed R100 she is going to lunch and then will get her up asking R100 if she will be ready. On 4/15/25, at 11:37 a.m., Surveyor observed CNA/CC-P and CNA-CC place PPE (personal protective equipment) on and remove the bedding off R100. CNA/CC-P & CNA-CC removed the pillows from under R100's lower legs, R100's upper left side and the blue foam & pillow under R100's upper right side. R100's gown was removed and placed on the chest. CNA-CC washed R100's face while CNA/CC-P removed the dressing around R100's G (gastrostomy) tube, washed R100's abdomen, under arms, arms and squeezed water over R100's peri water. CNA/CC-P & CNA-CC dried the areas CNA/CC-P had washed. CNA/CC-P unfastened the catheter strap stating it's tight and then washed R100's frontal perineal area. CNA/CC-P removed her gloves, washed her hands and placed gloves on. CNA/CC-P placed deodorant on R100 and asked if she's ready to roll towards CNA-CC. CNA/CC-P & CNA-CC positioned R100 to the right side of the bed and then rolled R100 onto her left side. CNA/CC-P washed R100's back, squeezed water on R100's buttocks and using a chux removed stool from R100's rectal area. CNA/CC-P squeezed water on R100's rectal area and washed R100's rectal area & buttocks. CNA/CC-P removed her gloves, washed her hands and placed gloves on. CNA/CC-P wiped R100's mouth with a towel, applied barrier cream on R100's buttocks, removed her gloves, washed her hands, and placed gloves on. CNA/CC-P placed a chux & sling under R100's right side, informed R100 they were going to roll her towards CNA/CC-P and positioned R100 on the right side. CNA-CC removed the soiled items and dried R100 buttocks. The chux and sling were straighten out, a towel was placed over R100's frontal area and staff placed a gown on R100. CNA/CC-P applied lotion to R100's arms, feet, & legs and crossed the sling between R100's legs. CNA/CC-PP & CNA-CC removed their gloves & washed their hands. At 12:09 p.m. Licensed Practical Nurse (LPN)-MMM entered R100's room, disconnected R100's tube feeding, flushed the tube with 60 cc (cubic centimeters) of water and placed dressing around R100's G tube and suprapubic site. CNA/CC-P placed gripper socks on R100 and LPN-MMM suctioned R100. At 12:15 p.m. CNA-CC brought the full body mechanical lift over by R100's bed and staff connected the full body mechanical lift sling to the lift. During this observation Surveyor did not observe either CNA/CC-P or CNA-CC perform range of motion nor did they asked R100 about doing range of motion. On 4/17/25, at 10:00 a.m., Surveyor observed CNA-BB wearing PPE (personal protective equipment) in R100's room. At 10:01 CNA-CC, wearing PPE, entered R100's room with a full body mechanical lift. CNA-CC washed R100's face while CNA-BB removed R100's gown placing the gown on R100's chest. CNA-BB washed R100's chest & underarms, placed deodorant on and asked R100 if she wants powder under her breasts. CNA-CC removed her gloves, washed her hand, placed gloves on, lowered the head of the bed down and R100's tube feeding was shut off. CNA-BB placed a gown on R100 and pillows were removed from R100's upper right & lower side. CNA-BB washed R100's frontal peri area telling R100 she has to move her legs apart. R100 was positioned on the left side and CNA-BB washed R100's rectal area to remove stool multiple times. A sling was placed under R100 and R100 was positioned to the other side. CNA-CC rewashed R100's buttocks to remove stool with disposable wipes, removed the soiled items, removed her gloves, washed her hands, and placed gloves on. The sling and soaker pad were straightened and staff crossed the sling between R100's legs. (continued on next page)

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	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor observed during this observation neither CNA-CC or CNA-BB performed range of motion nor did either staff member ask R100 about doing range of motion. On 4/17/25, at 11:31 a.m., Surveyor asked PT (physical therapist)-H where Surveyor would find what the facility was doing so R100's contractures do not decline. PT-H informed Surveyor it would be in the care plan. Surveyor asked PT-H when the CNA's would be expected to do range of motion. PT-H informed Surveyor when doing cares, washing them up would move each joint. Surveyor asked PT-H if there is a specific number of times the CNA would move a resident's joint. PT-H informed Surveyor not sure what they were trained on and that would be a [first name] of Director of Nursing (DON)-B question. On 4/17/25, at 12:55 p.m. Surveyor asked CNA-BB how she knows which residents she should do range of motion for. CNA-BB replied it would be on the care card. Surveyor asked CNA-BB if there is anyone on the unit that requires ROM (range of motion). CNA-BB replied [first name of R105] then stated let me check, don't want to give you the wrong answer. CNA-BB then went to the computer screen in the hallway. Surveyor then asked what range of motion they do for R100. CNA-BB informed Surveyor she would asked R100 as R100 doesn't like when her legs are moved and she can move her arms so we really don't do anything with her arms. I would asked her what she wanted us to do. Surveyor informed CNA-BB Surveyor did not observed range of motion being done for R100 or not being asked about any range of motion. On 4/17/25, at 1:02 p.m., Surveyor asked Licensed Practical Nurse (LPN)-JJ how the CNAs know who they are suppose to do range of motion for. LPN-JJ replied it should be on the CNA care cards. On 4/17/25, at 2:04 p.m. Surveyor observed R100 sitting in a Broda chair in her room. Surveyor asked R100 when staff are washing her up do they ask her about doing range of motion, moving her joints. R100 mouthed no. R100 communicates by mouthing her words or writing on a white board. On 4/17/25, at 2:15 p.m., Surveyor asked Registered Nurse (RN) Supervisor-AA if range is motion is on the CNA care card would the CNAs be expected to perform range of motion. RN Supervisor-AA replied yes that is correct. Surveyor asked RN Supervisor-AA how many repetitions for each joint would the CNA do. RN Supervisor-AA replied that I would have to look into, would have to ask therapy. Surveyor informed RN Supervisor-AA during two care observations Surveyor did not observe range of motion being done for R100 nor did staff ask about doing range of motion.

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	525069	A. Building B. Wing	05/01/2025

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on observation, interview, and record review, the facility did not ensure Residents received adequate supervision and assistive devices to prevent accidents for 11 (R49, R72, R83, R12, R315, R79, R100, R51, R38, R94, and R6) of 14 Residents reviewed for accidents. This has the potential to affect 64 residents who use a mechanical hoyer lift, a mechanical sit to stand, or a Sara Steady lift. Staff did not always use the correct lift or use it correctly. The facility does not have a process in place for staff to ensure residents that are transferred using a mechanical lift or sit to stand have the appropriate sling to use during the transfer. *On 3/23/25, R72 fell from a Sara Steady and suffered a displaced spiral fracture of the left femur. At the time, R72 was to be transferred with the use of a mechanical sit to stand. *R83, R12 and R315 were observed during a transfer with a mechanical hoyer lift to not have the correct size sling used. On 3/28/25, R49 slid off a mechanical lift sling left under R49 while in the wheelchair to the floor. The facility had not assessed the safety risks associated with leaving a sling under R49 including whether the presence of the sling could lead to an unsafe seating situation for R49 in their wheelchair. R49 suffered a right humerus fracture. The facility policy is to remove all slings once the Resident has been transferred. *R79 was observed to be sitting in a wheelchair with a sling left underneath. The facility policy is to remove all slings once the Resident has been transferred. *R100 was up in the air over R100's Broda chair when the mechanical lift battery stopped working. *R51 was observed being pushed a long distance in the Sara Steady to the bathroom., however, the Sara Steady is only designed for a simple very short distance transfer. *R38 was observed during a transfer with a mechanical lift to not have the correct size sling. *Upon interview, staff did not know what size sling to safely transfer R42. *Upon interview, staff did not know what size sling to safely transfer R6. *R94's care plan documented R94 was to transfer with the assistance of a 2 wheeled walker which was not available during the survey process. Facility failure to have a process in place for staff to ensure the safe transfer of residents created a finding of immediate jeopardy that began on 3/23/2025. Surveyor notified Nursing Home Administrator (NHA)-C, Director of Nursing (DON)-B, Chief Executive Officer (CEO)-A, and Director of Clinical Operations (DOC)-D of the immediate jeopardy on 4/21/2025 at 2:07 PM. The Immediate Jeopardy was removed on 5/1/25, however, the deficient practice continues at a scope/severity of E (potential for more than minimal harm/pattern) as the facility continues to implement its removal plan. (continued on next page)

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	525069	A. Building B. Wing	05/01/2025

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Findings include: The facility's Safe Resident Handling (Safe Lift/No Lift Transfers) Effective 10/09, Revised 3/19, Reviewed 3/24 documents: Guidelines: Therapy/Nursing will complete the following: 1. Therapy will determine the safest transfer technique for each Resident being assessed or followed by therapy. Therapy will communicate to nursing the best method of transfer in electronic health record (EHR). 2. If Resident is not on therapy caseload, nursing will consult with therapy as needed to update Resident transfer status. a. Admission Screening -Therapy will determine Residents transfer status upon admission within 48 hours. 1. Therapy/Nursing will document transfer technique on the Resident care plan and Resident care guide in EHR. 2. Therapy/Nursing will provide training and education as needed to nursing staff regarding safest transfer technique for Resident being assessed. 3. Therapy/Nursing staff will monitor safety of current transfer technique and implement changes as appropriate. 4. Nursing staff will receive annual education and training on the safe transfer techniques by therapy/nursing. Criteria for determining transfer status of Resident: 3. Mechanical Stand (Sit to Stand) 1-2 people a. Resident is partially dependent and has some weight bearing ability and has sufficient upper body strength and usage. b. Residents that have difficulty following directions, panics during transfers or grabbing for a perceived safe surface. c. Compromised balance. d. Resident stands for less than 5 seconds or is unpredictable. 4. Full Mechanical lift-2 people (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	a. Resident is non-weight bearing. b. Resident is weight bearing but won't bear weight. 5. Non-mechanical/One Person (Sara Steady): a. Suitable for who can partially weight-bear, but need an extra hand tasks like dressing or stabilizing during transfer b. Have some upper body strength and can follow basic transfer instructions c. May have compromised balance or difficulty following directions but can still participate in the transfer. 10. A minimum of two people must be present for mechanical lift transfers. 11. Caregivers may NEVER utilize less assistance with a transfer than the care plan states. If more assistance is required, the CNA must report change in status to the nurse. The nurse will determine safest transfer at time and inform therapy of change and document change in transfer in EHR. 12. Slings must be correctly matched to Residents (Small, Medium, Large, X-Large). 13. Slings must be matched to appropriate mechanical lift by manufacturer name. QIC 1. Regular observation of the staff CNA's transferring of Residents will take place on hire and/or annually with evaluation. Unit nurses, managers, supervisors, nurse educator and therapy should perform these evaluations in room observations. 2. Transfer incidents/injuries will be reported and thoroughly investigated per policy by interdisciplinary, as needed. Education and Training of Staff 1. All current nursing staff will be in serviced to the Safe Resident Handling Policy. 2. Nursing staff to complete demonstration for each device at training evaluation and annual evaluation. 3. All new staff to complete education and training within first orientation period. 4. Therapy and/or Nursing to re-evaluate Resident's current abilities to continue with current plan of care if a noted change in condition is identified (decline or improvement). 5. All Residents requiring physical assist and/or devices will be screened quarterly. Equipment Inspection and Maintenance (continued on next page)

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	525069	A. Building B. Wing	05/01/2025

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1. Daily visual by nursing staff prior to all transfers. 2. Preventative Maintenance Program by Buildings and Grounds. 3. Monthly form inspections with documentation for each type of lift device done by Buildings and Grounds . On 4/21/25, at 7:22 AM, Surveyor reviewed the manuals for the mechanical hoyer lifts and sit to stands that the facility provided. Medline MDS400SA and MDS600-Revised 4/16/13 .Warning! -Page 5 Together with the Resident's doctor, nurse, or medical attendant, select a Medline sling that is both practical and comfortable. The sling selected should be one that serves the needs of the Resident, while providing the Resident with optimal safety. .Warning! -Page 5 Medline slings are specially designed for use on Medline Lift equipment. For optimum performance use only, Medline stand assist slings. USE OF NON-MEDLINE SLINGS IS UNSAFE AND MAY RESULT IN INJURY TO THE RESIDENT OR CAREGIVER. Warning! Do not put anything between the Resident and the sling. This may cause the Resident to slide out of the sling and cause injury. .Page 12 Maintenance Schedule Slings-Check entire sling inventory for fraying, tearing, excessive wear of any kind and replace any worn or damaged slings with Medline slings. .Page 13 Do Not Operate Lift Unless All Maintenance Points Pass Inspection Warning: -Always carry out the daily checklist before using the lift -Do not use a sling unless it is recommended for use with the lift -Always check if the sling is suitable for the particular patient and is of the correct size and capacity (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Never use a sling which is frayed or damaged -Always fit the sling according to the instructions provided -Always check the safe working load of the lift to be sure it is suitable for the weight of the patient -DO NOT use electric lifts in the shower -DO NOT charge an electric lift in a bathroom or shower room -CAUTION: Keep the batteries fully charged. Arjo Huntleigh [NAME] 300-11/2014 .Page 9 Preparation before transfer Before approaching the Resident, the caregiver shall always tell the Resident what they are going to do and have the correct size sling ready. .Using Standing Sling, and their different parts referred to in this manual Warning! An assessment must be made for each individual Resident being raised by the [NAME] 3000-by a medically qualified person-as to whether the Resident requires the lower leg straps when using the standing sling. The top of the sling can be recognized by the washing label which is placed on the outside top rim of the sling. .Pg 19 Caution:! It is recommended that equipment, accessories and slings supplied by ARJO Huntleigh are regularly cleaned and/or disinfected between each Resident use if necessary, or daily as a minimum. .Page 21 Care and Preventative Maintenance. The Arjo Huntleigh [NAME] 300 takes 2 different slings, a transfer and standing sling. .Providing the right sling for the individual patient type and need, is vital, to promote optimal safety and comfort. MAXI 500 4/2016 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2 different models in the facility, 1 takes a straight bar, 1 does not. .Page 11 Sling Selection The spreader bar that is attached to the lift determines what slings can be used to transfer a patient Slings are color coded for size by having a different color edge binding or attachment strap coloring. Invacare Roze Stand Assist Patient Lift 2017 .Pg 15 Warning! Risk of Injury of Death Improperly attached, improperly adjusted or damaged slings can cause the Resident to fall -Use Invacare approved sling that is recommended by a health care professional for the comfort and safety of the individual being lifted -Invacare slings and Resident lift accessories are specifically designed to be used in conjunction with Invacare patient lifts -After each laundering (in accordance with instructions on the sling) inspect sling(s) for wear, tears, and loose stitching. Invacare Roze Stand Assist Patient Lift 2017 .Pg 15 Warning! Risk of Injury of Death Improperly attached, improperly adjusted or damaged slings can cause the Resident to fall -Use Invacare approved sling that is recommended by a health care professional for the comfort and safety of the individual being lifted -Invacare slings and Resident lift accessories are specifically designed to be used in conjunction with Invacare patient lifts (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-After each laundering (in accordance with instructions on the sling) inspect sling(s) for wear, tears, and loose stitching. Invacare Get-U-Up 2018 .Page 7 Invacare Stand Assist and Transfer slings are specifically designed to be used in conjunction with Invacare patient lifts. Slings and accessories are designed by other manufacturers are not to be utilized as a component of Invacare's patient lift system. Use the sling that is recommended by the individual's doctor, nurse or medical assistant for the comfort and safety of the individual that is being lifted. Surveyor notes all the models specify must use their sling for safety. On 4/16/25, at 10:38 AM, Surveyor was approached by the Occupational Therapist (OT)-E who has worked at the facility for about one year. OT-E shared that OT-E felt that there were significant safety concerns in regard to the Residents who required mechanical lifts, mechanical sit to stands, or a Sara Steady. OT-E explained to Surveyor that any Resident that is a minimal assist requires a Sara Steady. A Sara Steady is for only very short transfers, for instance from bed to wheelchair. It is not meant to be pushed to the bathroom with the Resident on it. OT-E informed Surveyor that physical therapy determines the safe transfer status of a Resident. OT-E stated that an outside therapy consultant (TC)-F came in and trained the therapy department about two weeks ago. OT-E stated that the therapy department was told by TC-F that something had happened to a Resident. A Resident had been left unattended on a Sara Steady. OT-E had no further details. OT-E explained to Surveyor that each Resident has to have the right sling for the right lift. OT-E informed Surveyor the facility has a [NAME] podge of slings. Certified Nursing Assistants (CNAs) take whatever sling is available, use the same sling from Resident to Resident, wiping the sling down between Residents. OT-E spends a lot of time searching for the right sling to match the machine. No one has been trained on what sling to use. CNAs don't know what sling to use or what loop to put it on. There is no care plan of what sling to use for each Resident. OT- E has sometimes seen a single CNA transfer a resident using a mechanical lift when it should have been two-person transfer. There is a major issue of the batteries not working. Looks green like it is charged, but then can't handle the load of the Resident so it stops working with the Resident up in the air. Because of short staff, the therapy department uses the Sara Steady by themselves, but it should be two to assist. On 4/16/25, starting at 11:17 AM, Surveyor took a tour with OT-E of all six units in the facility. Surveyor observed all mechanical lifts, and all areas that stored the slings. Some mechanical lifts in the hallways with slings draped over the lifts. Storage of mechanical lifts and sit to stands, and slings was very haphazard on each unit. ParkView 1 Multiple slings. Different colors, different brands, unable to determine what sizes on most. 1 hoyer and 1 mechanical sit to stand. TerraceView 1 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2 mechanical sit to stands. 1 pump up sit to stand. Multiple different brands of slings-1 sling marked XL 650 pounds on the sit to stand. SunnyView 1 L sling marked 650 pounds on a sit to stand. On a mechanical lift a sling marked L 650 pounds was marked. ParkView 2 The end room has a wheelchair with a pile of multiple slings, multiple brands, multiple colors. OT-E stated, That's why they don't know what slings to use, that's why they use the same sling on all the Residents. TerraceView 2 3 different sit to stands in the closet, hoyer is a different brand other than maxi move from the other units. Certified Nursing Assistant (CNA)-I came into the room at this time. Surveyor interviewed CNA-I. CNA-I explained to Surveyor that CNA-I was checking on the midline sit to stand because it wasn't working in the morning. Surveyor asked if the Resident was still in bed. Surveyor notes it was about 11:10 AM. CNA-I stated, I just used another sit to stand. Per CNA-I, slings are piled up or hanging over the mechanical lift and CNA-I never knows what size to use. CNA-I informed Surveyor the mechanical lift is a Midline and the battery has not been charged and doesn't know what sling to use for that one. SunnyView 2 The shower room has 3 different mechanical lifts, 5 different slings, different brands, and colors. The netting is shredded on one sling. OT-E stated OT-E doesn't know what the colors mean. OT-E explained that 1 sling hanging is a sling from the hospital which is meant for a lift that is anchored to the ceiling. OT-E stated that if it was used on a facility lift it would act as like an accordion and fold in on the Resident. On 4/16/25, at 2:01 PM, Surveyor interviewed CNA-J about all the different slings. CNA-J stated, that you just look at the sling and decide if it fits the size of the Resident. There is no actual size to the sling, and they are not marked. On 4/16/25, at 2:20 PM, Surveyor made observations in the shower room. There were multiple different slings on hooks, multiple brands, no sizes on the slings. CNA Care Coordinator (CCC)-P came into the shower room and informed Surveyor that CCC-P was doing an audit of slings and mechanical lifts. CCC-P stated, She was doing an audit because state is here. The slings here are a waste of money. There are no actual sizes available in the shower room. Can't use any of these. Right now, there are 58 Hoyer's (sic) and 37 slings that I have counted. We have been telling the facility there is a problem for a couple of years. On 4/16/25 at the daily exit meeting with the facility, Surveyor requested a count of how many Residents require the assistance of mechanical lifts, mechanical sit to stands, and Sara Steady's. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/17/25, Surveyor notes that currently the facility states the facility has the following: 50 Residents require a mechanical hoyer lift 5 Residents require a mechanical sit to stand 9 Residents require a Sara Steady On 4/17/25, starting at 7:30 AM, Surveyor observed 3 mechanical lift transfers. On the mechanical lift, the color code read: XS burgundy Small red Medium yellow Large green LL light blue XL dark blue 1.) R83 was admitted to the facility on [DATE] with diagnoses that include Hemiplegia and Hemiparesis following Unspecified Cerebrovascular Disease Affecting Left Dominant Side (complete paralysis on one side of body and partial/incomplete weakness on one side following stroke). R83 currently has an activated Health Care Power of Attorney (HCPOA). R83's Quarterly Minimum Data Set (MDS) completed 3/11/25 documents R83's Brief Interview for Mental Status (BIMS) score to be 11, indicating R83 demonstrates moderately impaired skills for daily decision making, requiring cues and supervision. R83 has range of motion (ROM) impairment on one side. R83 is dependent assistance for dressing, mobility, and transfers. R83 requires partial/moderate assistance for eating. R83's Assistance of Daily Living (ADL) care plan initiated 12/9/24 documents R83 has impaired mobility and requires a full body mechanical lift with assist of 2. On 4/9/25, R83 weighed 149 pounds. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/17/25, at 7:30 AM, Surveyor asked CNA-L where CNA-L obtained the sling that CNA-L was using for R83. CNA-L stated CNA-L found it in the shower room. Surveyor asked CNA-L what size it was. CNA-L stated, I do believe it's a large, no its a medium. Surveyor notes CNA-L was not wearing glasses when CNA-L shared the size. Surveyor observed the sling was light blue with blue edging. CNA-L informed Surveyor the size was on the white tag. Surveyor asked CNA-L where the size was. CNA-L and Surveyor both went to look. CNA-L informed Surveyor that CNA-L can't see a thing and Surveyor observed CNA-L put CNA-L's glasses on. The tag on the sling read XL. CNA-L informed Surveyor that CNA-L likes to get a little larger sling than what the Resident is. CNA-L informed Surveyor we can use whatever sling we can find. We take what we can get. It really just matters what end we use for the sling we get. Either the loop or the clip one. It doesn't matter what size. 2.) R12 was admitted to the facility on [DATE] with diagnoses that include Chronic Congestive Heart Failure (long term condition where the heart muscle is too weak or still to pump blood efficiently), Paroxysmal Atrial Fibrillation (Irregular, rapid heart rate that causes poor blood flow), Legal Blindness (visual impairment), and Dementia(loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life). R12 currently has an activated HCPOA. R12 is currently on hospice. R12's Significant Change MDS completed 2/6/25 documents R12 has short and long term memory impairment and demonstrates severely impaired skills for daily decision making. R12 has no range of motion impairment and is dependent for eating, dressing, mobility, and transfers. R12's care plan initiated 12/5/24 documents R12 is a full body lift and extensive assist of two. On 4/9/25, R12 weighed 192 pounds. On 4/17/25, at 8:12 AM, Surveyor observed R12's transfer utilizing the same mechanical lift as R83. Surveyor observed a different sling, different brand being used on the same mechanical lift as R83. Surveyor observed the sling had green edging. The sling matched as a large per color code on the mechanical lift. Surveyor interviewed CNA-N where CNA-N obtained the sling. CNA-N informed Surveyor the sling was in R12's Broda chair already. CNA-N stated, we have a hard time finding slings. R12 is on hospice and hospice brought two slings in with R12's name on it. They must be down in laundry and waiting for them to come back up, so I used this one. 3.) R315 was admitted to the facility on [DATE] with diagnoses that include Vascular Dementia (brain damage caused by multiple strokes), and Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side (complete paralysis on one side of body and partial/incomplete weakness on one side following stroke). R315 currently has an activated HCPOA. R315's care plan initiated on 4/9/25 documents R315 is a full body lift with extensive assist of two. On 4/16/25, R315 weighed 116 pounds. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/17/25 at 8:30 AM, Surveyor observed CNA-O pull a sling out of R315's drawer. Surveyor observed a blue sling with yellow trim. Surveyor interviewed CNA-O on how CNA-O knows what sling to use. CNA-O explained to Surveyor it's a small. According to yellow on the mechanical hoyer lift, the sling would be a medium. CNA-O stated, I thought it was a small. Some slings are medium but look and fit like a small because they shrunk. I hide it in R315's drawer because I know it fits R315. Surveyor observed CNA-O use the loop of the sling and not the clip. Surveyor asked how CNA-O knew what loop to use. I use the one closer because it's just easier. R315 was transferred to a reclining Broda chair. Surveyor notes that R83, R12, and R315's sling size are not documented on their comprehensive care plans or on the CNA assignment sheet. The unit SunnyView 1 where R83, R12, and R315 reside have CNA care cards. Surveyor notes that R12 is listed on there as being a sit to stand lift. Surveyors on other units indicated there were different CNA care cards being utilized than those on the SunnyView 1.unit. On 4/17/25, at 10:54 AM, Surveyor interviewed physical therapy (PT)-H. PT-H stated that slings are not supposed to be left under the Resident. Physical Therapy establishes the transfer status of a Resident and determines what is the safest transfer for that Resident. PT-H would then update the care plan, 24 hour board, and find a staff member to tell them what the transfer status is. Surveyor asked PT-H how many brands of mechanical lifts the facility has. PT-H stated, Great question, not sure how many. Surveyor asked PT-H how many brands of mechanical sit to stands. PT-H is not sure of that as well. PT-H explained that slings for Residents should be based on weight. You have to know the weight of the Resident and grab the appropriate sling. Therapy does not care plan the size for the Resident. Once the size is found, it should stay in the Resident's room. Therapy is not responsible for putting the size in a Resident's care plan. CNA-H stated that there is a question about safety of all the different types of slings in the facility. PT-H agreed that there are multiple different mechanical lifts and sit to stands and multiple different brands of slings. That's a lot of different slings, variety, opens up the door for a lot of confusion. PT-H also explained that the loop should be closer if transferring to a sitting position, farther away if transferring to a reclining Broda chair. PT-H also stated that the batteries are not holding a charge, and therapy is not responsible for completing audits of slings in disrepair. Surveyor notes that based on PT-H's explanation of what loop to use on the sling when transferring a Resident with the mechanical lift, CNA-O should have used the loop farthest away as R315 was being transferred to the reclining Broda chair. 4.) R79 was admitted to the facility on [DATE] with diagnoses that include Lumbar Spina Bifida (birth defect where the spine doesn't close completely), Unspecified Osteoarthritis (breakdown of cartilage), and Tachycardia (rapid heartbeat). R79 is currently her own person. R79's Quarterly MDS completed 3/10/25 documents R79 BIMS score to be 12, indicating R79 demonstrates moderately impaired skills for daily decision making. R79 has ROM impairment on one side of upper and lower extremity. R79 is set up for eating, and dependent for dressing, mobility, and transfers. R79's care plan initiated 12/6/24 documents R79 is a full body mechanical lift with assist of 2. R79's sling size is not documented on R79's care plan. On 4/15/25, R79 weighed 127 pounds. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R79's most recent fall risk assessment completed 3/4/25 documents a score of 6 indicating R79 is moderate risk for falls. On 4/17/25, at 8:42 AM, OT-E pointed out to Surveyor that R79 was sitting in R79's wheelchair in the dining room and was sitting on a sling with green edging. R79 informed Surveyor that the facility always leaves the sling underneath R79. Surveyor notes that PT-H informed Surveyor that all staff had recently received a re-education to not leave any Resident sitting on a sling while up in the chair. Surveyor notes that R83 was observed in an XL sling but as of 4/18/25 has now a care plan in place for medium, R315 was observed in a medium sling, but now has a care plan in place for a small, and R79 was observed sitting on a large sling while in wheelchair, but now has a care plan in place for a medium sling. Surveyors requested a list of Residents with major injury. The facility informed Surveyors there were two Residents in the last 90 days with an incident involving a major injury. R49 and R72. 5.) R49 was admitted to the facility on [DATE] with diagnoses that include Chronic Respiratory Failure with Hypoxia (long-term condition where the lungs are unable to adequately exchange oxygen and carbon dioxide).R49 currently has an activated HCPOA. R49's Fall Risk completed 2/18/25 documents R49 is at high risk for falls. R49's Quarterly MDS completed 3/4/25 documents R49 has a BIMS score of 5, indicating R49 demonstrates severely impaired skills for daily decision making. R49's MDS documents R49 requires supervision for eating, has no ROM impairment and substantial/maximum assistance for mobility. R49 is dependent for dressing and transfers. R4's care plan documents: Initiated 11/22/24 -Potential for falls -Full body mechanical lift with assist of 2 On 3/28/25, R49's sling was left under R49, contrary to facility policy, and R49 slid off the sling from the wheelchair. The facility had not assessed the safety risks associated with leaving a sling under R49 including whether the presence of the sling could lead to an unsafe seating situation for R49 in their wheelchair. R49 was sent to the emergency room due to pain and right tenderness to R49's right shoulder. Surveyor reviewed R49's hospital paperwork dated 3/28/25. R49 suffered a fractured right humerus and a hematoma of the right upper forehead. R49 then required an immobilizer. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Surveyor reviewed R49's facility incident report. On 3/29/25, Nursing Home Administrator (NHA)-C documented that R49 was assessed and deemed to have the appropriate sling size at time of fall. There was no assessment of what factors contributed to the fall. A review of all other Residents' slings was conducted to ensure they had the correct sling size, and it was confirmed that all Residents were equipped with appropriate slings. Educations was started on 3/28/25 regarding proper techniques for safely removing lift slings from Residents while in the seated position. Ongoing training will continue until all staff members demonstrate competency in safely removing slings without requiring the Resident to lie down. On 4/3/25, R49 had a significant change MDS completed due to the right humerus fracture. R49 now has range of motion impairment on 1 side of upper extremity, now requires partial/moderate assistance with eating and is dependent for mobility. On 4/17/25, at 3:23 PM, Surveyors met with NHA-C, Director of Nursing (DON-B), CEO-A, and Director of Clinical Operations (DCO)-D. Surveyor asked NHA-C how many different mechanical lifts are used in the building. NHA-C is unsure and will have to get back to Surveyor. Surveyor asked how may mechanical sit to stands are used in the building. NHA-C is unsure and will have to get back to Surveyor. Surveyor asked how you determine what sling to use for what machine and how do you determine which sling is appropriate for each Resident. NHA-C informed Surveyor it is based on the Residents' weight. NHA-C repeated this 3 times to Surveyor that it is based on weight throughout the interview. Surveyor asked who determines the correct size and what is the process of finding the right size sling? NHA-C stated nursing would look at it and therapy completes an evaluation and then nursing, and therapy work together. Surveyor asked where the size of the sling for each Resident is documented. NHA-C was quiet and did not answer the question. I can't answer that, I'm not sure where it is located. Surveyor explained that therapy had shared that therapy did not complete an audit of sling sizes for each Resident requiring a mechanical machine for transfers. NHA-C stated that ideally each Resident should have their own size sling in a drawer in their room. Slings should be the same manufacturer for the same manufacturer lifts. 47094 6.) R72 was admitted to the facility on [DATE] and has diagnoses that include Congestive heart failure, muscle weakness, osteoporosis, adult failure to thrive, depression, and radiculopathy of the lumbar region. R72's quarterly minimum data set (MDS) dated [DATE] indicated R72 had intact cognition with a Brief Interview of Mental Status (BIMS) score of 15 and the facility assessed R75 needing moderate assistance with 1 staff member for transferring with a gait belt and 2 wheeled walker and 1 staff member repositioning. R75 used a wheelchair for long distances and R72 did not have impairments to the upper or lower extremities. (continued on next page)

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	05/01/2025

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R72's activity of daily living (ADLs) care plan was initiated on 11/19/2024. (R72) has impaired mobility related to recent falls and new atrial fibrillation (A-fib) as evidenced by decrease mobility. On 2/17/2025 R72's ADL care plan was revised with the following intervention: -Transfer: Limited assist with 1 staff member (X1) with 2 wheeled walker and gait belt, if fatigued may use sit to stand mechanical lift with assist X2. Surveyor reviewed a physical therapy (PT) discharge summary for date of service 2/17/2025 - 3/20/2025. R72's baseline was documented as . - Sara Steady transfers= unable to complete due to complaints of pain in left hip. - Unit transfers= limited assist X1 staff member with 2 wheeled walker and gait belt, if fatigued may use sit to stand mechanical lift with assist X2. On 3/21/2025, at 8:38 PM, in the progress notes nursing documented (R72) had witnessed fall. The certified nursing assistant (CNA) was trying to get (R72) up from the wheelchair for transfer. (R72) became weak when standing and the CNA lowered R72 to the floor. (R72) was lifted off the floor with a Hoyer lift. On 3/23/2025, at 8:49 PM, in the progress notes registered nurse (RN) supervisor-QQ documented (R72) had witnessed fall, noted (R72) sitting up on R72's bedroom floor with back resting against the bed. (R72) left leg slightly inverted and unable to move it without pain. sent out to hospital for further evaluation. On 3/23/2025, at 9:30 PM, in the progress notes licensed practical nurse (LPN)-OO documented (R72) was lowered to the floor during a transfer with the Sara Steady. CNA-PP with nurse-OO lowered (R72) to the floor after (R72's) left leg buckled [TRUNCATED]

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 49845 Based on interview and record review, the facility did not ensure sufficient nursing staff was provided to allow residents to maintain or attain their highest practicable physical, mental, and psychosocial well-being. This deficient practice has the potential to affect 2 of 6 units at the facility. *On 04/15/2025, staff member informed Surveyor that 4 residents, who required an assistance of 2 staff with a mechanical lift, remained in bed due to not having a second staff assistance available. *On 04/17/2025, Surveyor observed residents receiving meal trays 1.5 hours after breakfast was scheduled- due to staff being unavailable to help pass trays and/or assist residents with eating. *On 03/31/2025, The Facility's schedule documented residents were unable to be rounded on, due to staffing. Findings include: On 04/15/2025, at 12:46 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-W. Surveyor asked CNA-W how the staffing is at the Facility. CNA-W indicated horrible. Surveyor asked CNA-W to elaborate on what horrible means. CNA-W informed Surveyor that there is only CNA on TV1 (Terrace view 1), the second shift nurse doesn't help on TV1 and has expressed these concerns to DON-B and NHA-C. CNA-W indicated that CNA-W was not able to get residents up due to being alone on unit with 8 residents requiring hoyer lifts that need 2 people. CNA-W indicated CNA-W was able to get 2 residents up with hoyer's, with the help of staff from another unit, but 4 residents are not able to get up who require hoyer lifts. On, 04/17/2025, at 09:09 AM, Occupational Therapist (OT)-E requested Surveyor come to the dining room. OT-E informed Surveyor that there were not enough staff to assist passing trays and assist residents with eating in dining room on first floor. Surveyor went to the first-floor dining room and noted no aides were in the dining room. On 04/17/2025, at 09:13 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-II. LPN-II indicated this is the first day the dining room is open again and that breakfast starts at 08:15 AM. LPN-II indicated CNA's will start passing room trays from the hall cart first and then aides will come to the dining room. On 04/17/2025, at 09:41 AM, Surveyor observed 14 residents in the dining room, 2 residents being assisted with feeding. On 04/17/2025, at 09:43 AM, Surveyor observed the last resident receive a meal tray in the dining room. Surveyor noted trays were still being made and delivered to the halls for the residents who did not come to the dining room. Surveyor reviewed the Facility's Assessment and noted for staffing the following, for Nurses- AM shift- 5, PM shift -5 and night shift- 4. For CNA's AM shift- 8, PM shift- 8 and night shift- 4. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor reviewed staff schedules from February 2025 to current. Surveyor noted on 03/31/2025 during night shift, a note on the schedule documents . Help with TV2 (Terrace view 2)/ this is how it was on the schedule when writer got here; CNA was no where to be found after 23:00; did not do rounds on TV2. On 04/21/2025, at 03:28 PM, Surveyor interviewed Staff Coordinator-RR. Staff Coordinator-RR indicated that Staff Coordinator-RR does the schedule and schedules staff based on the Facility's census, but will usually schedule the following, AM and PM shift CNA's- 13 to 14, and on night shift 8 CNA's. Staff Coordinator-RR indicated AM and PM shift for Nurses is 9 and on night shift 6, not including a supervisor. Staff Coordinator-RR informed Surveyor that the Facility does utilize agency staff for nurses but not for CNA's, but when there is a call in, supervisors will send out an email to staff, supervisor or Staff Coordinator-RR will call for people to pick up. Staff Coordinator-RR indicated staff concerns, that staff get upset about call ins, especially on units with higher acuity residents and sometimes they must pull from a different unit or Staff Coordinator-RR will help. Staff Coordinator-RR indicated that unit TV1 on 4/15/2025 had to split the hall to add some residents to the workload of the 2 CNA's on unit PV1 (Parkview 1). Staff Coordinator-RR expressed that it is terrible, but the staff really try to work together to get things done. Staff Coordinator-RR was not sure who wrote the comment on the 03/31/2025 schedule. On 04/22/2025, at 10:57 AM, Surveyor interviewed DON-B regarding staffing. DON-B indicated that staffing depends on the unit, census of unit and acuity of residents on the unit. DON-B was unsure about the comment left on the 03/31/2025 schedule but would look into it. Surveyor asked DON-B about how the Facility Assessment was determined for the staffing portion, DON-B informed Surveyor that Previous NHA-C is the one who created the Facility Assessment. On 04/22/2025, at 03:26 PM, Surveyor informed the Facility regarding concerns that staff was unable to round on residents or get residents out of bed due to not having enough staff on 04/15/2025 and 03/31/2025. On 04/23 and /2025, at 03:51 PM, Surveyor spoke with Director of Clinical Operations-D regarding the Facility Assessment due to Previous NHA-C no longer being at the Facility, Director of Clinical Operations-D indicated to Surveyor to speak with Chief Clinical Officer (CEO)-A. On 04/24/2025, at 09:08 AM, Surveyor interviewed CEO-A. CEO-A indicated that CEO-A was not part of the specific conversations regarding staffing numbers in the Facility Assessment, and indicated that was discussed with leadership with minimum staffing regulations in mind and the consensus was to keep it conservative. CEO-A shared the very recent shift in NHA responsibilities in the facility and would further discuss staffing and the Facility Assessment moving forward.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49845 Based on interview and record review the facility did not ensure nursing staff had the competencies and skill sets necessary to care for resident's needs for 1 (R414) of 1 resident with a chest tube (a plastic catheter inserted between the ribs to drain air, fluid, or blood from the pleural space around the lungs, heart, or esophagus) and PICC (a long flexible tube inserted into an arm vein and threaded into a large vein near the heart) line, 20 of 20 residents that utilize ventilators and tracheostomies, and all 108 of 108 residents for general nursing competencies. *Review of 16 staff indicate they did not have competencies for providing care of a chest tube and PICC line for R33. *20 residents in facility that are on ventilators and have tracheostomies, 12 of 47 staff members reviewed had incomplete competencies for ventilator and tracheostomy care. *On the 03/11/2025 PM shift and 04/12/2025 night shift, there was no competent Registered Nurse (RN) to oversee the vent unit. *The Facility does not have an effective process to ensure all new staff and Agency staff have the necessary competencies to care for residents residing in the facility. Findings include: *General Staffing process On 04/21/2025, at 03:28 PM, Surveyor interviewed Staff Coordinator-RR regarding staff orientation and competencies. Staff Coordinator-RR indicated that the Facility uses agency nursing staff for Licensed Practical Nurses (LPN)s and RNs. Staff Coordinator-RR indicated that Agency staff will get a folder out of the education office and will sign acknowledging receipt of the contents in the folder. On 04/22/2025, at 12:13 PM, Surveyor interviewed Agency LPN-QQQ. Agency LPN-QQQ informed Surveyor that they began picking up shifts at the Facility about 3 years ago and received no orientation. Agency LPN-QQQ indicated that the staffing agency said to get to the Facility an hour early, Agency LPN-QQQ received a log in for computer, a tour, and after that Agency LPN-QQQ stated it was an ask and learn as you go process. On 04/22/2025, at 12:15 PM, Surveyor interviewed LPN-HH. LPN-HH indicated they started at the Facility last month around March 17th. LPN-HH informed Surveyor that LPN-HH is a new nurse and obtained their LPN license in January 2025. LPN-HH informed Surveyor that orientation sucked, especially for a brand-new nurse. LPN-HH indicated LPN-HH was put on floor with nurses who just got off orientation, no check off list and no training on ventilators. (continued on next page)

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	525069	A. Building B. Wing	05/01/2025

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 04/22/2025, at 12:31 PM, Surveyor interviewed Staff Development Specialist-Q. Staff Development Specialist-Q informed Surveyor that Staff Development Specialist-Q is brand new to the position and started 1 week ago. Staff Development Specialist-Q indicated that she is still working on developing and implementing a more solid process with new hires. Staff Development Specialist-Q indicated speaking with Wound Care RN-EE, who was doing the position prior, regarding Agency orientation. Staff Development Specialist-Q indicated on the first day of staff orientation, they will come in on a Tuesday, will do TB (tuberculosis) skin test, fitted for N-95 mask, verify flu shot, vaccines, and go over hand washing competency. The new staff member will then come back Thursday to have their TB test read and have Human Resources (HR) training in the morning. Thursday afternoon- will go through Electronic Health Record (HER) and sign in, with the goal to be able to sign in and get familiar prior to going on the floor. New staff will also get a tour of the whole building. Staff Development Specialist-Q indicated at the very end, they will bring the new staff to their manager and set up schedule for orientation shifts. Staff Development Specialist-Q indicated Nurses/ CNAs have orientation check lists that they get while on the floor, it is the preceptors' responsibility to ensure going over those, although Staff Development Specialist-Q has not been able to get that far in the process yet. Staff Development Specialist-Q indicated Staff Development Specialist-Q would like to set up time where new staff will do one week check ins regarding competencies. On 04/22/2025, at 12:40 PM, Surveyor interviewed Wound Care RN-EE. Wound Care RN-EE indicated that there is an orientation check list for new hires. New hires will go through the check list with whomever they are paired with and before their first shift on their own they are supposed to go through with their supervisor. It is the responsibility of new employees to bring check list with them, but the check list disappears, and this has been an issue. Wound Care RN-EE indicated the Facility has talked about how they can make it better and have now made a full-time staff development position, where responsibilities can be divided and to ensure things are going well with new staff. For Agency staff, Wound Care RN-EE indicated a packet is given to the agency staff but they do not give a check list. Agency will have a sign off sheet of basic topics included in folder and contact information for supervisors and departments. They are supposed to contact a supervisor with any questions. Wound Care RN-EE indicated Staff Development Specialist-Q will be taking on the Agency orientation process as well. Wound Care RN-EE indicated a staff member who is no longer at the Facility was doing the new staff/agency orientation, as of January 1st, 2025, a gentleman took over who did not work out and quit without notice. Staff Coordinator-RR oversees making sure competencies for Agency staff and will email confirming with Agencies on those competencies. On 04/23/2025, at 01:19 PM, Surveyor interviewed Staff Coordinator-RR who indicated Staff Coordinator-RR will reach out to the agency and the agency will send the paperwork to Staff Coordinator-RR if needed. On 04/23/2025, at 03:51 PM, Surveyor informed the Facility of the concerns regarding new staff/Agency staff orientation and ensuring competency process. *03/11/2025 PM shift and 04/12/2025 night shift, no competent Registered Nurse (RN) to oversee the vent unit. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Surveyor reviewed direct care staff schedules from March to current. Surveyor noted on the 03/11/2025 PM shift, there was no RN supervisor scheduled and no RN with competencies to oversee the ventilator unit. On 04/12/2025, night shift, Surveyor noted there was no RN supervisor scheduled and no competent RN to over see the ventilator unit from 0315 AM to 6 AM the next morning. On 04/23/2025, at 03:51 PM, Surveyor informed the Facility of the concerns regarding new staff orientation process and no competent RN for the ventilator unit on 03/11/2025 and 04/12/2025. On 04/24/2025, at 07:44 AM Director of Clinical Operations-D informed Surveyor that all competencies were given to Previous NHA-C and that Respiratory Therapist-JJJ was working with the staff to ensure competencies. On 04/24/2025, at 12:55 PM, Surveyor interviewed DON-B. DON-B indicated that if there was a code or an emergency that other nurses (LPNs) with competencies, as well as expert Respiratory Therapists would have been available to respond to the vent unit. Surveyor asked DON-B about the Facility's plan from a previous survey (cross reference event ID HUY911) regarding staffing for the vent unit which documents the following, A competent registered nurse (RN) will be available to always respond to all emergency situations for ventilator and tracheostomy residents. The RN will be available on a STAT basis to ensure a timely and comprehensive response to any resident demonstrating a potential change in condition when a competent Respiratory Therapist (RT) is assigned to the ventilator unit. In the absence of an assigned RT, a competent RN will be assigned to the ventilator unit ensuring there is no gap in competent staff on the unit. DON-B did not provide any further information. 20483 * Staff competencies to care for a resident with a chest tube and PICC line The facility assessment dated [DATE] under the section Staff Education, Training, and Competencies documents Education and competencies for all staff include dementia training upon hire and annually. Ventilator education is available to our clinical staff who are working in those areas and opportunities for education both on boarding and annually exist for the clinical staff focusing on rehabilitation. Modifications were made to our general orientation process that moved most training to an online module format. Clinical on boarding includes in-person competency skills check offs with our Staff Educator. We require all of our direct care vendors to provide competency training in abuse/neglect, infection control/BBP (blood borne pathogens)/PPE (personal protective equipment), customer service and HIPPA (Health Insurance Portability and Accountability Act) annually. Additional competencies are determined according to the amount of resident interaction required by the job role, job-specific knowledge, skills and abilities, and those needed to care for the resident population. * R414 was admitted to the facility on [DATE] at 2:27 p.m. and left AMA (against medical advice) on 3/22/25. Diagnoses includes pleural effusion (fluid accumulate between lungs & chest wall), acute respiratory distress, malignant neoplasm (cancer) of unspecified ovary, anxiety disorder, and depression. (continued on next page)

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	525069	A. Building B. Wing	05/01/2025

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The hospital assessment/plan not dated under recommendations documents (1) Pleurx placed -Drain daily -Up to 1L (liter) drainage -Bedside nurse to complete self education for patient and patient's son -Interventional Pulm (pulmonary) f/u (follow up) as outpatient. (2) Neoadjuvant therapy for metastatic ovarian cancer per Gyn/Onc (Gynecology/Oncology). R414's pre admit note dated 3/20/25, at 1:28 p.m., written by Director of Admissions/ Licensed Practical Nurse (LPN)-FF for admission diagnosis document R (right) pleural effusion. For PICC (peripherally inserted central line catheter) documents R brachial double lumen. Under notes documents R side chest tube-hospital sending back up Pleurx kit, NO chemo planned while in rehab. R414's admission note dated 3/20/25, at 4:00 p.m., written by Licensed Practical Nurse (LPN)-PPP documents Skin assessment:: Per Supervisor, BUE (bilateral upper extremity) bruising, Dressing R side. Devices/equipment (dentures, catheters, IVs (intravenous), CPAP (continuous positive airway pressure) etc):: Double lumen PICC RUE (right upper extremity), Bilateral HA (hearing aids). Bowel/Bladder continence:: Continent of bowel, Continent of bladder. Admission Transfer Status:: 1 assist. Other assessment details:: General diet, Bilateral Ovarian CA (cancer), Dressing R side s/p (status post) Pleurx. R414's nurses note dated 3/21/25, at 12:51 p.m., written by LPN-JJ documents writer called into residents room by CNA (Certified Nursing Assistant) and therapy dept. (department) to meet w/ (with) resident and son. Son demonstrated cares for chest tube drainage and site care. Writer observed site; no inflammation or drainage present. There are approx. (approximately) 4 stitches present on pt's (patients) right side (mid intercostal) bra line holding chest tune in place. Pt uses padding underneath tubing and gauze w/ tegaderm on top for protective measures. Dressing must be removed prior to draining tube into PLEUR -X drainage vacuum bottle. Writer and son remove 1L (liter) of fluids. Drainage can be held if pt experiences pain. R414's nurses note dated 3/22/25, at 2:46 p.m., written by LPN-SSS documents Res (Resident) left the building with the her son -AMA (against medical advice). Writer received report that this res was upset in regards to a drain/treatment. Day shift nurse stated to writer that she did not see any order in regards to a drain/treatment. Stated that she looked in the orders and didn't see any orders listed or charting. Writer did review orders and was reviewing DC (discharge) summary when staff nurse approached writer to state that this resident left the grounds. Res did not voice any concerns/complaints with writer before leaving. On duty RN made aware. Surveyor reviewed the facility's daily nursing schedule and noted the following: On 3/20/25 the following staff worked on R414's unit: Agency LPN-VVV, Agency LPN-QQQ, & LPN-DD worked the day shift. LPN-WWW, LPN-PPP, & LPN-DD worked the evening shift. LPN-XXX & Agency LPN-YYY worked the night shift. On 3/21/25 the following staff worked on R414's unit: Agency LPN-VVV, Agency LPN-ZZZ, LPN-JJ & LPN-HH worked the day shift. LPN-PPP & LPN-DD worked the evening shift. LPN-AAAA & LPN-XXX worked the night shift. On 3/22/25 the following staff worked on R414's unit: Agency LPN-BBBB, Agency LPN-CCCC, and LPN-DDDD worked the day shift. LPN-WWW, LPN-SSS and LPN-PPP worked the evening shift. (continued on next page)

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	525069	A. Building B. Wing	05/01/2025

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Surveyor noted the following staff were nursing supervisors while R414 resided at the Facility: Registered Nurse (RN)-X, RN Supervisor-QQ, and RN Supervisor-AA. On 4/23/25, at 12:42 p.m., Surveyor asked Director of Nursing (DON)-B for licensed staff chest tube competencies. On 4/23/25, at 3:49 p.m., during the end of the day meeting Surveyor informed DON-B and Director of Clinical Operations-D Surveyor has not received any chest tube competencies. On 4/24/25, at 8:16 a.m. Director of Clinical Operations-D informed a Surveyor this is all she could find. Surveyor was provided with the facility's policy Chest Tube, Caring for a Resident with a & inservice sign in sheet dated 4/2/25. Surveyor was not provided with any chest tube competencies and noted this inservice was provided after R414 was discharged . On 4/24/25, at approximately 9:00 a.m., Surveyor asked Director Clinical Operations-D for any PICC line competencies for licensed staff. On 4/24/25, at 10:10 a.m. Surveyor asked Director Clinical Operations-D if she has any PICC line competencies. Director of Clinical Operations-D informed Surveyor she could not find any and provided Surveyor with education provided on PICC lines on 4/2/25. Surveyor noted this education was after R414 was discharged . On 4/24/25, at 9:42 a.m. Surveyor asked Staffing Coordinator-RR if she had any chest tube or PICC line competencies for agency staff. Staffing Coordinator-RR informed Surveyor she will have to look into this. Surveyor provided Staffing Coordinator-RR with the names of agency staff who worked R414's unit from 3/20/25 to 3/22/25. On 4/24/25, at 10:52 a.m., Staffing Coordinator-RR informed Surveyor she does not have any chest tube or PICC line competency for agency staff but can call the agency and ask. On 4/24/25, at 11:27 a.m., Staffing Coordinator-RR informed Surveyor so far two of the agencies have gotten back to her and they do not do training on chest tubes or PICC lines. On 4/24/25, at 11:57 a.m. during a meeting with Chief Executive Officer (CEO)-A, DON-B, & Director Clinical Operations-D Surveyor informed staff Surveyor was not provided chest tube or PICC line competencies for licensed staff. No information was provided to Surveyor as to why these competencies were not completed. 38253 * Staff competencies to care for residents with tracheostomies and ventilator care The facility had 10 residents that had tracheostomies and 10 residents that had tracheostomies and were ventilator dependent. The facility assessment dated [DATE] under the section Staff Education, Training, and Competencies documents (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Education and competencies for all staff include dementia training upon hire and annually. Ventilator education is available to our clinical staff who are working in those areas and opportunities for education both onboarding and annually exist for the clinical staff focusing on rehabilitation. Modifications were made to our general orientation process that moved most training to an online module format. Clinical onboarding includes in-person competency skills check offs with our Staff Educator. We require all of our direct care vendors to provide competency training in abuse/neglect, infection control/BBP/PPE, customer service and HIPPA annually. Additional competencies are determined according to the amount of resident interaction required by the job role, job-specific knowledge, skills and abilities, and those needed to care for the resident population. Surveyor observed a sign posted on the window at the nurses' station on the ventilator unit: ATTENTION!!! Nurses and RTs, if you were unable to attend the mandatory competency training on 2/7 (2025) and have not received the training, you are not permitted to work on the unit until you receive the training. Please see the nurse supervisor to complete your competency. The RN Supervisor's cell phone number was posted after the statement. In an interview on 4/22/2025 at 12:13 PM, Surveyor asked Registered Nurse (RN)-AA what kind of training RN-AA went through to be competent on taking care of ventilator residents. RN-AA stated a class was offered by Respiratory Therapist (RT)-JJJ at the end of February or the beginning of March 2025; RN-AA was not sure of the date. RN-AA stated the class was a couple of hours long and included papers that RN-AA has in RN-AA's office that RN-AA still refers to when needed. Surveyor asked RN-AA if administration knew who attended the training sessions. RN-AA stated administration should have a list and there were at least six or seven sessions offered. Surveyor asked RN-AA if agency staff were included in the training. RN-AA stated yes. In an interview on 4/22/2025 at 12:24 PM, Surveyor asked RT-JJJ when and how many classes were offered to staff at the facility to provide care to residents on a ventilator. RT-JJJ stated RT-JJJ had eight classes in February, March, and April 2025 and when anyone new comes in, RT-JJJ goes over the training with the employee and the employee takes the test. Surveyor asked RT-JJJ who keeps the completed tests. RT-JJJ stated previous Nursing Home Administrator (NHA)-C was given all the materials after completion by the employee. RT-JJJ stated RT-JJJ does not keep any copies for RT-JJJ's record. RT-JJJ stated RT-JJJ had worked at the facility previously and left in 2023 but returned January 2025 per diem and then full time 4/7/2025. On 4/22/2025 at 1:21 PM, Surveyor asked previous Nursing Home Administrator (NHA)-C what staff members had been trained to work on the ventilator unit. NHA-C stated all RTs, RNs, and LPNs that work on the ventilator unit have been trained and competencies have been completed. Surveyor requested from NHA-C a list of those trained and competent staff as well as the training and competencies that had been completed for review. NHA-C provided a list of 41 facility and agency staff. The list was not in any discernable order, did not include the position the individual held, the date of the training and competencies completed. Surveyor noted there was no master list of employees and agency staff that were required to have the specialized training in ventilator residents to cross reference. NHA-C provided a stack of packets for the employees that had been trained and deemed competent to work on the ventilator unit. Surveyor received 44 packets. (continued on next page)

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	05/01/2025

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

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Surveyor reviewed the packets provided comparing them with the list of employees provided. A complete packet consisted of a Training Acknowledgement cover sheet with the employee's name, signature, and date, a Nursing Tracheostomy Exam with 23 multiple choice questions, a Ventilator Care for Nurses Post Test B with 50 multiple choice questions, and a Skills Module Checklist for tracheostomy suctioning. None of the exams or skills checklists had the employee's name or date written on them. The competent staff list had 41 facility and agency staff names. A total of 47 staff were reviewed. -1 staff member on the list did not have a packet. -4 staff members had packets that were not named on the list. -2 staff members had the Training Acknowledgement cover sheet but no other documents. -9 staff members did not have a Nursing Tracheostomy Exam. -2 staff members did not have a Nursing Tracheostomy Exam or a Skills Module Checklist. -7 staff members had Nursing Tracheostomy Exam and Ventilator Care for Nurses Post Test B photocopies. One test had been photocopied 7 times and placed in staff packets. Surveyor noted the photocopied exams to have consistent errors: Nursing Tracheostomy Exam question #2 was left unanswered, Ventilator Care for Nurses Post Test B question #4 had A and D circled, and question #5 was left unanswered. The circled answers on the multiple exams were consistent in shape and size and were easily determined to be photocopied. No names were on any of the exams or skills checklist within the packets. On 4/22/2025 at 3:10 PM at the daily exit with the facility, Surveyor asked who was responsible for ensuring staff on the ventilator unit are trained and who keeps the packets. NHA-C stated RT-JJJ creates the training packets and NHA-C keeps track of all the training packets. In an interview on 4/22/2025 at 3:39 PM, Surveyor shared with NHA-C concerns with the ventilator training packets. Surveyor shared with NHA-C the observation of not all packets included the Nursing Tracheostomy Exam. NHA-C stated after review by NHA-C and RT-JJJ, it was discovered the questions in the Nursing Tracheostomy Exam were covered in the Ventilator Care for Nurses Post Test B and it was duplicating the content, so they no longer had staff complete the Nursing Tracheostomy Exam. Surveyor reviewed and compared the content of the two exams and agreed the Ventilator Care for Nurses Post Test B was comprehensive of all the content. NHA-C stated because of that decision, the packets only need to contain the Ventilator Care for Nurses Post Test B and the skills checklist. NHA-C stated RT-JJJ gives NHA-C the completed packets and NHA-C puts them in a binder. Surveyor shared with NHA-C the concerns of incomplete packets, missing skills checklist to show competencies, missing pages of exams, not all staff were listed on the staff list provided by NHA-C as well as not all staff listed had packets, and the Nursing Tracheostomy Exam and the Ventilator Care for Nurses Post Test B for 7 staff members had been photocopied. Surveyor showed NHA-C the 7 photocopied exams and NHA-C agreed one exam had been photocopied and placed in employee packets. NHA-C stated NHA-C gets the packets but did not verify the information in the packets. NHA-C was no longer available for interview after this encounter. (continued on next page)

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	525069	A. Building B. Wing	05/01/2025

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 4/22/2025 at 4:13 PM, Surveyor asked RT-JJJ for a copy of the training packet that is provided to staff on the ventilator unit. RT-JJJ stated a new RT was starting the next shift and had a packet all ready that Surveyor could have. Surveyor noted the packet consisted of the Ventilator Care for Nurses Post Test B. The packet did not contain a Training Acknowledgement form or a skills checklist. Surveyor asked RT-JJJ who completes the skills checklist with the staff. RT-JJJ did not know what checklist Surveyor was referring to. RT-JJJ stated RT-JJJ has a Ventilator Check Off for Respiratory Therapists, which RT-JJJ provided, but does not have a checklist for nurses. In an interview on 4/23/2025 at 9:49 AM, Surveyor confirmed with RT-JJJ the Tracheostomy Exam was no longer given to staff as NHA-C had stated. RT-JJJ stated the trach exam was for Certified Nursing Assistants (CNAs) and the vent test covered both the trach and the vent. Surveyor had not heard of CNAs being trained to suction residents. Surveyor asked RT-JJJ what the process was for training ventilator staff. RT-JJJ stated if the class size was small, RT-JJJ would grade the test papers but if it was a larger class, then RT-JJJ would go over the answers at the end of the class. RT-JJJ stated RT-JJJ would not necessarily write anything on the papers, but that would also depend on class size. RT-JJJ stated then the completed packet would be given to NHA-C. RT-JJJ stated RT-JJJ used to keep a soft file of all the training and attendees, but RT-JJJ does not do that anymore. Surveyor showed RT-JJJ the competency checklist. On the checklist at the top of the form, it included DON-B and RT-JJJ's names as being the educators. RT-JJJ stated RT-JJJ had nothing to do with that paper. RT-JJJ stated DON-B used the checklist before RT-JJJ came back full time. RT-JJJ stated they are not using the checklist anymore, but RT-JJJ had nothing to do with the checklist. Surveyor showed RT-JJJ the seven copied tests. RT-JJJ agreed one test had been photocopied multiple times. RT-JJJ denied making any copies stating RT-JJJ would never do that. RT-JJJ stated RT-JJJ did not know what happened with those packets. In an interview on 4/23/2025 at 12:49 PM, Surveyor asked DON-B who did education and competencies with staff on the ventilator unit. DON-B stated DON-B did some education with nurses and observations for ventilators and tracheostomies along with RT-JJJ, but DON-B stated DON-B could not give the names of the staff that DON-B personally trained. Surveyor asked DON-B if DON-B was familiar with the skills checklist form. DON-B stated DON-B had seen the checklist for return demonstration and thought RT-JJJ had completed those checklists with staff. Surveyor shared with DON-B that RT-JJJ had never seen the checklist until Surveyor showed it to RT-JJJ earlier that day. DON-B did not know if anyone else had watched staff do a return demonstration and speculated an RT on the second shift may have completed some but was not sure. DON-B stated once the training was done, NHA-C took over all the documentation and DON-B had nothing further to do with it. DON-B stated NHA-C was very possessive of the training packets. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 4/23/2025 at 2:12 PM, Surveyor shared with Director of Clinical Operations (DCO)-D the same concerns that were shared with NHA-C the previous day. Surveyor shared with DCO-D the conversation with NHA-C the questions in the Nursing Tracheostomy Exam were covered in the Ventilator Care for Nurses Post Test B and it was duplicating the content, so they no longer had staff complete the Nursing Tracheostomy Exam. Surveyor shared with DCO-D the packets only need to contain the Ventilator Care for Nurses Post Test B and the skills checklist. Surveyor shared with DCO-D the concerns of incomplete packets, missing skills checklist to show competencies, missing pages of exams, not all staff were listed on the staff list provided by NHA-C as well as not all staff listed had packets, and the Nursing Tracheostomy Exam and the Ventilator Care for Nurses Post Test B for 7 staff members had been photocopied. Surveyor showed DCO-D the 7 photocopied exams and DCO-D agreed one exam had been photocopied and placed in employee packets. DCO-D stated every staff member had a competency for the revisit survey by the State Survey Agency on 3/10/2025. DCO-D stated everybody's full packet was there. DCO-D stated DCO-D made sure everything was complete at that time. DCO-D stated DCO-D was not sure what happened to the packets since that time. DCO-D stated the records were not kept in good order with no names or dates on the paperwork. DCO-D stated DCO-D was finding random pages from packets but with no name on them, DCO-D could not know who they belonged to. DCO-D stated DCO-D would check each employee's personnel file to see if the originals were kept there. DCO-D agreed with Surveyor that papers were just copied and stapled in no particular order to make up the packets. Surveyor shared the concern that with the packets as they were presented, it was not possible to determine which staff had been trained on the care of residents with tracheostomies and ventilators. DCO-D agreed and would be working with RT-JJJ to come up with a system to ensure there is documentation of all staff that need to be competent to work on the ventilator unit.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22692 Based on observation, record review and interviews the facility did not provide pharmaceutical services, including services that assure the accurate storage, dispensing and administering of all drugs and biological's to meet the needs of residents for 1 of 22 residents (R10) investigated for proper medication administration. *R10 did not have the correct order for her B12 injection transcribed Findings include: R10 was admitted to the facility on [DATE] with diagnoses that included Vitamin B Deficient Anemia due to Intrinsic Factor Deficiency. R10's Significant Change in Status Minimum Data Set, dated dated dated [DATE] documented a Brief Interview for Mental Status Score of 15 (fully intact long and short term memory), R10 is able to make her own care and financial decisions. On 4/22/25 at 1:30 PM R10's Vitamin B injectable medication was observed in R10's room where she stores it. The bottle documented: methylcobalamin (Vitamin B12) 20 milligrams (mg) per milliliter (ml) inject 1 ml daily (20,000 micrograms) (mcg). R10 indicated the nurses had been giving her injection daily with the medication in her room for several months. R10 indicated she obtains the medication herself as the facility pharmacy is too expensive. On 4/22/25, R10's current physician's orders were reviewed and documented: cyanocobalamin (vitamin B-12) 1,000 mcg daily with a start date of 12/18/24. On 4/22/25, R10's Medication Administration Records (MAR) from 1/1/25 to 4/21/25 were reviewed and documented: cyanocobalamin (vitamin B-12) 1,000 mcg daily was administered and signed out by a nurse daily. On 4/22/25 at 4:11 PM Registered Nurse Supervisor-AA brought in R10's corrected order for methylcobalamin 20,000 mcg injected daily. The above findings were shared with Former Nursing Home Administrator-C and Director of Nurses-B on 4/22/25 at 3:30 PM. Additional information was requested if available, None was provided as to why R10's medication order was transcribed incorrectly.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50700 Based on interview and record review, the facility did not ensure each resident's drug regimen was free from unnecessary medication for 4 (R93, R514, R8 & R72) of 6 Residents reviewed. * R93 is currently prescribed Eliquis an anticoagulant and has no documented monitoring for the side effects to the medication, such as monitoring for bleeding or bruising as directed by their care plan. * R514 is currently prescribed Eliquis an anticoagulant and has no documented monitoring for the side effects to the medication, such as monitoring for bleeding or bruising as directed by their care plan. * R8 is currently prescribed Eliquis an anticoagulant and has no documented monitoring for the side effects to the medication, such as monitoring for bleeding or bruising as directed by their care plan. * R72 is currently prescribed Eliquis an anticoagulant and has no documented monitoring for the side effects to the medication, such as monitoring for bleeding or bruising as directed by their care plan. Findings include: On 4/22/2025, at 3:17 PM, Surveyor was informed by Nursing Home Administrator (NHA)/ Chief Executive Officer (CEO)-A, that the facility does not have a policy for anticoagulation or high-risk medication. 1) R93's was admitted to the facility on [DATE] with diagnoses that includes pulmonary embolism without acute cor pulmonale, chronic obstructive pulmonary disease, repeated falls and weakness. R93's quarterly Minimum Data Set (MDS) assessment, dated 1/28/2025, documents a Brief Interview Mental Score (BIMS) of 15, which indicates R93 is cognitively intact. R93's blood thinner care plan, dated 7/12/2024, documents under the intervention section, monitor for presence or absence of active bleeding such as hematuria, petechiae, bruising, bloody stools, or nosebleeds at least daily. R93's current physician order is: Eliquis tablet 2.5 milligrams,1 tablet, orally, twice a day. On 4/17/2025, at 8:30 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-O, who indicated that the facility changed the matrix program (CNA's program used to chart resident care)and that the new program no longer indicates to staff if someone is to be monitored for side effects of medications. CNA-O stated that the facility also had older, printed packets that staff could carry with them, that would have information on them for monitoring for bleeding, but the facility took them away when the facility switched to the new program. (continued on next page)

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	525069	A. Building B. Wing	05/01/2025

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/21/2025, at 11:18 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-KKK, who stated that if a resident is on blood thinners, that something should be in place for monitoring for bleeding, if a resident is on blood thinners, then they should be getting monitored. On 4/21/2025, at 11:40 AM, Surveyor interviewed Director of admissions-FF, who stated to be the person responsible for entering physician orders, but not the person who enters monitoring for side effects to medications. Director of admissions-FF stated the unit supervisors will put in orders for monitoring if they are needed. On 4/21/2025, at 3:57 PM, Surveyor interviewed Registered Nurse (RN) Supervisor-QQ who acknowledged that residents on blood thinners don't have an order to monitor for bleeding, but that it's a good idea, and will be looking into this. Registered Nurse (RN) Supervisor-QQ indicated it is in the care plan only but not getting documented on. On 4/22/2025, at 11:59 AM, Surveyor interviewed Director of Nursing (DON)-B, who stated the facility does not have monitoring for side effects in current orders on the CNA care plan but that information on blood thinners is in R93's nursing care plan. Surveyor asked if there is any documentation that monitoring is occurring and DON-B stated no, it only needs to be in the care plan. On 4/24/2025, at 7:55 AM, Surveyor interviewed Director of Clinical Operations-D, who stated that pharmacy explained to the facility, that they don't need to monitor this drug for bleeding and that's the beauty of this drug, it just must be on the care plan. Surveyor explained the care plan is where it is documented that monitoring daily should be occurring. On 4/24/2025, at 2:30 PM, Surveyor informed NHA (CEO)-A, DON-B, and Director of clinical operations-D, of the concern that no monitoring of the side effects of anticoagulation medication is occurring for R93, even know it is in R93's care plan. No additional information received as to why R93 has no monitoring of side effects to anticoagulation medication. 2) R514 was admitted to the facility on [DATE] and has diagnoses of permanent atrial fibrillation, diverticulitis of large intestines, enterocolitis due to clostridium difficile, long-term use of anticoagulants. R514's admission, Minimum Data Set (MDS) assessment, dated 3/28/2025, had a Brief Interview Mental Score (BIMS) of 00, which indicates R514 is not cognitively intact. Under section B, the hearing, speech, and vision section, it documents a 2, which indicates that R514 sometimes is understood/understands. R514's care plan for blood thinner, dated 3/25/2025 documents, if side effects are noted, a nurse note should reflect this issue with immediate follow up notification to the physician via phone call. Monitor for presence or absence of active bleeding such as hematuria, petechiae, bruising, bloody stools, or nosebleeds at least daily, every shift: day, evening, night. R514's current order for Eliquis is: Eliquis 5 milligram tablet, take orally for blood clot prevention, twice a day. (continued on next page)

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	525069	A. Building B. Wing	05/01/2025

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/17/2025, at 8:30 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-O, who indicated that the facility changed the matrix program (CNA's program used to chart resident care). CNA-O stated that the new program no longer indicates to staff if someone is to be monitored for side effects of medication. CNA-O stated that the facility also had older, printed packets that staff could carry with them, that would have information on them for monitoring for bleeding, but the facility took them away when the facility switched to the new program. On 4/21/2025, at 11:18 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-KKK, who stated that something should be in place for monitoring for bleeding, if a resident is on blood thinners they should be getting monitored. On 4/21/2025, at 11:40 AM, Surveyor interviewed Director of admissions-FF, who stated to be the person responsible for entering physician orders, but not the person who enters monitoring for side effects to medications. Director of admissions-FF stated the unit supervisors will put in orders for monitoring if they are needed. On 4/21/2025, at 3:57 PM, Surveyor interviewed Registered Nurse (RN) Supervisor-QQ who acknowledge that residents on blood thinners don't have an order to monitor for bleeding, but that it's a good idea, and will be looking into this. Registered Nurse (RN) Supervisor-QQ indicated it is in the care plan only but not getting documented on. On 4/22/2025, at 11:59 AM, Surveyor interviewed Director of Nursing (DON)-B, who stated the facility does not have monitoring for side effects in current orders or on the cna care plan, that information is just in R93's nursing care plan. Surveyor asked if there is any documentation that monitoring is occurring and DON-B stated no, it is only in the care plan. 04/24/25 07:55 AM Surveyor interviewed Director of Clinical Operations-D, who stated that pharmacy explained to the facility, that they don't need to monitor this drug for bleeding and that's the beauty of this drug, it just must be on the care plan. Surveyor explained the care plan is where it is documented that monitoring daily should be occurring. On 4/24/2025, at 2:30 PM, Surveyor informed NHA (CEO)-A, DON-B, and Director of clinical operations-D, of the concern that no monitoring of the side effects of anticoagulation medication is occurring for R514, even know it is in R514's care plan. No additional information received as to why R514 has no monitoring of side effects to anticoagulation medication. 42037 3.) R8 was admitted to the facility on [DATE] with diagnoses including chronic embolism (A blockage in a blood vessel caused by a foreign substance, often a blood clot.) and heart disease. R8's Quarterly MDS (Minimum Data Set) Assessment with an assessment reference date of 3/18/2025 indicates R8 received an Anticoagulant medication during the assessment period. R8's medical record was reviewed including physician orders, MARs (Medication Administration Records) TARs (Treatment Administration Records) and comprehensive care plans. (continued on next page)

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	525069	A. Building B. Wing	05/01/2025

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R8's physician orders document the following: . 9/20/2021 .Eliquis Tablet (Apixaban), Give 5 mg (milligrams) by mouth every 12 hours . Surveyor noted R8 has been receiving Eliquis (an anticoagulant medication) on a scheduled basis since September 2021. Surveyor reviewed R8's comprehensive care plan. R8's comprehensive care plan with an initiation date of 10/24/2024 documents the following: (R8) is at risk for complications from blood thinning medications. List name of medication(s): Eliquis . R8's care plan interventions include the following: . Monitor for presence or absence of active bleeding such as hematuria, petechiae (tiny brown-purple spots from bleeding under the skin), bruising, bloody stools, or nose bleeds at least daily. Surveyor reviewed R8's MARs and TARs for November 2024-April 2025. Surveyor was unable to locate any medication monitoring related to R8's use of the anticoagulant medication Eliquis. On 4/23/2025 on 2:16 PM, Surveyors conducted interview with Director of Clinical Operations-D regarding expectation for side effect monitoring for a resident receiving the medication Eliquis. Director of Clinical Operations-D replied that Eliquis does not have a standard to monitor for bleeding but there should be a care plan in place for those residents that receive Eliquis. On 4/23/2025 at the daily exit meeting, Surveyors informed DON-B that Surveyor was unable to locate any medication monitoring for R8's use of Eliquis, an anticoagulant medication, in their medical record. No additional information was provided by facility at this time. 3.) R72 was admitted to the facility on [DATE] with diagnoses including acute embolism (a sudden blockage in a blood vessel caused by a foreign substance, often a blood clot) and Congestive Heart Failure (the inability of the heart to adequately pump leading to side effects such as cough and a build up of fluid in the body.) R72's Quarterly MDS (Minimum Data Set) Assessment with an assessment reference date of 2/11/2025 indicates R72 received an Anticoagulant medication during the assessment period. Surveyor reviewed R72's electronic medical record and could not locate a person-centered care plan addressing the need to monitor for adverse side effects related to the use of an anticoagulant. R72's medical record was reviewed including physician orders, MARs (Medication Administration Records) TARs (Treatment Administration Records) and comprehensive care plans. R72's physician orders document the following: . 4/9/2025 .Eliquis Tablet (Apixaban), Give 5 mg (milligrams) by mouth every 12 hours . Surveyor noted R72 has been receiving Eliquis (an anticoagulant medication) on a scheduled basis since April 2025. Surveyor reviewed R72's MARs and TARs for April 2025. Surveyor was unable to locate any medication monitoring related to R72's use of the anticoagulant medication Eliquis. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/23/2025 on 2:16 PM, Surveyors conducted interview with Director of Clinical Operations-D regarding expectation for side effect monitoring for a resident receiving the medication Eliquis. Director of Clinical Operations-D replied that Eliquis does not have standard to monitor for bleeding but there should be a care plan in place for those residents that receive Eliquis. On 4/23/2025 at the daily exit meeting, Surveyors informed DON-B that Surveyor was unable to locate any medication monitoring for R72's use of Eliquis, an anticoagulant medication, in their medical record. No additional information was provided by facility at this time.

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	05/01/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 20483 Based on observation, interview, and record review the Facility did not ensure there was a medication error rate below 5 percent. There were 3 medication errors in 35 opportunities which resulted in a medication error rate of 8.57%. Medication errors were identified for R38 & R82. * R38's Sodium Chloride was crushed. * R82 received the incorrect dosage of Vitamin D and was administered multivitamin with minerals instead of adult multivitamin Findings include: 1. On 4/17/25, at 11:06 a.m., Surveyor observed Licensed Practical Nurse (LPN)-DD prepare R38's medication which consisted of one tablet Baclofen 20 mg (milligrams), one capsule Mexiletine 150 mg, and Sodium chloride 1 gm (gram). LPN-DD opened the capsule Mexiletine 150 mg and crushed Baclofen 20 mg & Sodium Chloride 1 gm separately and then poured all three medications together in one medication cup. At 11:13 a.m. LPN-DD washed her hands and placed the appropriate PPE (personal protective equipment) on. LPN-DD flushed the G (gastrostomy) & J (jejunostomy) tube with 30 cc (cubic centimeters) of water and administered R38's medication through the G tube. On 4/21/25, at 4:02 p.m., Surveyor asked Registered Nurse (RN) Supervisor-QQ if Sodium Chloride should be crushed. RN Supervisor-QQ informed Surveyor she thinks it's suppose to be dissolved in water. This observation resulted in one medication error for R38. 50700 2.) On 4/22/2025, at 8:25 AM, Surveyor observed RN (Registered Nurse)-LL prepare R82's medication which consisted of Aspirin 81 milligrams(mg) one tablet (tab), bupropion hydrochloride 300 mg 1 tab, vitamin D 25 micrograms (mcg) 1000 units(u) 2 tabs, furosemide 20 mg 1 tab, lisinopril 20 mg 1 tab, metformin 850 mg 1 tab, amlodipine 5 mg 1 tab, omeprazole 20 mg delayed release capsule (cap) 20 mg 1 cap, senna plus 8.6-50 mg 2-tab, venlafaxine hydrochloride 150 mg 1 tab, diclofenac sodium 1%, tacrolimus 0.1%, ketotifen fumarate ophthalmic solution 5 milliliters (ml), multi-vitamin with minerals 1 tab. At 8:28 AM, Surveyor verified with RN-LL the number of pills in the medication cup. RN-LL then brought the medication cup with the medication in it to R82. At 8:55 AM, Surveyor observed RN-LL administer the medications from the medication cup to R82. (continued on next page)

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	525069	A. Building B. Wing	05/01/2025

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/22/2025, at 12:38 PM, Surveyor reviewed R82's physician orders. Surveyor noted R82's physician orders included an order dated 12/5/2024 Cholecalciferol (vitamin D) capsule, 50 mcg (2000 units), amount give 5 tabs; oral Once a day. This observation resulted in one medication error for R82. 3.) On 4/22/2025, at 8:25 AM, Surveyor observed RN (Registered Nurse)-LL prepare R82's medication which consisted of Aspirin 81 milligrams(mg) one tablet (tab), bupropion hydrochloride 300 mg 1 tab, vitamin D 25 micrograms (mcg) 1000 units(u) 2 tabs, furosemide 20 mg 1 tab, lisinopril 20 mg 1 tab, metformin 850 mg 1 tab, amlodipine 5 mg 1 tab, omeprazole 20 mg delayed release capsule (cap) 20 mg 1 cap, senna plus 8.6-50 mg 2-tab, venlafaxine hydrochloride 150 mg 1 tab, diclofenac sodium 1%, tacrolimus 0.1%, ketotifen fumarate ophthalmic solution 5 milliliter (ml), multi-vitamin with minerals 1 tab. At 8:28 AM, Surveyor verified with RN-LL the number of pills in the medication cup. RN-LL then brought the medication cup with the medication in it to R82. At 8:55 AM, Surveyor observed RN-LL administer these medications to R82. On 4/22/2025, at 12:38 PM, Surveyor reviewed R82's physician orders. Surveyor noted R82's physician orders include an order dated 12/5/2024, adult multivitamin - min - iron - FA - VIT K tablet, 18 mg iron - 400 mcg 25 mcg, amount 1 tab orally, once a day. Surveyor reviewed the bottle of multivitamin and mineral that was administered during R82's medication pass. The multivitamin and mineral vitamin is not the same as the prescribed adult multivitamin, there was no vitamin k in this multivitamin and no iron. This observation resulted in one medication error for R82. On 4/21/2025, at 3:57 PM, Surveyor informed RN Supervisor-QQ, that during Observations of medication administration for R82, that only 2,000 units of vitamin D was administered. R82's order documented to administer 5 tablets, which equals 10,000 units of vitamin D. RN Supervisor-QQ indicated that if the order says 5 tabs, then it should have been 5 tabs administered. Surveyor also informed RN Supervisor-QQ that the wrong multivitamin was administered. On 4/22/2025, at 7:54 AM, Surveyor interviewed Central Service Lead-GGGG, who stated that the nurses have both vitamin and minerals and senior tabs, there is a lot of options they just need to look for it. On 4/22/2025, at 12:03 PM, Surveyor informed director of nursing (DON)-B, of the concern with R82's observed medication administration. No additional information was received as to why R82 received 2000 units instead of the ordered dose of 10,000 units, or why the multivitamin with minerals was administered instead of the adult multivitamin.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on observation, interview, and record review, the facility did not ensure that drugs and biological's used in the facility were labeled in accordance with currently accepted professional principles and include the expiration date when applicable for 3 of 6 medication carts and 2 of 2 medication refrigerators located in the nurses station. Concerns include: * An expired Basaglar insulin pen for R22 with an open date of [DATE]. * Used Lantus Solostar insulin which was not labeled with a resident's name and an expired bottle of Humalog insulin for R42 with an open date of ,d+[DATE]. * A bottle of Extra Strength Rapid Release Tylenol 500 mg (milligrams) with the expiration date of ,d+[DATE]. * A used Semglee insulin pen for R13 that was not dated when opened and a used bottle of Lispro insulin for R13 that was not dated when opened. * Inside a plastic bag marked with R1's name is a bottle of used Lispro insulin that is not labeled with a resident's name or dated when opened. Inside R1's bag there is also a bottle of Lispro insulin for R13. R13's Lispro insulin was not dated when opened. * A used bottle of Lispro insulin for R49 that was not dated when opened. * A used bottle of Glargine insulin for R13 that was not dated when opened. * A used bottle of Novolin N insulin for R216 that was not dated when opened. * A used Levemir flextouch insulin pen that is not labeled with a resident's name or date when the pen was opened located in the TerraceView 2 medication refrigerator. * A used bottle of Lispro insulin for R48 that was not dated when opened located in the TerraceView 1 medication refrigerator. Findings include: The facility's policy titled, Subcutaneous Insulin and dated ,d+[DATE] under procedure documents 6. Date vial or device after first use. (continued on next page)

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	525069	A. Building B. Wing	05/01/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's policy titled Medication Administration General Guidelines and dated ,d+[DATE] under the section Medication Administration documents 8c. Certain products or package types such as multi-dose vials and ophthalmic drops have specified shortened end -of-use dating, once opened, to ensure medication purity and potency (Refer to Section ,d+[DATE] - Medications With Shortened Expiration Dates). When date open expiration dating is not available from the manufacturer, the following may be considered in determining facility policy: * Multi-dose vials: 28 days after open date or per manufacturer's guidelines. * Ophthalmic preparations (solutions, suspensions, ointments): discard per manufacturer's guidelines or may implement a facility specific policy for shortened expiration dates (see customizable form in 12.3 Optional P/P (policy/procedure) Templates). 1.) On [DATE], at 9:24 a.m., Surveyor observed in the 3rd drawer on the left side of the Parkview 1 medication cart an expired Basaglar insulin pen for R22 with an open date of [DATE]. 2.) On [DATE], at 9:27 a.m., Surveyor observed in the 3rd drawer on the left side of the Parkview 1 medication cart a bottle of used Lantus Solostar insulin which was not labeled with a resident's name and an expired bottle of Humalog insulin for R42 with an open date of ,d+[DATE]. On [DATE], at 9:30 a.m., Surveyor asked Licensed Practical Nurse (LPN)-JJ after an insulin bottle has been dated with the open date does she know how long can the insulin be used before it is expired. LPN-JJ replied No don't know off top of my head. Surveyor showed LPN-JJ the expired insulin. LPN-JJ informed Surveyor she will dispose the insulin. 3.) On [DATE], at 9:32 a.m., Surveyor observed in the top right drawer of the Parkview 1 medication cart a bottle of Extra Strength Rapid Release Tylenol 500 mg (milligrams) with the expiration date of ,d+[DATE]. On [DATE], at 9:33 a.m., Surveyor asked LPN-JJ who checks the medication cart for expired medication. LPN-JJ informed Surveyor the nurses are suppose to check every month and then they have them do random audits. 4.) On [DATE], at 9:55 a.m., Surveyor observed in the 3rd draw of the front half medication cart on the SunnyView 2 unit a used Semglee insulin pen for R13 that was not dated when opened and a used bottle of Lispro insulin for R13 that was not dated when opened. On [DATE], at 10:01 a.m., Surveyor asked Licensed Practical Nurse (LPN)-HH if there should be an open date after insulin has been opened. LPN-HH informed Surveyor there should be. 5.) On [DATE], at 10:02 a.m., Surveyor observed in the 3rd draw of the front half medication cart located on the SunnyView 2 unit a plastic bag marked with R1's name. Inside R1's bag is a bottle of used Lispro insulin that is not labeled with a resident's name or dated when opened. Inside R1's bag there is also a bottle of Lispro insulin for R13. R13's Lispro insulin was not dated when opened. 6.) On [DATE], at 10:07 a.m., Surveyor observed in the 3rd draw of the front half medication cart located on the SunnyView 2 unit a used bottle of Lispro insulin for R49 that was not dated when opened. (continued on next page)

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	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7.) On [DATE], at 10:09 a.m., Surveyor observed in the 3rd draw of the front half medication cart located on the SunnyView 2 unit a used bottle of Glargine insulin for R13 that was not dated when opened. On [DATE], at 10:14 a.m., Surveyor showed LPN-HH R13's Lispro insulin which is in a plastic bag labeled with R1's name. LPN-HH informed Surveyor she's going to take a picture of it as she is not usually on this medication cart. 8.) On [DATE], at 10:20 a.m., Surveyor observed in the third medication cart located on the SunnyView 2 unit in the top drawer a used bottle of Novolin N insulin for R216 that was not dated when opened. On [DATE], at 10:25 a.m., Surveyor asked Licensed Practical Nurse (LPN)-DD if insulin bottles should be dated when opened. LPN-DD informed Surveyor it should be dated. Surveyor showed LPN-DD R216's Novolin N insulin bottle that was not dated when opened. 9.) On [DATE], at 8:03 a.m., Surveyor observed in the TerraceView 2 medication refrigerator located in the nurses station. Inside the refrigerator there is a beige box with a used Levemir flextouch insulin pen that is not labeled with a resident's name or date when the pen was opened. On [DATE], at 8:04 a.m. Surveyor asked Registered Nurse (RN) Supervisor-AA when a nurse opens an insulin bottle or pen what should the nurse do. RN Supervisor-AA replied should be dated. Surveyor asked if there is a resident's name on the insulin bottle or pen. RN Supervisor-AA informed Surveyor they come from the pharmacy that way. Surveyor asked RN Supervisor-AA if anyone checks to make sure insulin is dated when opened. RN Supervisor-AA informed Surveyor the floor nurse or unit nurse. Surveyor asked when the insulin bottles or pens should be checked. RN Supervisor-AA replied I would hope they would do it on a daily basis. Surveyor showed RN Supervisor-AA the used Levemir flextouch insulin pen that was not labeled with a resident's name or date when opened. 10.) On [DATE], at 8:13 a.m., Surveyor observed in the TerraceView 1 medication refrigerator located in the nurses station a used bottle of Lispro insulin for R48 that was not dated when opened. On [DATE], at 8:20 a.m., Surveyor asked Licensed Practical Nurse (LPN)-II when an insulin bottle is opened should the bottle be dated. LPN-II replied yes. Surveyor informed LPN-II R48's Lispro insulin was not dated when opened. LPN-II replied that's weird, I'll throw it in the trash, I wouldn't use it.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51016 Based on observation, interview, and record review the facility did not ensure that food was prepared to conserve nutritive value and flavor. This has the potential to effect 95 out of 108 residents service by the facility kitchen. *The Lead Cook-VV did not follow a recipe for preparing texture and modified consistency of pureed food to ensure nutritive value and consistency. **Food on Surveyor's test tray was cold and lacked flavor. ***Resident council complained to Surveyor that food was consistently cold and lacked flavor. Findings Include: The Facility's Policy titled, Food services policy and procedure, subject: Standardized recipes effective 7/92, revised 9/21, reviewed 10/21, documents: Policy: Standardized recipes are used for the preparation of all food items to ensure consistent quality and quantity of the food. Procedure: 1. Standardized recipe books are maintained in the facility kitchen according to classification. 2. A standard recipe has the following characteristics: a, Ingredient amounts are specified. b, Method is specified, including temperature and cooking time. C, Portion size is specified. 3. Recipe yields and portion sizes. Have been established for all standardized recipes: a, 100 servings Standard acceptable yields for recipes used for general entrees, soups, starches, vegetables, and desserts. 4. Ingredients: Recipe Ingredients reflects items approved for purchase by the facility. 5. Nutritional adequacy: a, Trace Provide one serving of the meat group defined as 2 to 3 ounces of cooked meat per serving of entree. 6.m Portion instructions are specified: Portion control/count items: yield. b, Soups, sauces: ladle size. c, Vegetables: cup amount, spoon scoop or ladle size. d, Purees, scoop or ladle. e, Panned items: scoop ladle, or pan dimensions and cutting directions. The Facility's Policy titled: Food services policy and procedure, Subject: Food consistency modifications effective 2/21, revised 2/21, reviewed 3/23, documents: (continued on next page)

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	525069	A. Building B. Wing	05/01/2025

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy: To provide food consistency that meets special nutritional needs due to residents' condition, disease, injury, and or activity while maintaining each resident at their highest functional level, foods may be modified in consistency, with no additional charge to resident. Procedure: 1. consistency modifications based on the guidelines find found in the diet manual- a comprehensive nutritional care guide and are individualized by speech therapy, doctor's orders, nursing, clinical nutrition staff, and when appropriate, the resident and family. 2. Food consistency modifications are noted on doctor's order. 3. Consistency modifications cannot be upgraded without doctor's approval or under speech therapy guidance. 4. Consistency modifications may be changed for a three-day trial period by speech therapy or downgraded by nursing or clinical nutrition staff until speech can evaluate the residents. 5. Speech therapy may request a combination of consistencies or request a particular item not served to an individual. 6. Consistencies are defined in the following: a, Regular, no modification to food. b, Finger food: any food cut into pieces, slices, or strips that can be picked up with the fingers. Sandwiches are cut into quarters. Meats are cut into strips or made into sandwiches. Fresh fruit is cut into quarters. Cheese sticks, hard cooked eggs, soups and mugs, pudding in ice cream cones may be used. c, Mechanical soft: meats are ground to facilitate chewing and ease of swallowing. Soft fresh fruit is served without seeds, rinds or membranes and cut into pieces the size of canned peach slices. Bananas may be served whole. Vegetables are cooked soft. No corn, peas, potato skins, rice or dried fruit and stewed prunes. Raisin bread approved by Speech Language Pathologist (SLP). d, Puree: All meats and vegetables are pureed into smooth, firm egg custard. Consistency. Hot broth or gravy may be added to meat starches. i.e. rice, potatoes and noodles are pureed into mashed potato like consistency if a food does not puree to a smooth consistency with no lumps, membranes or seeds and appropriate substitute of equal nutritional value will be used. oatmeal approved by SLP. d, Chopped Meats: meats are chopped, ground and or cooked, soft to facilitate ease and chewing. Tender meats that can be broken apart with a plastic fork, like baked fish or meatloaf, are served whole. 7. All recipes and menu items are coated for appropriate consistencies using the current Facility computer program and are printed on Resident's tray ticket. (continued on next page)

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	525069	A. Building B. Wing	05/01/2025

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/17/25, at 10:21 AM, Surveyor interviewed Director of Dietary-SS, Lead Cook-VV and Cook-UU about observing 2 dishes prepped from beginning to service. Surveyor asked Cook-VV to observe a regular and a mechanical dish preparation. Cook-VV informed Surveyor we usually prepare the ground and puree meals the day before and then we reheat to 165 degrees Fahrenheit before servicing. Surveyor asked Cook-VV if the pureed meals were prepared individually for residents. Cook-VV informed Surveyor the facility had only 3 types of food prepared for the current resident population those diets consisted of ground, pureed, and regular. Cook-VV informed Surveyor that ground and pureed were prepared in mass for all residents receiving these diets. Director of Dietary-SS informed Surveyor that these diets were approved by the facility's speech therapy department and overseen by the dietician. Director of Dietary-SS confirmed the current resident population receives the diet's Cook-VV indicated. Cook-VV informed Surveyor the Cook-VV would show the Surveyor the meals for today's lunch and make the pureed and ground also. Cook-VV showed Surveyor his recipe for the ground crusted pork chop and the pureed crusted pork chop. On 04/17/25, at 10:33 AM, Surveyor observed Cook-VV make the pureed pork chop to serve 3 residents. Surveyor observed the prebreaded pork chop was a temperature of 172 F. coming out of the oven. Cook-VV informed Surveyor that Cook-VV cooks for 3 dining rooms and will place into steamer to make sure they are reheated to 165 per the recipe. Surveyor observer that Cook-VV didn't use the thickener as it indicates in the recipe and that Cook-VV kept adding more meat and broth. Cook-VV informed Surveyor the recipe calls for thickener, Cook-VV does not use it because of the flavor. Surveyor asked Cook-VV why the recipe is calling for specific amount's pork, chicken base, water and commercial thickener and the kitchen doesn't follow that instruction to maintain consistency. The cook informed the Surveyor that he has been doing this for [AGE] years and that the thickener is not needed and just is not flavorful for the residents. Cook-VV informed Surveyor that adding more broth and meat will achieve the consistency and flavor that Cook-VV believes is what the residents want. Surveyor asked if Cook-VV followed a national standard and which standard did Cook-VV follow. Cook-VV informed the Surveyor that Cook-VV's 20-year experience wouldn't allow the kitchen to serve anything unsafe. Surveyor asked how Cook-VV knew it was the same thickness, calories and nutritional standard each time if the recipe was not followed. Cook-VV informed the Surveyor that through [AGE] years of experience Cook-VV knows how to get it to the consistency that was needed for safe nutritional eating. Surveyor asked Cook-VV if the cooks deviated from the recipes often. Cook-VV informed Surveyor that Cook-VV tries to make things taste better for the people here. Cook-VV informed Surveyor cooks will substitute more broth or use beef broth instead of chicken broth rather than the thickener or add more meat for more flavor and proper thickness. On 04/17/25, at 10:33 AM, Surveyor interviewed Director of Dietary-SS who was watching the preparation of the pureed crusted pork chop. Surveyor asked Director of Dietary-SS what standards the recipes are based on and for a copy of the recipes Surveyor observed today. Director of Dietary-SS gave copies of the ground crusted pork and pureed crusted pork recipes. Director of Dietary-SS informed Surveyor that all recipes are from corporate and that the dietician and speech therapy staff review the recipes weekly before they are made for the residents. Director of Dietary informed Surveyor that speech therapy and dietary will make changes as needed for specific residents needs and let the kitchen staff know what the change should be. (continued on next page)

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	05/01/2025

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/21/25, at 03:03 PM, Surveyor interviewed Dietician (DT)-III about the facility's diets. Surveyor asked DT-III did DT-III provide full time dietary services to the facility. DT-III informed Surveyor that DT-III worked full time at the facility. Surveyor asked DT-III what dietary standards are followed by the facility and DT-III. DT informed Surveyor the recipe standards are from the food service company. Surveyor asked DT-III what the dieticians's role was in the nutritional aspect of the recipes and reviewing of resident meals. DT-III informed Surveyor DT-III will look at the protein and calories to make sure they are meeting the residents' nutritional needs. Surveyor asked DT-III what standards DT-III used for the residents' nutritional needs. DT-III informed Surveyor DT-III starts with a 2000 calorie diet with at least 80-90 gram of protein from the American Dietetic Association recommendations and adjusts diets from there. DT-III informed Surveyor DT-III will not go lower than the 2000 calorie diet. DT-III informed Surveyor DT-III will look at a weeks' worth of menus to make sure the nutritive, protein and calorie needs are met. DT-III informed Surveyor that DT-III meets with Dietary District Manager-TT and Director of Dietary-SS several times a month because their company provides the food service and recipes. On 04/22/25, at 08:12 AM, Surveyor interviewed Dietician (DT)-III about the facility's diets. Surveyor asked DT-III would DT-III expect the cooks to follow the recipes to ensure nutritional value and consistency. DT-III informed Surveyor that DT-III would expect the cooks to follow the recipes to make sure each resident gets the nutrition and consistency for what each resident is expected to get on their plate. Surveyor asked DT-III if the cooks didn't follow the recipe can you assure that the nutritional value of the pureed diet is what you expect. Dietician informed Surveyor that DT-III can't guarantee nutritional value or constancy without the cooks following the recipe. DT-III informed Surveyor that DT-III expects the kitchen to follow the recipes to ensure the resident gets what they are supposed to receive nutritionally and consistently according to their needs. DT-III informed Surveyor it irks DT-III when the cooks don't follow the recipe. DT-III informed the Surveyor if the cooks go off the recipes we do not know if what the residents are getting in their diet is appropriate nutrition or calories for that resident. DT-III informed Surveyor that DT-III has informed the kitchen staff they cannot change recipes without going through proper channels. DT-III informed Surveyor that DT-III told the kitchen staff in the past this is not a restaurant environment, if the cooks want to do something different, it needs to be reviewed and approved through proper channels. On 04/22/25, at 09:05 AM, Surveyor noted trays were on the unit. Surveyor was given the test tray on 04/22/25 at 09:07 AM, Surveyor sat at table and temperatures were taken right after removal from the food distribution cart on 04/22/25, at 09:08 AM. The temperature of the food was documented: eggs temperature was recorded at 90.7 degrees F, toast temperature was recorded at 81.5 degrees F, coffee temperature was recorded at 118.2 degrees F in a thermal cup with a cover. Surveyor's thermometer was calibrated on 4-21-25, at 06:00 PM. The Surveyor noted the plate was cold. Surveyor noted eggs are cold to taste and toast is very cold to taste. Surveyor noted the coffee tasted lukewarm. (continued on next page)

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	05/01/2025

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Maplewood Center	8615 W Beloit Rd West Allis, WI 53227

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/22/25, at 07:44 AM, Surveyor interviewed Speech Language Pathologist (SLP)-HHH about diets in the facility. Surveyor asked SLP-HHH if SLP-HHH oversaw and made the final decisions on the recipes and mechanical diets. SLP-HHH informed Surveyor SLP-HHH will decide on the mechanical diets especially if a resident has a change or decline. SLP-HHH informed Surveyor the facility does not use any particular dysphagia diet standard. SLP-HHH informed Surveyor the facility has 3 diets used general diet, mechanical soft and Pureed. Surveyor asked SLP-HHH what the standards are you base these diets off. SLP-HHH informed the Surveyor that is the dieticians area. SLP-HHH informed the Surveyor these diets are mechanical soft diet which has ground meat and doesn't have certain fruits; the pureed diet is blended. Surveyor asked SLP-HHH where you get the information for preparing these diets. SLP-HHH informed Surveyor after [AGE] years SLP-HHH knows some things are harder to chew and some are softer based on SLP-HHH's experience. Surveyor asked SLP-HHH would SLP-HHH expect the kitchen staff to follow the recipe regarding these types of diets. Surveyor asked SLP-HHH If the diet called for thickener to achieve the proper pureed consistency for safe swallowing would you expect the cooks to follow that recipe. SLP-HHH informed Surveyor yes SLP-HHH would expect the cooks to follow the recipe for the use of thickener for safety in the pureed diets. SLP-HHH informed Surveyor that staff should always follow the recipe for safety. On 04/22/25, at 03:10 PM Surveyor informed Director of Nursing-B Nursing Home Administrator-C and Nursing Home Administrator-A Surveyors kitchen concerns with the cold test tray, Resident complaints of cold food and cooks not following recipes. 38829 Surveyor reviewed the last six months of Resident Council Minutes prior to the Resident Council Group Meeting held on 4/16/25. On November 12, 2024, it is documented that a Resident was concerned that cold food was not kept at 40 degrees or less, and hot food was not kept at 140 degrees or warmer and was concerned about botulism. The response was that staff are being trained and educated to avoid temperatures ranging into unsafe temperatures. Also, hot plates will be used to help keep temperatures at acceptable levels. On March 11, 2025, it is documented that training is being done on the plate warmers. The plate warmers are turned on and warmed in advance of placing plates in them, the food will stay hot. On 4/16/25 at 10:10 AM, Surveyor met with Residents for the Resident Council Group Meeting. Surveyor asked the Residents if they had any food concerns. R54 was the first to answer that the food is cold and overall not good. All Residents who actively participated in the Group Meeting except for 2, informed Surveyor that the food is quite cool whether the Residents eat in their room or in the dining room. The Residents were in agreement that the plates are not hot on the bottom. The Residents expressed to Surveyor that everyone doesn't like the food. During the Resident Council Group Meeting, R54, informed Surveyor cold food has been an ongoing issue, but what are we going to do, we eat it anyway. (continued on next page)

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	525069	A. Building B. Wing	05/01/2025

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* R54 was admitted to the facility on [DATE] with diagnoses of Unilateral Primary Osteoarthritis (degenerative joint disease), Left Hip, Unspecified Diastolic Congestive Heart Failure(left ventricle stiffens and can't fill properly between heartbeats), Hypothyroidism (under active thyroid), Essential Hypertension (chronic condition of persistently high blood pressure), and Vitamin B12 Deficiency Anemia (lack of vitamin B12, essential for producing red blood cells). R54's Annual Minimum Data Set(MDS) completed 4/1/25, documents R54's Brief Interview for Mental Status (BIMS) score to be 15, indicating R54 is cognitively intact for daily decision making. * R5 was admitted to the facility on [DATE] with diagnoses of Unspecified Diastolic Congestive Heart Failure (left ventricle stiffens and can't fill properly between heartbeats), Hypothyroidism (under active thyroid), Essential Hypertension (chronic condition of persistently high blood pressure), Gout (inflammatory arthritis that causes pain and swelling in joints), Anemia (lack of blood), Unspecified Protein-Calorie Malnutrition (deficiency of both protein and energy), Chronic Kidney Disease (progressive damage and loss of function in the kidneys), Stage 4, and Depression (mood disorder that causes persistent feelings of sadness and loss of interest). R5's Quarterly Minimum Data Set(MDS) completed 3/18/25, documents R5's Brief Interview for Mental Status (BIMS) score to be 11, indicating R5 demonstrates moderately impaired skills for daily decision making. * R22 was admitted to the facility on [DATE] with diagnoses of Hemiplegia and Hemiparesis Following Cerebral Infarction (complete paralysis on one side of body and partial/incomplete weakness on one side following stroke), Type 2 Diabetes Mellitus with Hyperglycemia (adult onset of trouble controlling blood sugar with persistent elevated blood sugar levels), Iron Deficiency Anemia (blood does not have enough healthy red blood cells to carry oxygen throughout body), Chronic Kidney Disease (progressive damage and loss of function in the kidneys), and Major Depressive Disorder (persistent feelings of sadness, hopelessness, and a loss of interest or pleasure in activities). R22's Significant Change Minimum Data Set (MDS) completed 3/14/25, documents R22's Brief Interview for Mental Status (BIMS) score to be 11, indicating R22 demonstrates moderately impaired skills for daily decision making. * R9 was admitted to the facility on [DATE] with diagnoses of Cerebral Infarction (stroke), Type 2 Diabetes Mellitus (adult onset of trouble controlling blood sugar), Essential Hypertension (chronic condition of persistently high blood pressure), Adult Failure to Thrive, [NAME]-[NAME] Syndrome (at birth condition characterized by the abnormal fusion of 2 or more cervical vertebrae, resulting in short neck), Alzheimer's (progressive disease that destroys memory and other important mental functions), Unspecified Dementia (loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life), and Depression (mood disorder that causes persistent feelings of sadness and loss of interest). R9's Admission Minimum Data Set (MDS) completed 3/19/25, documents R9's Brief Interview for Mental Status (BIMS) score to be 3, indicating R9 demonstrates severely impaired skills for daily decision making. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/21/25, at 3:21 PM, Surveyor shared the concern of cold food with Nursing Home Administrator (NHA)-C, Director of Nursing (DON)-B, Chief Executive Officer (CEO)-A, and Director of Clinical Operations (DOC)-D. At this time, no further information has been provided by the facility. 20483 * On 4/15/25, at 10:53 a.m., during the screening process Surveyor asked R23 how the food is at the facility. R23 informed Surveyor it is blah and barely warm. Surveyor asked R23 if she has ever asked staff to heat up her food. R23 replied no I haven't but my neighbor lady has. * On 4/15/25, at 1:21 p.m., during the screening process Surveyor asked R33 if there is anything she is not happy with. R33 replied I think the food sucks. They put hot food on a cold plate and expect it to stay hot. The poor CNAs (Certified Nursing Assistants) are running around sticking food in microwaves to heat it up which isn't their job.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51016 Based on observation and interview, the facility failed to store and serve food in accordance with professional standards for food service safety for 95 of 108 residents that receive food from the kitchen. * In the facility's main kitchen, observations of partially used and undated food were made in the dry storage and walk-in freezers/coolers. Several food items were observed in the facility's dry storage uncovered open to air and undated. * Inadequate hand hygiene was observed by multiple kitchen staff working in the main kitchen area. * Contaminated utensils were placed back into food ready to be served to residents. Findings include: Facility policy titled; Food Services: Food and Supply Storage Effective ,d+[DATE] Revised ,d+[DATE] Reviewed ,d+[DATE] Policy: All food, non-food items, and supplies used in food preparation shall be stored in such a manner as to maintain the wholesomeness of the food for human consumption. To ensure food and supplies are stored according to facility, state and federal guidelines Procedures: Dry Storage: 4. Date indicating month, date and year. Rotate stock to ensure shelf life, use first in, first out method for storing food. 5. Remove any expired items from storage. 6. Maintain designated area for items that are damaged (such as dented cans) that are to be returned for credit. 7. Store bulk items in NSF approved containers that have tight fitting lids. Label both the bin and the lid. (scoops are not stored in the bin) 8. Use plastic bags that are NSF (national sanitization standard for food equipment) approved for food storage. Do not use garbage can liners Refrigerated Storage: (continued on next page)

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	525069	A. Building B. Wing	05/01/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Labeling, dating, and monitoring refrigerated food, including but not limited to leftovers, so it is used by its use-by date, or frozen (where applicable) or discarded. 8. Refrigerated, ready to eat, potentially hazardous food, prepared and held more than 24 hours. Must be marked with the date of preparation or used by date. Must be discarded if not consumed within 5 calendar days from the date of preparation. A container of refrigerated, ready to eat, potentially hazardous food prepared and packaged by a food processing plant must be marked to indicate the date by which the food must be consumed. Or it must be consumed or discarded within 5 calendar days after the original package is opened. 9. Leftovers cover label, date and store above raw foods. Store cooked meat above raw meat. Facility policy titled; Food Services: Hand Washing and Glove Usage Effective ,d+[DATE] Revised , d+[DATE] Reviewed ,d+[DATE] Policy: To ensure all Food Services employees properly wash their hands. Handwashing is the single most important procedure in ensuring food safety and preventing food-borne illness. Proper hand washing can be the most effective action food service workers can take to control contamination of food, utensils, and equipment. Procedure: Food handler must wash their hands after the following activities: 1. When employees begin their work shift. 2. After using the restroom. 3. During food preparation, as often as necessary to remove soil and prevent cross contamination when changing tasks. 4. When switching between working with raw food and ready to eat food, 5. After touching hair, face, or body. 6. After sneezing, coughing, or using a handkerchief or tissue. 7. After smoking eating or drinking. 8. After using any cleaning, polishing or sanitizing chemical. 9. After taking out the garbage. 10. After handling soiled utensils, dishes, glasses, and equipment. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11. Before receiving clean dished from the dish machine. 12. After touching clothing or apron. 13. After touching anything that may contaminate hands. 14. Before putting on gloves to initiate a task that involves working with food and removing gloves. Proper handwashing procedure: 1. Use the sinks designated for hand washing. 2. Turn on water and adjust the temperature so that it is warm. 3. Wet hands and wrists with warm running water holding them downward over the sink so that the water runs toward the fingertips. 4. Apply enough soap to cover all hand surfaces. 5. Scrub each hand with the other creating as much friction as possible. The more vigorously you rub the more microorganisms you remove. 6. Wash the front and back of your hands, in between your fingers, and under your nails. 7. Continue to wash hands for 20 seconds. 8. Dry hands completely using a single-use disposable paper towel and dispose of used paper towel. 9. Turn off water, using another dry towel to cover faucet handle Bare hand contact with ready to eat foods is prohibited Contamination of hands from unclean surfaces is the leading causes of the spread of bacteria that leads to human illnesses. Avoiding bare hand contact with any foods, ready to eat or otherwise that will be immediately consumed is one way to protect food from contamination. Strict handwashing practices are absolutely critical in all food operations. After proper handwashing, use the following items to minimize bare when handling ready to eat food to prevent cross contamination such as deli tissue, spatulas, tongs, single use gloves, forks or dispensing equipment. Ready to eat food is a food that is edible without additional preparation washing, cooking, etc. and is expected to be consumed in that form. Examples of ready to eat food: 1. Toast 2. Sandwiches (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Raw fruits and vegetables 4. Salads 5. Lunch meat and cheeses 6. Cooked foods 7. Bakery items 8. Toppings 9. Sugar, spices and seasonings CDC (Center for Disease Control) document titled; clean hands dated February 16, 2024 Washing your hands is easy, and it's one of the most effective ways to prevent the spread of germs. Follow these five steps every time. Wet your hands with clean, running water (warm or cold), turn off the tap, and apply soap. Lather your hands by rubbing them together with the soap. Lather the backs of your hands, between your fingers, and under your nails. Scrub your hands for at least 20 seconds. Need a timer? Hum the Happy Birthday song from beginning to end twice. Rinse your hands well under clean, running water. Dry your hands using a clean towel or an air dryer, Facility policy titled; Food Handling Guidelines Effective ,d+[DATE] Revised ,d+[DATE] Reviewed ,d+[DATE] Policy: To ensure all food items intended for consumption at the facility are received, stored and prepared in accordance with safe food handling guidelines as outlined by state and federal food codes and Servsafe guidelines Procedures: Cross contamination precautions: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Food shall be protected against cross contamination by: Appropriately separating types of raw animal products such as beef, fish, lamb, pork, and poultry during storage and processing with the use of separate equipment or areas or by scheduling and cleaning: and appropriately separating raw potentially hazardous foods from ready to eat products during storage, preparation and/or service. Boards and other food contact surfaces are sanitized and cleaned between different food preparation steps. Deferent boards are used raw animal meats and non-animal foods. 1 Hand should be scrubbed following hand washing policy, i.e. after toilet use, between food preparation tasks etcetera. 2 Clean and sanitize work surfaces, including cutting boards and food contacting equipment, example food processors, blenders, preparation tables, knife blades, utensils, bowls, sink can openers and slicer's etcetera between uses and consistent with applicable code. 3 Use clean, sanitized equipment when switching from 1 raw animal product to another . 6 Sanitize cutting boards after each use. 7 Between uses, store towels/cloths used for wiping surfaces during the kitchen's daily operation In containers filled with sanitizing solutions at the appropriate concentration per manufacturers specifications. Assure that these sanitizing solutions are safe and do not have a risk chemical contamination when preparing foods. Periodically testing the sanitizing solutions helps assure that it the correct concentration . Prevention of food infection: 1 Follow proper handwashing Contaminated equipment-Equipment can become contaminate in various ways including but not limited to: a) Poor personal hygiene. b) Improper sanitation . Food Storage Observations: On [DATE], at 10:34 AM, Surveyor observed in the kitchen food storage areas: Dry storage observations: Open bag of Sweetened coconut not dated. Open bag of graham cracker crumbs with hole in bag undated. 2 bags of [NAME] noodles opened not sealed or dated. 1 Bag of Cortona noodles opened sealed with saran wrap and not dated. A Box of gelatin mixes that do not have received on dates or open dates. An unmarked box with 5 individual packages of undated graham crackers that should come in larger labeled graham cracker box. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A badly dented condensed milk can on the shelf with undented cans of condensed milk. Walk-in cooler observations: A container of chicken base and a container of ham base opened with no open or use by date. A partially used Jar of Grey Poupon mustard with a came in on date that reads only ,d+[DATE] with no open or use by date. Line tray cooler observations: A box of cups on floor. On [DATE], at 07:30 AM, Surveyor observed the kitchen food storage areas. Dray storage observations: Open loosely rolled bag of graham cracker crumbs with hole in bag. 2 loosely rolled bags of [NAME] noodles opened not sealed or dated. On [DATE], at 10:16 AM Surveyor observed the kitchen food storage areas. Dry storage observations: Completely open to air bag of graham cracker crumbs with hole in bag undated. 2 completely open to air bags of [NAME] noodles opened not sealed or dated. Bags completely open to the air. All other items observed by Surveyor on [DATE] had been removed or corrected. On [DATE], at 10:20 AM, Surveyor interviewed Director of Dietary-SS about food storage policies. Surveyor asked Director of Dietary-SS what the facility's expectation are after opening food products. Director of Dietary-SS informed Surveyor the products should be dated when opened and a use by date placed and then sealed tight. Surveyor informed Director of Dietary-SS that several undated items, a dented can, and cups on the floor had been removed after the Surveyors first observation. Director of Dietary-SS informed Surveyor that they had rectified those items after the Surveyor went through the first day. Surveyor asked the Director of Dietary-SS about the open bags of graham cracker crumbs and noodles that look recently used. Director of Dietary-SS informed the Surveyor those bags are not even closed. Director of Dietary-SS informed Surveyor education would be done immediately, and this was not the facility's food storage practice. Inadequate hand hygiene observations: On [DATE], at 11:21 AM, Surveyor observed Assistant Director of Dietary (ADD)-EEE taking temperatures on the food service line. Surveyor observed Cook-UU come over to tray line with a clip board and pen to start writing down temperatures with Assistant Director of Dietary (ADD)-EEE. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE], at 11:31 AM, Surveyor observed the thermometer was dropped into the Soup by ADD-EEE. Surveyor observed Cook-UU put down the un-sanitized clip board and pen on the clean food service tray line table and walk over to retrieve a clean utensil to fish out the thermometer from the soup. Surveyor observed Cook-UU fish out the thermometer with the clean utensil. Surveyor observed Cook-UU place utensil on clean tray line service table. Director of Dietary (DOD)-SS came over and instructed Cook-UU not to use that soup because it was now contaminated. Surveyor observed DOD-SS drop a pen on the floor and Cook-UU picked the pen up and handed it back to DOD-SS. Surveyor then observed Cook-UU get a can of soup and open the soup can and place it in a pot to heat the soup up. Surveyor did not observe Cook-UU wash Cook-UU's hands as per facility policy after touching unclean surfaces and changing kitchen stations. Surveyor observed Cook-UU Walk over to wipe down the puree station food particles from the cooked ground pork earlier with a cloth and bare hands and then go back to taking foods in the oven without hand hygiene which is facility policy after touching unclean surfaces and changing kitchen stations. On [DATE], at 11:12 AM, Surveyor observed Cook-WW checking temperatures of the meatloaf in the oven. Surveyor observed Cook-WW rinsed and clean temp gage under water and clean with sanitizing wipes. Surveyor observed that Cook-WW was ungloved during the process and did not wash hands before grabbing a clean wash towel from a drawer and a clean bucket getting water from the prep sink for warming mashed potatoes then placed hands in armpit. Surveyor did not observe Cook-WW and did not wash hands throughout the process. On [DATE], at 11:22 Am, Surveyor observed Dietary Aide (DA)-XX move carts around, getting utensils ready and then touched ear buds then started to dish up food on the service line with washing hands. DOD-SS came over and mentions it to DA-XX. DA-XX washed hands after DOD-SS told DA-XX to wash DA-XX's hands. Surveyor observed DA-XX place hands under water quickly and then dried with towel while Surveyor noted time. DA-XX washed hands for approximately 5 sec seconds. On [DATE], at 11:35 AM Surveyor observed Dietary Aide (DA)-CCC leaning with elbows on the plate holders with DA-CCC's elbows on the plate holder on the clean train line service table while playing with the plate holder and plate holder covers while waiting to start meal service which is against facility policy to touch sanitized serving utensils-plate holders on which food to be served to resident's will be placed on the clean service tray line. Surveyor observed DA-CCC had then started looking at DA-CCC phone and DA-CCC placed DA-CCC's phone in DA-CCC's back pocket. Surveyor observed DA-CCC place hands back on the tray warming holders without washing hands per facility policy after touching unclean areas. On [DATE], at 11:39 AM, Surveyor observed DA-CCC grab DA-CCC's hair net and placed hands back on plate holders tapping plate holders on clean tray line service table with ungloved hands. DA-CC failed wash hands per facility policy after touching unclean areas. On [DATE], at 11:37 AM, Surveyor observed Dietary Aide (DA)-XX on tray service line waiting to start meal service for the residents. Surveyor observed DA-XX placed hands-on DA-XX's hip and while leaning against the dish warmer and rubbing DA-XX's lower back. DA-CC failed to wash hands per facility policy after touching unclean areas. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE], at 11:38 AM, Surveyor observed Dietary Aid (DA)-DDD moved from meal service tray line area and left the kitchen. Surveyor observed DA-DDD washed hands on reentry to kitchen. Surveyor observed DA-DDD's handwashing process with watch timer. DA-DDD handwashing took 5 seconds which is not consistent with standards of practice for handwashing. On [DATE], at 11:42 AM, Surveyor observed meal service from the tray line. DA-CCC started removing the saran wrap and grabbing utensils and dishing up food on the tray line. DA-CCC started placing food on the plate holders and covering the plated food with the covers DA-CCC was previously leaning on. Surveyor observed DA-CCC leaning on tray line reaching on the top shelf. Surveyor observed DA-CCC's shirt top on ladle and DA-CCC placed the ladle back into the food container to dish up contents for a resident's plate. Surveyor Informed the DOD-SS that DA-CCC placed an unclean utensil back into pureed burger and was dishing up plates of food and covering the plates with plate covers that DA-CCC was leaning on and touching with DA-CCC's bear hands. Surveyor observed DOD-SS stop service of the food that had been touched by DA-CCC. Surveyor observed DOD-SS remove all the items in questions from the meal service tray line. Surveyor asked DOD-CCC if it was facility policy to use kitchen utensils and plate holders and covers after staff touch them with bare hands or leaned on the items then serve the residents using these unclean utensils. DOD-SS informed Surveyor it was not policy to use unclean utensils during meal service and that service should be stopped before a resident received a tray potentially contaminated by these items. On [DATE], at 11:52 AM, Surveyor interviewed DOD-SS about the kitchen expectations for handwashing. Surveyor asked DOD-SS what DOD-SS's expectations for staff washing their hands in the kitchen. DOD-SS informed Surveyor the DOD-SS expected staff to wash hands for 20 seconds per facility policy. DOD-SS informed Surveyor that DOD-SS expected staff to wash their hands after each station change and after touching unclean surfaces. Surveyor informed DOD-SS that DOD-SS's people were washing hands for less than 5 seconds and that staff were moving from station to station with no hand washing in between. Surveyor informed DOD-SS that staff were touching items such as ear buds, phones, hairnets, and other unclean surfaces then touching clean areas on the meal service tray line without proper handwashing. DOD-SS informed Surveyor DOD-SS was aware handwashing was to be take at least 20 seconds per their facility policy and that staff was to wash hands between stations in the kitchen per their facility policy. DOD-SS informed Surveyor that DOD-SS had already started handwashing education for staff because of situations DOD-SS had observed. On [DATE], at 10:30 AM, Surveyor informed Nursing Home Administrator (NHA)-C Surveyor's concerns with the 3 bags of open and undated bulk products Surveyor observed on [DATE],[DATE] and [DATE]. Surveyor informed NHA-C of Surveyor's observations of undated already partially used products on [DATE]. NHA-C informed Surveyor that undated open food containers are a problem, and the facility will fix this right away. Surveyor informed NHA-C that cooks did not follow the recipe for a pureed meal and that cooks informed Surveyor they have adjusted recipes based on flavor in the past. NHA-C informed Surveyor cooks should have followed the recipe and cannot change recipes without prior approval from the dietician or speech therapy. (continued on next page)

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	525069	A. Building B. Wing	05/01/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE], at 11:58 AM, Surveyor informed DOD-SS and NHA-C Surveyor went to kitchen to watch the tray line during meal service to residents. Surveyor informed NHA-C about concerns with staff handwashing times being less than 5 seconds and staff moving from station to station without handwashing. Surveyor informed NHA-C concerns with observations noted above and that Surveyor shared these concerns with DOD-SS. Surveyor informed NHA-C that DOD-SS had to intervene when a thermometer was dropped into the soup to make sure the soup was not served. DOD-SS informed NHA-C that DOD-SS had observed some of these concerns and started handwashing education with all kitchen staff. NHA-C informed Surveyor that hand washing should be at least 20 seconds and that staff moving from one kitchen station to another station should wash their hands. NHA-C informed Surveyor expectation of the facility was staff should wash their hands after touching their faces and other dirty areas before returning to the tray line for meal service. DOD-SS informed NHA-C that these concerns brought up by the Surveyor were corrected and handwashing was especially a concern that DOD-SS addressed immediately.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47094 Based on interview and record review, the facility did not ensure the Hospice communication process was followed for 1 (R41) of 2 residents reviewed for Hospice services. The facility did not ensure Hospice required documentation was maintained in R41's medical record. The facility did not have a communication process in place between the facility and Hospice. Findings include: Surveyor reviewed the Signed contract between the facility and Hospice dated 12/12/2018. The following is documented: - . 2.1.5 Medical Records Documents (Page 5)- (Hospice) shall retain responsibility for ensuring that applicable requirements related to hospice medical records are met. Facility shall allow (Hospice) to access to appropriate medical records and permit the inclusion of (Hospice) care plans and other appropriate documentation in the Hospice Patient's Facility medical record. (Hospice) shall coordinate with the facility to ensure documentation of services is completed . - 3.2 Clinical Records (Page 16)- The parties will each maintain and subject to applicable laws, rules, and regulations governing the confidentiality of medical records, make available to each other for inspection and copying, detailed clinical records concerning each Residential Hospice Patient in accordance with applicable laws, rules, and regulations and Medicare and Medicaid guidelines. The parties will each permit the other and its representative(s) reasonable access to those records for 5 years from each Residential Hospice Patient's date of discharge. - 3.3 Communication (Page 16)- The parties will communicate pertinent information with each other either verbally or in the Residential Hospice Patient's record at least weekly and/or at each hospice patient visit to ensure that the needs of each Residential Hospice Patient are addressed and met 24 hours a day. Documentation of such communication shall be included in the Residential Hospice Patients' medical record. R41 was admitted to the facility on [DATE] and has diagnoses that include cerebrovascular disease, vascular dementia, schizoaffective disorder, mild cognitive impairment, and weakness. R41's quarterly minimum data set (MDS) dated [DATE] indicated R41 had severely impaired cognition with a Brief Interview of Mental Status (BIMS) score of 3 and the facility assessed R41 needing total assist with 1 staff member for all activities of daily livings (ADLs). R41 was admitted on to Hospice on 9/8/2022 with diagnoses of cerebrovascular disease and vascular dementia. On 4/17/2025 at 9:37 AM Surveyor reviewed R41's Hospice binder that was located in the nurse's station. Surveyor noted there were no progress notes from Hospice. Surveyor reviewed the visit logs and noted the hospice aide signed in on 4/16/2025, and the hospice registered nurse (RN) last signed in on 4/8/2025. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/17/2025 at 9:37 AM, Surveyor interviewed RN-LL who stated was not sure where hospice notes/ communication is kept for R41. RN-LL stated that hospice nurses speak with facility staff before or after seeing the hospice residents, if there are new orders a copy is obtained for the record. Surveyor asked what is documented when hospice visits R41. RN-LL stated that RN-LL does not typically chart on R41 unless there are concerns or new orders for R41 from hospice, otherwise nothing is charted. Surveyor asked if hospice notes are obtained to put into the resident's hospice binder or medical record. RN-LL stated not sure how hospice noted are kept or if someone takes care of that. RN-LL stated RN-LL does not obtain notes for R41 from hospice to put in the binder or for R41's medical record. Surveyor reviewed R41's medical record. Surveyor was unable to locate hospice progress notes/ documentation in R41's medical records. On 4/17/20205, at 3:35 PM, Surveyor requested to see Hospice progress/ communication notes for R41. Surveyor did not receive hospice progress/ communication notes for R41. On 4/21/2025 at 9:26 AM, Surveyor asked previous nursing home administrator (NHA)-C what staff collects documentation from hospice related to R41. NHA-C stated that the director of nursing (DON)-B, and supervisors connect with Hospice for residents. NHA-C also stated that social work may have a role in communicating with hospice as well. On 4/21/2025, at 11:00 AM, Surveyor interviewed social worker (SW)-MM who stated nursing does more direct care, nurse to nurse communications. SW-MM was not sure who was in charge of making sure progress/communication notes from hospice were available for R41's medical record. SW-MM usually communicates with the hospice social workers to get the hospice process rolling/ initiated and then will call and notify of any care conferences or other concerns that way. On 4/21/2025, at 3:40 PM, Surveyor interviewed RN supervisor (RN sup)-QQ who stated nursing staff will usually receive the notes from the hospice nurse and copy them for R41's medical record. RN sup-QQ stated sometimes the hospice nurse will fax the notes if they are not able to finish the notes while at the facility. Surveyor asked who is in charge of making sure the hospice notes are collected on a routine basis for R41's medical record. RN sup-QQ stated that medical records collects the documents and scans them into the residents medical record On 4/22/2025, at 9:09 AM, Surveyor received a hospice comprehensive assessment dated [DATE] for R41. Surveyor asked NHA-C if there were anymore hospice notes for R41 and requested to view the last 6 months of hospice notes for R41. NHA-C stated NHA-C will look. On 4/22/2025, at 9:35 AM, Surveyor interviewed medical records clerk (MRC)-NN who stated hospice will typically leave paperwork in the resident's hospice binder or fax documents to the facility, nursing will make a copy and put in a box for medical records to collect and scan into the resident's medical record. MRC-NN stated that hospice does not fax routinely, every once in awhile hospice will fax a bunch of documents and the facility goes through it. MRC-NN stated that typically the hospice nurse will only leave orders. (continued on next page)

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	525069	A. Building B. Wing	05/01/2025

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/22/2025, at 10:06 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-II who stated that hospice will notify nursing staff if there is a medication change or if they have questions. LPN-II stated that hospice will provide a copy of the medication order and then nursing will put in the basket for medical records. LPN-II stated that the hospice nurse will give a report to nursing staff and if there are concerns nursing staff will document in the progress notes, otherwise nursing typically does not write progress notes when hospice visits the residents. LPN-II stated that R41 is pretty stable so typically does not have anything to document on. Surveyor asked LPN-II where staff look to see what hospice documented during their visit incase nursing had to go back a review the hospice notes. LPN-II was not sure where to look if the documents were not in the resident's medical chart or hospice binder. On 4/22/2025, at 11:45 PM, Surveyor interviewed DON-B who stated hospice will usually give a verbal report to the nurse on duty and the nurse documents in the progress notes. DON-B also stated that sometimes hospice provides notes to put in the hospice binders in the units but that does not always happen. Surveyor asked when nursing staff is supposed to document in progress notes. DON-B stated that when hospice visits a resident on hospice it will be documented in the progress notes. Surveyor shared concern with DON-B that hospice progress/ communication notes are not readily available in R41's medical record and there are no progress notes in R41's hospice binder. Surveyor also shared with DON-B that nursing states documenting in progress notes if there is a change or concern with R41 and not for every hospice visit. On 4/22/2025, at 12:15 PM, Surveyor reviewed R41's progress notes and noted that nursing did not chart when hospice nurse or aide visited with R41. On 4/22/2025, at 3:01 PM, DON-B notified Surveyor that the hospice RN stated that because R41 has been stable, there has been no care plan updates or new orders for R41 in the last 3 months that hospice RN would normally not provide the hospice notes to the facility because hospice notes are typically 6 pages long. Surveyor informed DON-B that hospice records, progress notes need to be accessible to nursing staff and in part of R41;s medical record regardless of how long the documentation was. The facility needs to be able to access those documents as stated in the Facility/ Hospice contract. Surveyor also suggested a point person to make sure R41 and other residents on hospice had all the necessary documentation available in the medical record on a consistent basis for better continuity of care between the facility and Hospice. No further information was provided at this time.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51016 Based on observations, interviews, and record review, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 (R614, and R83) of 3 residents observed. * R614 was not placed in Enhanced Barrier precautions with a foley catheter and a Physician's order for R614 to be in Enhanced Barrier precautions until Surveyor brought it to the facility's attention. *R83 has been placed in Enhanced Barrier Precautions (EBP) and staff did not put a gown on when assisting with cares. Finding Include: The Facilities Policy titled, Infection Control policy and procedure. Subject: enhanced barrier precautions. Effective 6-20. Revised Reviewed 11-24. Documents: Policy: To prevent the spread of infection within the facility through the use of enhanced barrier precautions with residents when appropriate. Background: Residents in nursing homes are at increased risk of becoming colonized and developing infections with multi drug resistant organisms (MDRO). More than 50% of nursing home residents may be colonized with an MDRO, nursing homes have been the setting for MDRO outbreaks and when these MDRO's result in resident infections limited treatment options are available. Implementation of contact precautions is perceived to create challenges for nursing homes trying to balance the use of PPE and room restriction to prevent MDRO transmission with residents' quality of life. Focusing only on residents with active infection fails to address the continued risk of transmission from residents with MDRO colonization who by definition have no symptoms of illness. MDRO colonization may persist for long periods of time, example months, which contributes to the silent spread of MDRO's with the need for an effective response to the detection of serious antibiotic-resistant threats. There is growing evidence that the traditional implementation of contract precautions in nursing homes is not implementable for most residents for prevention of MDRO transmission (continued on next page)

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	525069	A. Building B. Wing	05/01/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procedure: Enhanced Barrier Precautions (EBP): Expand the use of PPE and refer to the use of gown and gloves during high contact resident care activities that provide opportunities for transfers of MDRO's to staff hands and clothing. MDRO's may be indirectly transferred from resident to resident during these high contact care activities, Nursing home residents with wounds and indwelling medical devices are especially high risk of both acquisition of and colonization with MDRO's. The use of gown and gloves for high contact resident care activities is indicated when contact precautions do not otherwise apply for nursing home residents with wounds and or indwelling medical devices, regardless of MDRO colonization as well as for residents with MDRO infection or Colonization. Infection prevention or delegate shall identify resident risk factors according to CDC (Centers for Disease Control and Prevention) guidelines and or local health department directives. These residents will be placed in enhanced barrier precautions, which includes maintaining a list of all residents on precautions and placing clear signage on the resident door. Example of high contact resident care activities require gown and glove use for enhanced barrier precautions include dressing, bathing, showering, transferring, providing hygiene, changing linens, changing briefs, or assisting for toileting, device care or use central line, urinary catheter, feeding tubes, tracheostomy ventilator. In general, gown and gloves would not be required for resident care activities other than those listed above unless otherwise necessary for adherence to standard precautions. Residents are not restricted to their rooms or limited from participation in Group activities. Because enhanced barrier precautions do not impose the same activity in room placement restrictions as contact precautions. They are intended to be in place for the duration of a resident stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk. Enhanced barrier precautions: All residents with any of the following infection or colonization with an MDRO when contact Precautions do not otherwise apply. Wounds and or indwelling medical devices (example central line urinary catheter feeding tube, tracheostomy ventilator regardless of MDRO colonization status). Personal Protective Equipment (PPE) Required in these situations: during high contact resident care activities. Dressing, bathing, showering, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting device care or use, central line, urinary catheter, feeding tube, tracheostomy, ventilator, wound care, any skin opening requiring a dressing. Required PPE: gloves and gown prior to the high contact care activity change PPE before caring for another resident. Face protection may also be needed if performing activity with risk of splash or spray Document/Room Signage titled, (STOP) Enhanced Barrier Precautions documents: Everyone Must: Clean their hands, including before entering and when leaving the room. Providers and Staff Must Also: Wear gloves and a gown for the following activities. Dressing, Bathing/Showering, Transferring, Changing Linens, providing hygiene, changing briefs or assisting with toileting. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Device care or use: central line, urinary catheter. Feeding tube, tracheostomy. Wound Care: any skin opening requiring a dressing. Do not wear the same gown and gloves for the care of more than one person. 2.) R614 was admitted on [DATE] with diagnosis that included: Retention of Urine, Chronic Kidney Disease, Benign Prostatic Hyperplasia with lower Urinary Tract Symptoms. R614's MDS (Minimum Data Set) assessment with an assessment reference date of 3/31/25 documents: Section C cognitive patterns a BIMS (Brief Interview for Mental Status) score of 6, indicating severe cognitive impairment. Section H Bowel and Bladder documents under appliances, R614 has an indwelling catheter. Section I Active diagnosis documents R614 had a urinary tract infection in the last 30 days. R614's Physician's Order dated 3/31/25, at 12:28 PM documents: Enhanced Barrier Precautions for foley catheter: Frequency: Every Shift. R614's April 2025 Medication Administration Record (MAR) documents: Enhanced Barrier Precautions for foley catheter: Frequency: Every Shift. Surveyor noted the MAR has been signed out as completed on every shift since R614's return from the hospital on 4/11/25. R614's Certified Nursing Assistant (CNA) assignment sheet dated 4-17-25 Section titled Pathogens of Concern documents: 1. Utilize enhanced barrier precautions to limit the spread of infection if I have an open wound or uses a medical device such as a catheter, PICC (peripherally inserted central catheter) line, IV (intravenous), tracheotomy. R614's Care Plan titled: Pathogens of Concern, R614 is at risk for colonization with multi drug resistant organisms due to Community prevalence. Start date: 3/27/2025. R614's Approach section documents: Approach start date 3/27/25, Utilize enhanced barrier precautions to limit the spread of infection if I have an open wound or uses a medical device such as a catheter, PICC line, IV, tracheotomy or g-tube (regardless of MDRO colonization or infection status). R614's Nursing note dated 04/11/2025, at 9:32 PM, documents: Patient was readmitted today around suppertime. He came from [name of hospital] where he was dx (diagnosed) with sepsis, UTI, lethargy. He has a foley catheter in with clear urine and has no C/O (complaint of) pain at this time. On 4/15/25, at 12:15 PM, Surveyor observed R614 had no enhanced barrier precautions (EBP) signage or PPE outside of R614's room. Surveyor notes R614 has a foley catheter and a physician's order dated 3/31/25 to be in EBP. On 4/15/25, at 03:30 PM, Surveyor observed R614 dressed on bed and no enhanced barrier (EBP) signage or PPE outside of R614's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/15/25, at 03:32 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-KKKK. Surveyor asked LPN-KKKK if R614 had a foley catheter. LPN-KKKK informed Surveyor R614 just got back from the hospital about a week ago. LPN-KKKK informed Surveyor LPN-KKKK thinks R614 has a Foley, I am not sure. Surveyor asked if R614 does have a catheter would staff provide daily care for the catheter. LPN-KKKK informed Surveyor staff would provide daily care for the catheter. On 04/16/25, at 07:52 AM Surveyor interviewed Register Nurse Supervisor (RN)-QQ. Surveyor asked RN-QQ if R614 had a Foley catheter. RN-QQ informed Surveyor RN-QQ believes R614 has a catheter leg bag when R614 is up for the day. RN-QQ informed Surveyor R614 looks dressed so R614 was gotten up by staff already for the day. Surveyor noted no EBP signage outside R614's room. Surveyor observed RN-QQ walked in and out of R614's room when RN-QQ went to examine if R614 had a catheter without sanitizing RN-QQ's hands, a requirement for EBP rooms. On 04/16/25, at 07:49 AM, Surveyor exited R614's room, and observed MT-AAA passing meds on the unit. Surveyor asked MT-AAA if R614 had a foley catheter. MT-AAA informed Surveyor MT-AAA didn't know if R614 a foley catheter. MT-AAA informed Surveyor MT-AAA just started working at the facility recently. Surveyor asked MT-AAA where would staff find information about a resident's foley catheter. MT-AAA informed Surveyor MT-AAA could look that up in the computer. On 04/17/25, at 07:17 AM, Surveyor interview Certified Nursing Assistant CNA-BB about staff's knowledge on enhanced barrier precautions. Surveyor asked CNA-BB who should be on enhanced barrier precautions in the facility. CNA-BB informed Surveyor everyone has enhanced barrier precautions who has a peg tube, catheter, or open area. Surveyor asked CNA-BB what would that entail for the resident. CNA-B informed Surveyor a sign would be placed on the door and a cart with gloves and gown outside of the door. On 04/17/25. at 09:33 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-W walking out of R614's room. Surveyor asked CNA-W if R614 has a foley catheter. CNA-W informed Surveyor CNA-W would have to check the chart. CNA-W walked away from the Surveyor. Surveyor observed CNA-W did not sanitize hands when exiting R614's room a requirement for EBP rooms. On 04/17/25, at 09:51 AM, Surveyor interviewed CNA-O. Surveyor asked CNA-O if R614 Surveyor asked if R614 had a catheter. CNA-O informed Surveyor that CNA-O wasn't aware if R614 had a catheter. Surveyor asked CNA-O if staff provides daily care for R614. CNA-O informed Surveyor staff provides care for R614, but R614 can be uncooperative. On 04/17/25, at 09:55 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-II standing outside of R614's room. Surveyor asked LPN-II if R614 had a catheter. LPN-II informed Surveyor I believe so. Surveyor asked LPN-II if R614 received catheter care daily by staff. LPN-II informed Surveyor R614 would receive catheter care daily by staff. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/17/25, at 03:43 PM during the exit meeting Surveyor informed Director of Nursing (DON)-B and Nursing Home Administrator (NHA)-C R614 has had a physician's order for EBP since 3/31/25. Surveyor informed NHA-C and DON-B R614 has Foley catheter and Pathogens of Concern care plans but resident has not been in EBP since the start of the survey on 4/15/25. Surveyor informed NHA-C the Surveyor observed no gowns, gloves or hand sanitizing in or around interactions of staff with R614. Surveyor asked NHA-C and DON-B should staff follow the Physician's order for EBP when R614 has a Foley catheter. NHA-C and DON-B said yes staff should follow the Physician's order and R614 should be in EBP because of R614's foley catheter. NHA-C informed Surveyor R614 will be placed into EBP today. On 04/21/25, at 07:55 AM, Surveyor observed enhanced barrier precaution sign on R614's door and PPE outside of R614's room. 38829 2) R83 was admitted to the facility on [DATE] with diagnoses of Hemiplegia and Hemiparesis following Unspecified Cerebrovascular Disease Affecting Left Dominant Side (complete paralysis on one side of body and partial/incomplete weakness on one side following stroke), Chronic Respiratory Failure(long-term condition where the lungs are unable to adequately exchange oxygen and carbon dioxide), Chronic Obstructive Pulmonary Disease(lung disease that block airflow and make it difficult to breathe), Epilepsy (disorder in which nerve cell activity in brain is disturbed causing seizures), Gastrostomy Status(artificial opening in stomach used for feeding), Depression (mood disorder that causes persistent feelings of sadness and loss of interest) and Anxiety Disorder (mental health disorder characterized by feelings of worry, fear that interfere with daily activities). R83 currently has an activated Health Care Power of Attorney (HCPOA). R83's Quarterly Minimum Data Set (MDS) completed 3/11/25 documents R83's Brief Interview for Mental Status(BIMS) score to be 11, indicating R83 demonstrates moderately impaired skills for daily decision making, requiring cues and supervision. R83 has range of motion (ROM) impairment on one side. R83 is dependent assistance for dressing, mobility, and transfers. R83 requires partial/moderate assistance for eating. R83's current physician orders effective 3/18/25, document R83 requires Enhanced Barrier Precautions(EBP)(for foley). Surveyor reviewed R83's comprehensive care plan and notes R83 has a Peg Tube (feeding tube inserted directly into the stomach through skin and stomach wall) and it is flushed only, effective 12/9/24. R83's comprehensive care plan does not document R83 should be in EBP due to having a foley and Peg Tube. On 4/17/25, at 7:30 AM, Surveyor observed R83 has an EBP sign on R83's door and a cart with personal protective equipment (PPE) outside the door. The sign documents that Providers and Staff must also wear gloves and a gown for the following High-Contact Resident Care Activities: -Dressing -Bathing/Showering (continued on next page)

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	05/01/2025

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Transferring -Changing Linens -Providing Hygiene -Changing briefs -Device Care -Wound Care On 4/17/25, at 7:30 AM, Surveyor asked Certified Nursing Assistants (CNA), CNA-L and CNA-M to observe the mechanical hoyer type lift transfer with R83. Surveyor obtained permission from R83. Surveyor observed CNA-L wash CNA-L's hands and put gloves on. CNA-M put gloves on but did not perform hand hygiene prior. Surveyor observed both CNA-L and CNA-M take R83's gown off and put shirt on R83. CNA-M realized R83 had been incontinent of bowel. CNA-M with gloves on looked for a brief in the room, left the room, came back into R83's room with a brief and no gloves on. While CNA-M was outside the room looking for a brief, CNA-L with the same gloves on, was looking for something in the bedside cabinet drawer. CNA-M came back into R83's room, did not perform hand hygiene and obtained a new pair of gloves from the bathroom. Both CNA-L and CNA-M performed incontinence care. Both CNA-L and CNA-M were not wearing gowns while providing incontinence cares, dressing, or transferring from bed to wheelchair. Surveyor observed CNA-L and CNA-M put the sling under R83 while in bed, mechanically lift up R83 and place R83 into the wheelchair. CNA-M took CNA-M's gloves off and put sanitizer on. CNA-L with same gloves on, combed R83's hair and put glasses on. CNA-L then took the gloves off and used sanitizer. CNA-L went and retrieved wash cloths outside the room. CNA-L washed hands and put new gloves on. CNA-L assisted R83 with brushing dentures, then had R83 use mouth wash, and had R83 spit into basin. CNA-L put adhesive on R83's mouth and assisted with placing the dentures in R83's mouth. CNA-L took gloves off and used sanitizer. Surveyor observed CNA-L did not have a gown on while assisting R83 with hygiene. Surveyor then observed CNA-L take the mechanical lift and go into another Resident room without wiping down the mechanical lift between use. On 4/21/25, at 3:21 PM, Surveyor shared the concern of CNA-L and CNA-B not following EBPs standard of practice while providing cares to R83 with Nursing Home Administrator (NHA)-C, Director of Nursing (DON)-B, CEO-A, and Director of Clinical Operations (DOC)-D. NHA-C confirmed the mechanical lifts should be wiped down after each use. At this time, no further information has been provided by the facility.

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	525069	A. Building B. Wing	05/01/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program for all new and existing staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253 Based on interview and record review, the facility did not develop, implement and maintain an effective training program for all new and existing staff based on their facility assessment potentially affecting 108 of 108 residents in the facility. The facility did not have a training policy and procedure for new staff or continued training for existing staff. Findings include: The Facility assessment dated [DATE] documents: Staff are trained to care for residents on all units to meet the needs of the facility. Staff Education, Training, and Competencies Education and competencies for all staff include dementia training upon hire and annually. Ventilator education is available to our clinical staff who are working in those areas and opportunities for education both onboarding and annually exist for the clinical staff focusing on rehabilitation. Modifications were made to our general orientation process that moved most training to an online module format. Clinical onboarding includes in-person competency skills checkoffs with our Staff Educator. We require all of our direct care vendors to provide competency training and abuse/neglect, infection control/BBP/PPE, customer service and HIPPA annually. Additional competencies are determined according to the amount of resident interaction required by the job role, job-specific knowledge, skills and abilities, and those needed to care for the resident population. Training Topics for general orientation and ongoing education: -(Facility) Mission, Vision and Values -IT-Security policy/HIPPA Compliance- -Emergency Preparedness Plan -Codes/Disaster/Emergency/Fire Safety- -Resident Rights/Abuse and Neglect -Blood Borne Pathogens -Hepatitis -Transmission -Exposure Control Plans -Engineering Controls (continued on next page)

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	525069	A. Building B. Wing	05/01/2025

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Workplace Controls (handwashing, sharps safety, personal hygiene) -PPE -Good Housekeeping (general housekeeping, biohazard warning labels, eye wash) -TB/Introduction to N95 mask- -Open wounds/Infection Control -Change in condition (nursing) -STOP AND WATCH FOR ALL DEPARTMENTS -Gait belt use (nursing) -Oxygen Emergency- -Dementia Training -EMR and policies -Falls prevention- -Understanding Communication in Persons with Dementia -Blood Borne Pathogens -Customer Service- -Hazardous Chemicals- -HIPPA Overview -Workplace Emergencies and Natural Disasters: An Overview -Fire Safety -Hand Hygiene -Infection Prevention -Protecting Resident Rights -Corporate Compliance -Matrix care EMR Documentation (continued on next page)

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	525069	A. Building B. Wing	05/01/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/1/2025 at 10:23 AM, Surveyor requested from Director of Nursing (DON)-B a copy of the facility policy and procedure for training new employees and for annual training of all staff. Surveyor requested from DON-B the documentation of training for Licensed Practical Nurse (LPN)-AAAA, Registered Nurse (RN)-MMMM, Certified Nursing Assistant (CNA)-NNNN, CNA-OOOO, and CNA-BB. DON-B stated the facility uses Relias, a online computer-based training program, for staff education. Surveyor reviewed the provided training transcripts for LPN-AAAA, RN-MMMM, CNA-NNNN, CNA-OOOO, and CNA-BB. Each employee had required training topics (effective communication, resident rights, abuse/neglect/exploitation, QAPI, Infection Control, compliance and ethics, and behavioral health) that had not been addressed on their transcripts. On 5/1/2025 at 2:29 PM, Surveyor shared with Nursing Home Administrator NHA-A, DON-B and Director of Clinical Operations (DCO)-D the concern the five selected employees did not have training on the required topics either when hired or annually. DON-B requested a list of what training was required. Surveyor provided DON-B a list of the five employees selected for the review and the required training categories. DON-B stated DON-B would review the employee files to find the documentation of their training. Surveyor requested a copy of their policy and procedure for new employee training, such as their on-boarding training packet, as well as a policy and procedure for continuing, or annual, employee training. On 5/1/2025 at 4:21 PM, DON-B provided an agenda and sign-in sheet for a staff meeting dated November 13 and 14 (no year documented) and an agenda and sign-in sheet for a staff meeting dated March 19 and 20, 2025. The agendas did not contain any of the required training topics. CNA-OOOO and CNA-BB signatures were on the sign-in sheets for both staff meetings; LPN-AAAA, RN-MMMM, and CNA-NNNN did not have signatures on the sign-in sheets. On 5/5/2025 at 4:39 PM, Surveyor received an email from NHA-A documenting: While a formal education policy does not exist we do have our procedure on how Relias is registered and what modules are completed day one of orientation and those that are calendared annually. I am rechecking to support additional education and will send ASAP tomorrow. NHA-A included the attachment of the undated document: Annual Relias Trainings Procedure -All (facility) employees are registered in Relias upon hire. -They are activated and their hire date is added -The hire date prompts the start of their module's annual cycle -Upon Relias registration, employees are assigned a Hierarchy, which notes their work division (Nursing, Activities, Administration, etc.) -All employee accounts, regardless of hierarchy, are automatically added into the annual Mandatory Training Training Plan -Modules in the annual Mandatory Training training plan: (continued on next page)

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	525069	A. Building B. Wing	05/01/2025

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Hand Hygiene Basics -Dementia Care: Exploring Alzheimer's Disease -Workplace Emergencies and Natural Disasters: An Overview -Essentials of HIPPA -Understanding Bloodborne Pathogens -Basics of Corporate Compliance -Hazardous chemicals: SDS and Labels -Dementia Care: Understanding Communication -Basics of Personal Protective Equipment -Providing Customer Service -Safeguarding Resident Rights in Nursing Facilities -Infection Control: Essential Principles -Preventing, Recognizing, and Reporting Abuse -Fire Safety -Active Shooter Response -One to two training modules are released to employees each month. Surveyor noted not all the required training was listed on the training plan for new and existing hires. On 5/6/2025 at 12:55 PM, Surveyor received an email from NHA-A stating Relias reports for each of the employees were attached that indicated compliance. NHA-A documented: This exercise clearly demonstrates a need for deeper back-up as to how to run reports and have access to the administrative side of these platforms. I have reached out to them for that training. Surveyor reviewed the attached employee trainings and were the same as previously provided by DON-B; not all required trainings were completed by the employees. The facility did not have a policy and procedure for new staff or continued training for existing staff.

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	525069	A. Building B. Wing	05/01/2025

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 38253 Based on interview and record review, the facility did not ensure 3 of 5 direct care staff chosen at random received effective communication training potentially affecting all 108 residents in the facility. Certified Nursing Assistant (CNA)-NNNN, CNA-OOOO, and CNA-BB did not receive effective communication training. Findings include: On 5/1/2025 at 10:23 AM, Surveyor requested from Director of Nursing (DON)-B a copy of the facility policy and procedure for training new employees and for annual training of all staff. Surveyor requested from DON-B the documentation of training for Licensed Practical Nurse (LPN)-AAAA, Registered Nurse (RN)-MMMM, CNA-NNNN, CNA-OOOO, and CNA-BB. DON-B stated the facility uses Relias, an online computer-based training program, for staff education. Surveyor reviewed the provided training transcripts for LPN-AAAA, RN-MMMM, CNA-NNNN, CNA-OOOO, and CNA-BB. Surveyor noted CNA-NNNN was hired on 1/202025 and did not have any documentation of receiving effective communication training. CNA-OOOO was hired on 6/24/2024 and did not have any documentation of receiving effective communication training. CNA-BB had documentation of completing a course titled Understanding Communication in Persons with Dementia on 10/14/2020; no annual communication training was completed. On 5/1/2025 at 2:29 PM, Surveyor shared with Nursing Home Administrator (NHA)-A, DON-B and Director of Clinical Operations (DCO)-D the concern three of the randomly selected employees did not have the required communication training. DON-B stated DON-B would review the employee files to find the documentation of their training. Surveyor requested a copy of their policy and procedure for new employee training, such as their on-boarding training packet, as well as a policy and procedure for continuing, or annual, employee training. On 5/5/2025 at 4:39 PM, Surveyor received an email from NHA-A documenting: While a formal education policy does not exist we do have our procedure on how Relias is registered and what modules are completed day one of orientation and those that are calendared annually. I am rechecking to support additional education and will send ASAP tomorrow. NHA-A included the attachment of the undated document: Annual Relias Trainings Procedure -All (facility) employees are registered in Relias upon hire. -They are activated and their hire date is added -The hire date prompts the start of their module's annual cycle (continued on next page)

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	525069	A. Building B. Wing	05/01/2025

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Upon Relias registration, employees are assigned a Hierarchy, which notes their work division (Nursing, Activities, Administration, etc.) -All employee accounts, regardless of hierarchy, are automatically added into the annual Mandatory Training Training Plan -Modules in the annual Mandatory Training training plan: -Hand Hygiene Basics -Dementia Care: Exploring Alzheimer's Disease -Workplace Emergencies and Natural Disasters: An Overview -Essentials of HIPPA -Understanding Bloodborne Pathogens -Basics of Corporate Compliance -Hazardous chemicals: SDS and Labels -Dementia Care: Understanding Communication -Basics of Personal Protective Equipment -Providing Customer Service -Safeguarding Resident Rights in Nursing Facilities -Infection Control: Essential Principles -Preventing, Recognizing, and Reporting Abuse -Fire Safety -Active Shooter Response -One to two training modules are released to employees each month. On 5/6/2025 at 12:55 PM, Surveyor received an email from NHA-A stating Relias reports for each of the employees were attached that indicated compliance. NHA-A documented: This exercise clearly demonstrates a need for deeper back-up as to how to run reports and have access to the administrative side of these platforms. I have reached out to them for that training. Surveyor reviewed the attached employee trainings and were the same as previously provided by DON-B; CNA-NNNN, CNA-OOOO, and CNA-BB did not have any documentation of communication training.

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	525069	A. Building B. Wing	05/01/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. 38253 Based on interview and record review, the facility did not ensure 1 of 5 direct care staff chosen at random received resident rights training potentially affecting all 108 residents in the facility. Certified Nursing Assistant (CNA)-BB did not receive resident rights training annually. Findings include: On 5/1/2025 at 10:23 AM, Surveyor requested from Director of Nursing (DON)-B a copy of the facility policy and procedure for training new employees and for annual training of all staff. Surveyor requested from DON-B the documentation of training for Licensed Practical Nurse (LPN)-AAAA, Registered Nurse (RN)-MMMM, CNA-NNNN, CNA-OOOO, and CNA-BB. DON-B stated the facility uses Relias, an online computer-based training program, for staff education. Surveyor reviewed the provided training transcripts for LPN-AAAA, RN-MMMM, CNA-NNNN, CNA-OOOO, and CNA-BB. Surveyor noted CNA-BB did not have any documentation of receiving resident rights training since 4/14/2020. On 5/1/2025 at 2:29 PM, Surveyor shared with Nursing Home Administrator (NHA)-A, DON-B and Director of Clinical Operations (DCO)-D the concern one of the randomly selected employees did not have annual resident rights training. DON-B stated DON-B would review the employee file to find the documentation of the training. Surveyor requested a copy of their policy and procedure for new employee training, such as their on-boarding training packet, as well as a policy and procedure for continuing, or annual, employee training. On 5/5/2025 at 4:39 PM, Surveyor received an email from NHA-A documenting: While a formal education policy does not exist we do have our procedure on how Relias is registered and what modules are completed day one of orientation and those that are calendared annually. I am rechecking to support additional education and will send ASAP tomorrow. NHA-A included the attachment of the undated document: Annual Relias Trainings Procedure -All (facility) employees are registered in Relias upon hire. -They are activated and their hire date is added -The hire date prompts the start of their module's annual cycle -Upon Relias registration, employees are assigned a Hierarchy, which notes their work division (Nursing, Activities, Administration, etc.) -All employee accounts, regardless of hierarchy, are automatically added into the annual Mandatory Training Training Plan (continued on next page)

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	525069	A. Building B. Wing	05/01/2025

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Modules in the annual Mandatory Training training plan: -Hand Hygiene Basics -Dementia Care: Exploring Alzheimer's Disease -Workplace Emergencies and Natural Disasters: An Overview -Essentials of HIPPA -Understanding Bloodborne Pathogens -Basics of Corporate Compliance -Hazardous chemicals: SDS and Labels -Dementia Care: Understanding Communication -Basics of Personal Protective Equipment -Providing Customer Service -Safeguarding Resident Rights in Nursing Facilities -Infection Control: Essential Principles -Preventing, Recognizing, and Reporting Abuse -Fire Safety -Active Shooter Response -One to two training modules are released to employees each month. On 5/6/2025 at 12:55 PM, Surveyor received an email from NHA-A stating Relias reports for each of the employees were attached that indicated compliance. NHA-A documented: This exercise clearly demonstrates a need for deeper back-up as to how to run reports and have access to the administrative side of these platforms. I have reached out to them for that training. Surveyor reviewed the attached employee trainings and were the same as previously provided by DON-B; CNA-BB did not have any documentation annually of resident rights training.

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	525069	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 38253 Based on interview and record review, the facility did not ensure 5 of 5 direct care staff chosen at random received QAPI (Quality Assurance and Performance Improvement) training with the potential to affect all 108 residents in the facility. Licensed Practical Nurse (LPN)-AAAA, Registered Nurse (RN)-MMMM, Certified Nursing Assistant (CNA)-NNNN, CNA-OOOO, and CNA-BB did not receive QAPI training as a new hire or annually. Findings include: On 5/1/2025 at 10:23 AM, Surveyor requested from Director of Nursing (DON)-B a copy of the facility policy and procedure for training new employees and for annual training of all staff. Surveyor requested from DON-B the documentation of training for Licensed Practical Nurse (LPN)-AAAA, Registered Nurse (RN)-MMMM, CNA-NNNN, CNA-OOOO, and CNA-BB. DON-B stated the facility uses Relias, an online computer-based training program, for staff education. Surveyor reviewed the provided training transcripts for LPN-AAAA, RN-MMMM, CNA-NNNN, CNA-OOOO, and CNA-BB. LPN-AAAA, RN-MMMM, CNA-NNNN, CNA-OOOO, and CNA-BB did not have any documentation of receiving QAPI training. On 5/1/2025 at 2:29 PM, Surveyor shared with Nursing Home Administrator (NHA)-A, DON-B and Director of Clinical Operations (DCO)-D the concern the five randomly selected employees did not have QAPI training. DON-B stated DON-B would review the employee file to find the documentation of the training. Surveyor requested a copy of their policy and procedure for new employee training, such as their on-boarding training packet, as well as a policy and procedure for continuing, or annual, employee training. On 5/5/2025 at 4:39 PM, Surveyor received an email from NHA-A documenting: While a formal education policy does not exist we do have our procedure on how Relias is registered and what modules are completed day one of orientation and those that are calendared annually. I am rechecking to support additional education and will send ASAP tomorrow. NHA-A included the attachment of the undated document: Annual Relias Trainings Procedure -All (facility) employees are registered in Relias upon hire. -They are activated and their hire date is added -The hire date prompts the start of their module's annual cycle -Upon Relias registration, employees are assigned a Hierarchy, which notes their work division (Nursing, Activities, Administration, etc.) (continued on next page)

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	525069	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-All employee accounts, regardless of hierarchy, are automatically added into the annual Mandatory Training Training Plan -Modules in the annual Mandatory Training training plan: -Hand Hygiene Basics -Dementia Care: Exploring Alzheimer's Disease -Workplace Emergencies and Natural Disasters: An Overview -Essentials of HIPPA -Understanding Bloodborne Pathogens -Basics of Corporate Compliance -Hazardous chemicals: SDS and Labels -Dementia Care: Understanding Communication -Basics of Personal Protective Equipment -Providing Customer Service -Safeguarding Resident Rights in Nursing Facilities -Infection Control: Essential Principles -Preventing, Recognizing, and Reporting Abuse -Fire Safety -Active Shooter Response -One to two training modules are released to employees each month. Surveyor noted QAPI training was not included in the topics on the training plan. On 5/6/2025 at 12:55 PM, Surveyor received an email from NHA-A stating Relias reports for each of the employees were attached that indicated compliance. NHA-A documented: This exercise clearly demonstrates a need for deeper back-up as to how to run reports and have access to the administrative side of these platforms. I have reached out to them for that training. Surveyor reviewed the attached employee trainings and were the same as previously provided by DON-B; LPN-AAAA, RN-MMMM, CNA-NNNN, CNA-OOOO, and CNA-BB did not have any documentation of receiving QAPI training.

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	525069	A. Building B. Wing	05/01/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. 38253 Based on interview and record review, the facility did not ensure 1 of 5 direct care staff chosen at random received infection control training with the potential to affect all 108 residents in the facility. Certified Nursing Assistant (CNA)-BB did not receive infection control training annually. Findings include: On 5/1/2025 at 10:23 AM, Surveyor requested from Director of Nursing (DON)-B a copy of the facility policy and procedure for training new employees and for annual training of all staff. Surveyor requested from DON-B the documentation of training for Licensed Practical Nurse (LPN)-AAAA, Registered Nurse (RN)-MMMM, CNA-NNNN, CNA-OOOO, and CNA-BB. DON-B stated the facility uses Relias, an online computer-based training program, for staff education. Surveyor reviewed the provided training transcripts for LPN-AAAA, RN-MMMM, CNA-NNNN, CNA-OOOO, and CNA-BB. Surveyor noted CNA-BB had documentation of receiving Basics of Hand Hygiene and Prevention of Urinary Tract Infections on 7/17/2024 but had not had Infection Control: Essential Principles since 1/31/2021. On 5/1/2025, at 2:29 PM, Surveyor shared with Nursing Home Administrator (NHA)-A, DON-B and Director of Clinical Operations (DCO)-D the concern one of the randomly selected employees did not have annual infection control training. DON-B stated DON-B would review the employee file to find the documentation of the training. Surveyor requested a copy of their policy and procedure for new employee training, such as their on-boarding training packet, as well as a policy and procedure for continuing, or annual, employee training. On 5/5/2025 at 4:39 PM, Surveyor received an email from NHA-A documenting: While a formal education policy does not exist we do have our procedure on how Relias is registered and what modules are completed day one of orientation and those that are calendared annually. I am rechecking to support additional education and will send ASAP tomorrow. NHA-A included the attachment of the undated document: Annual Relias Trainings Procedure -All (facility) employees are registered in Relias upon hire. -They are activated and their hire date is added -The hire date prompts the start of their module's annual cycle -Upon Relias registration, employees are assigned a Hierarchy, which notes their work division (Nursing, Activities, Administration, etc.) (continued on next page)

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	525069	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-All employee accounts, regardless of hierarchy, are automatically added into the annual Mandatory Training Training Plan -Modules in the annual Mandatory Training training plan: -Hand Hygiene Basics -Dementia Care: Exploring Alzheimer's Disease -Workplace Emergencies and Natural Disasters: An Overview -Essentials of HIPPA -Understanding Bloodborne Pathogens -Basics of Corporate Compliance -Hazardous chemicals: SDS and Labels -Dementia Care: Understanding Communication -Basics of Personal Protective Equipment -Providing Customer Service -Safeguarding Resident Rights in Nursing Facilities -Infection Control: Essential Principles -Preventing, Recognizing, and Reporting Abuse -Fire Safety -Active Shooter Response -One to two training modules are released to employees each month. On 5/6/2025 at 12:55 PM, Surveyor received an email from NHA-A stating Relias reports for each of the employees were attached that indicated compliance. NHA-A documented: This exercise clearly demonstrates a need for deeper back-up as to how to run reports and have access to the administrative side of these platforms. I have reached out to them for that training. Surveyor reviewed the attached employee trainings and theywere the same as previously provided by DON-B. Surveyor noted CNA-BB did not have any documentation of receiving annual infection control training.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on interview and record review, the facility did not ensure that 3 of 5 CNAs (Certified Nursing Assistants)(CNA) reviewed completed the required annual 12 hours of educational training. CNA-V, CNA-W, and CNA-Y did not receive the annual 12 hours of educational training. This had the potential to affect all 108 Residents who reside in the facility. Findings include: The facility assessment dated [DATE] documents: Staff Education, Training, and Competencies . Education and competencies for all staff include dementia training upon hire and annually. Modifications were made to our general orientation process that moved most training to an online module format. We require all of our direct care vendors to provide competency training in abuse/neglect, infection control/BBP (Bloodborne Pathogens)/PPE (Personal Protective Equipment), customer service and HIPPA (Health Insurance Portability and Accountability Act) annually. On 4/25/25, at 8:25 AM, Surveyor randomly selected 5 CNAs for review of their annual training hours. Surveyor reviewed the employee records of CNA-V, CNA-W, and CNA-Y. The facility was unable to provide documentation CNA-V, CNA-W and CNA-Y received the required 12 hours of educational training within a year based on their hire date. CNA-V date of hire was 10/30/23. CNA-V completed 1.25 hours of the required 12 hours of training. Surveyor noted Abuse and Dementia training was not completed as part of the required 12 hours of training. CNA-W date of hire was 12/11/23. CNA-W completed 10.50 hours of the required 12 hours of training. CNA-Y date of hire was 4/18/05. CNA-Y completed the required 12 hours of training, however, Abuse and Dementia training was not completed as part of the required 12 hours of training. On 4/21/25, at 3:21 PM, Surveyor shared the above concerns with previous Nursing Home Administrator (NHA)-C, Director of Nursing (DON)-B, Chief Executive Officer (CEO)-A, and Director of Clinical Operations (DOC)-D. Additional information was requested, if available. At this time, no further information has been provided as to why CNA-V, CNA-W, and CNA-Y did not receive the required 12 hours of educational training. (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/22/25, at 9:02 AM, Surveyor interviewed Staff Development Specialist (SDS)-Q. SDS-Q informed Surveyor SDS-Q has only been in the position for a week, but is aware CNAs must complete the required 12 hours of training per year based on hire date. SDS-Q is aware 3 of 5 CNA employee records reviewed document CNA-V, CNA-W, and CNA-Y do not have the 12 hours of annual required training. Further, SDC-Q confirmed SDC-Q is aware part of the 12 hours of required training must include Abuse and Dementia training. SDC-Q plans to have more consistent trainings and do monthly check-ins with the CNAs in order to make sure the CNAs have completed their required trainings.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide behavior health training consistent with the requirements and as determined by a facility assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253 Based on interview and record review, the facility did not ensure 4 of 5 direct care staff chosen at random received behavioral health training potentially affecting all 108 residents in the facility. Registered Nurse (RN)-MMMM, CNA-NNNN, CNA-OOOO, and CNA-BB did not receive behavioral health training. Findings include: The Facility assessment dated ,d+[DATE] documents the facility cares for residents with psychiatric/mood disorders such as psychosis (hallucinations, delusion, etc.), impaired cognition, mental disorder, depression, post-traumatic stress disorder, anxiety disorder, and behavior that needs interventions. The number/average or range of residents per day with behavioral symptoms and cognitive performance is 1-2 with 8 hours per week to address behavioral health needs. The facility provides care and services based on the needs of the residents to include behavioral health issues and psychosocial support. On 5/1/2025, at 10:23 AM, Surveyor requested from Director of Nursing (DON)-B a copy of the facility policy and procedure for training new employees and for annual training of all staff. Surveyor requested from DON-B the documentation of training for Licensed Practical Nurse (LPN)-AAAA, Registered Nurse (RN)-MMMM, CNA-NNNN, CNA-OOOO, and CNA-BB. DON-B stated the facility uses Relias, an online computer-based training program, for staff education. Surveyor reviewed the provided training transcripts for LPN-AAAA, RN-MMMM, CNA-NNNN, CNA-OOOO, and CNA-BB and noted: LPN-AAAA completed the courses Caring for the Person with Dementia: Behaviors and Communication on 3/13/2024 and Dementia Care: Challenging Behaviors on 3/7/2024. RN-MMMM completed the courses Managing Elopement on 9/23/2024 and Dementia Care: Understanding Alzheimer's Disease on 7/31/2023 and 9/23/2024. CNA-NNNN and CNA-OOOO had no documentation of behavioral health training. CNA-BB completed the courses Managing Elopement on 7/17/2024 and Trauma-Informed Care on 1/17/2020. Surveyor noted no specific training behavioral health training was was identified as required and completed when newly hired or on an annual basis. (continued on next page)

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/1/2025, at 2:29 PM, Surveyor shared with Nursing Home Administrator (NHA)-A, DON-B and Director of Clinical Operations (DCO)-D the concern the randomly selected employees did not have annual behavioral health training. DON-B stated DON-B would review the employee file to find the documentation of the training as outlined in the facility assessment. Surveyor requested a copy of the facility policy and procedure for new employee training, such as their on-boarding training packet, as well as a policy and procedure for continuing, or annual, employee training. On 5/5/2025, at 4:39 PM, Surveyor received an email from NHA-A documenting: While a formal education policy does not exist we do have our procedure on how Relias is registered and what modules are completed day one of orientation and those that are calendared annually. I am rechecking to support additional education and will send ASAP (as soon as possible) tomorrow. NHA-A included the attachment of the undated document: Annual Relias Trainings Procedure -All (facility) employees are registered in Relias upon hire. -They are activated and their hire date is added -The hire date prompts the start of their module's annual cycle -Upon Relias registration, employees are assigned a Hierarchy, which notes their work division (Nursing, Activities, Administration, etc.) -All employee accounts, regardless of hierarchy, are automatically added into the annual Mandatory Training Training Plan -Modules in the annual Mandatory Training training plan: -Hand Hygiene Basics -Dementia Care: Exploring Alzheimer's Disease -Workplace Emergencies and Natural Disasters: An Overview -Essentials of HIPPA -Understanding Bloodborne Pathogens -Basics of Corporate Compliance -Hazardous chemicals: SDS and Labels -Dementia Care: Understanding Communication -Basics of Personal Protective Equipment -Providing Customer Service (continued on next page)

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Safeguarding Resident Rights in Nursing Facilities -Infection Control: Essential Principles -Preventing, Recognizing, and Reporting Abuse -Fire Safety -Active Shooter Response -One to two training modules are released to employees each month. Surveyor noted behavioral health training was not included in the topics on the training plan. On 5/6/2025, at 12:55 PM, Surveyor received an email from NHA-A stating Relias reports for each of the employees were attached that indicated compliance. NHA-A documented: This exercise clearly demonstrates a need for deeper back-up as to how to run reports and have access to the administrative side of these platforms. I have reached out to them for that training. Surveyor reviewed the attached employee trainings and were the same as previously provided by DON-B.