STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525085	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eastcastle Pl Bradford Ter Conv Ctr	2505 E Bradford Ave Milwaukee, WI 53211

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 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** Based on observation, interview, and record review the facility did not ensure residents with pressure injuries received the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent pressure injuries from developing for 1 (R38) of 4 residents reviewed with pressure injuries.R38 was admitted to the facility on [DATE] and was at risk for the development of pressure injuries. R38's admission assessment does not indicate R38 has pressure injuries. Hospital discharge paperwork dated 12/5/25 does not indicate R38 had pressure injuries or had treatment orders for pressure injuries. On 12/7/25 a registered nurse documents a list of skin concerns including scabbed areas on R38's bilateral heels. These areas are not comprehensively assessed. No treatment orders are obtained from a physician and the risks and care concerns of these areas are not addressed in R38's baseline plan of care. On 12/8/25 the facility Wound Licensed Practical Nurse (LPN)-I documented the bilateral heels to be unstageable. The areas are never comprehensively assessed by a Registered Nurse. During collection of data by Wound LPN-I R38 complains of pain that is not addressed on R38's plan of care. R38 refuses to wear bilateral blue boots however, R38's care plan including the Certified Nursing Assistant (CNA) care card does not include an alternative to address offloading of R38's heels with refusals. R38 self-propels their wheelchair with their feet/heels which is not addressed as a risk factor in the plan of care. On 2/16/26 R38 continued to complain of pain, expressing pain to their right heel during a meal. X-rays of R38's heel were obtained indicating findings suspicious for calcaneal osteomyelitis. Recommend MRI. On 2/18/26 R38 started receiving intravenous (IV) antibiotics.Findings Include:The facility's Prevention of Pressure Injuries dated as revised April 2020 documents:Purpose: The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors.Preparation: Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable.Risk Assessment1. Assess the resident upon admission for existing pressure injury risk factors. Repeat the risk assessment weekly and upon any changes in condition.2. Use a standardized pressure injury screening tool to determine and document risk factors.3. Supplement the use of a risk assessment tool with assessment of additional risk factors.Skin Assessment1. Conduct a comprehensive skin assessment upon (or soon after) admission, with each risk assessment, as indicated according to the resident's risk factors, and prior to discharge.2. During the skin assessment, inspect:a. Presence of erythemab. Temperature of skin and soft tissuec. Edema3. Inspect the skin on a daily basis when performing or assisting with personal care activities of daily living (ADLs)a. Identify any signs of developing pressure injuries. For darkly pigmented skin, inspect for changes in skin tone, temperature, and consistencyb. Inspect pressure pointsc. Wash the skin after any episodes of incontinenced. Moisturize dry skin dailye. Reposition resident as indicated on the care planSupport Surfaces and Pressure Redistribution1. Select appropriate support surfaces based on the resident's risk factors, in accordance with current clinical practice.Monitoring1. Evaluate, report and document potential changes in the skin2. Review the interventions and strategies for effectiveness on an ongoing basisR38 was admitted to the facility on [DATE] with diagnoses of (continued on next page)

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

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Fracture of One Rib, Right Side, Vascular Dementia (brain damage caused by multiple strokes), Atherosclerotic Heart Disease of the Native Coronary Artery (plaque buildup narrows the arteries that supply blood to the heart), Essential Hypertension (chronic condition of persistently high blood pressure), Insomnia (sleep disorder characterized by difficulty falling asleep), Anxiety Disorder (mental health disorder characterized by feelings of worry, fear that interfere with daily activities), and Depression (mood disorder that causes persistent feelings of sadness and loss of interest). Review of R38's hospital discharge documentation does not contain any documentation R38 had unstageable right and left heel pressure injuries in the hospital. There are no physician orders located in R38's hospital record for treatments to the right and left unstageable heel pressure injuries to be carried out upon discharge and admission to the facility.R38's facility Braden Scale for Predicting Pressure Ulcer Risk Evaluation completed 12/6/25 documents R38 is at risk for developing pressure injuries.R38's facility Skin Check completed 12/6/25 documents R38 has no skin issues.R38's facility Clinical admission completed 12/6/25 documents R38 has no skin issues. The Clinical admission does not document that a care plan needed to be initiated for pressure injuries and/or wound management.On 12/7/25, Registered Nurse (RN)-X documented:-Right lateral rib cage-Right outer hip region-Scabbed pinpoint wound to right posterior knee area-Scabbed wound to bilateral heels. Pressure relieving boots introduced but R38 will not keep on.-Left inner foot-Left gluteal and bilateral gluteal crease area-Skin turgor age appropriateSurveyor notes there isn't a comprehensive assessment (including measurements and characteristics of the wound/scab and surrounding tissue) of R38's bilateral heels.R38's undated and incomplete baseline care plan does not document if R38 had any skin issues, wound, or pressure injuries on admission. Areas are circled on the front view of the body image and nothing circled on the back body image; R38's bilateral heels are not identified as areas of concern. R38's baseline care plan has no other documentation related to any pressure injuries located on the right and left heels or need for interventions to address risk for pressure injuries.R38's history and physical data dated 12/8/25 documented by Nurse Practitioner (NP)-S contains no documentation that R38 has any skin issues, including right and left unstageable heel pressure injuries.On 12/8/25, 2 days after admission and same day as NP-S's history and physical, Licensed Practical Nurse (LPN) Wound Nurse (WN)-I assessed R38's right and left heel scabbed areas.Right Heel-First Observation - 12/8/251.3 x 1.0 x 1-Unstageable100% necrosis and/or slough in the wound bed. Surveyor noted it is not specified what type of tissue the necrosis is (scab/possible eschar or slough).No exudate, no odor. Full thickness tissue loss in which the base of the ulcer's is covered by brown, tan, blackish discoloration in wound bed, wound bed dry. Surveyor noted the detail of the discoloration still does not clearly identify if it is slough present, eschar/scab, or combination of tissue types. No drainage. Induration (abnormal hardening, thickening or firmness of the surrounding skin and tissue of the wound) of peri-wound tissue with well defined wound edges and shape. No inflammation. Surveyor noted there was no documentation or assessment indicating R38 had induration of the skin at the time of admission.Left Heel-First Observation - 12/8/250.9 x 1 x 1 -Unstageable100% necrosis and/or slough in the wound bed. Surveyor noted it is not specified what type of tissue the necrosis is (scab/possible eschar or slough).No exudate, no odor. Full thickness tissue loss in which the base of the ulcer's is covered by brown, tan, blackish discoloration in wound bed, wound bed dry. Surveyor noted the detail of the discoloration still does not clearly identify if it is slough present, eschar/scab, or combination of tissue types. No drainage. Induration (abnormal hardening, thickening or firmness of the surrounding skin and tissue of the wound) of peri-wound tissue with well defined wound edges and shape. No inflammation. Surveyor noted there was no documentation or assessment indicating R38 had induration of the skin at the time of admission.R38's admission Minimum Data Set (MDS) completed 12/12/25 assesses R38 with a Brief Interview for Mental Status (BIMS) score to be 0, indicating R38 demonstrates severely impaired skills for daily decision making. The MDS assesses: R38 has no depressive symptoms; R38 has range of motion (ROM) impairment on one side of upper extremity; No ROM impairment on lower extremities; R38's (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	MDS assesses R38 demonstrates physical and other behaviors for 1-3 days. No refusals of care noted. R38 requires supervision for eating; R38 requires partial/moderate assistance for transfers, substantial/maximum assistance for upper dressing and mobility, and is dependent for showers and lower dressing; R38's MDS assesses R38 is at risk for pressure injuries and has unhealed pressure injuries. R38 has two unstageable pressure injuries that are indicated as being present upon admission.R38's Care Area Assessment (CAA) is triggered for pressure injuries and indicates to proceed to care plan. Surveyor noted there is no narrative documented to analyze R38's risk for pressure injuries and explanation/details regarding the care planning process as a result of the assessment.R38's comprehensive care plan dated initiated 12/8/25 addressing R38's risk for skin concerns indicates unstageable bilateral pressure ulcers due to immobility and weakness.Interventions included:-Administer medications as ordered. Monitor/document for side effects and effectiveness. Initiated 12/8/25 -Administer treatments as ordered and monitor for effectiveness. Initiated 12/8/25-Assess/record/monitor wound healing every dressing change. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD. Initiated 12/8/25-Blue boots on while in bed. Initiated 12/8/25-Educate the resident/family/caregivers as to causes of skin breakdown; including: transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning. Initiated 12/8/25. Surveyor noted R38 is severely cognitively impaired.-Inform the resident/family/caregivers of any new area of skin breakdown. Initiated 12/8/25-Monitor dressing every shift/as needed to ensure it is intact and adhering. Report loose dressing to Treatment nurse. Initiated 12/8/25-Monitor nutritional status. Serve diet as ordered, monitor intake and record. Initiated 12/8/25-Monitor/document/report PRN (as needed) any changes in skin status: appearance, color, wound healing, signs/symptoms of infection, wound size (length X width X depth), stage. Initiated 12/8/25-Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Initiated 12/8/25-Teach resident/family the importance of changing positions for prevention of pressure ulcers. Encourage small frequent position changes. Initiated 12/8/25-(R38) requires supplemental protein, amino acids, vitamins, minerals as ordered to promote wound healing. Initiated 12/8/25-Treat pain as per orders prior to treatment/turning etc. to ensure R38's comfort. Initiated- 12/8/25-Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate. Initiated 12/8/25The treatment order initiated 12/8/25 indicates: Clean Left and Right heel Unstageable w (with)/ wound cleanser, pat dry, skin prep peri wound. Moistened Aquacel dressing w/ Therahoney gel. Cover w/ Optifoam dressing. Change QD (each day)/prn (as needed) is (sic) soiled or off. Monitor for signs of infection. in the morning AND as neededR38's Wound Data (in centimeters):Surveyor noted there are no wound assessments for both the right and left heel pressure injuries for the week of 12/15/25. Surveyor noted with review of weekly wound documentation completed by LPN WN-I there is no comprehensive assessment or validation of data collected by LPN WN-I by a registered nurse.According to the Wisconsin Nurse Practice Act, N6.03(1), An R.N. (Registered Nurse) shall utilize the nursing process in the execution of general nursing procedures in the maintenance of health, prevention of illness or care of the ill. The nursing process consists of the steps of assessment, planning, intervention, and evaluation. This standard is met through performance of each of the following steps of the nursing process:(a) Assessment. Assessment is the systematic and continual collection and analysis of data about the health status of a patient culminating in the formulation of a nursing diagnosis.(b) Planning. Planning is developing a nursing plan of care for a patient which includes goals and priorities derived from the nursing diagnosis.(c) Intervention. Intervention is the nursing action to implement the plan of care by directly administering care or by directing and supervising nursing acts delegated to L.P.N.s (Licensed Practical Nurse) or less skilled assistants.(d) Evaluation. Evaluation is the determination of a patient's progress or lack of progress toward goal achievement which may lead to modification of the nursing diagnosis.Left (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Heel data: 12/23/250.9 x 1 x 1-Unstageable100% necrosis and/or slough in the wound bed. Tissue type not specified (ie: eschar or slough or combination).No exudate, no odor. Full thickness tissue loss in which the base of the ulcer's is covered by brown, tan, blackish discoloration in wound bed, wound bed dry. No drainage. Induration of peri-wound tissue with well-defined wound edges and shape. No inflammation. R38 complaining of pain during assessment to left heel. No changes noted.Right Heel data: 12/23/251.3 x 1.0 x 1-Unstageable100% necrosis and/or slough in the wound bed. Tissue type not specified (ie: eschar or slough or combination)No exudate, no odor. Full thickness tissue loss in which the base of the ulcer's is covered by brown, tan, blackish discoloration in wound bed, wound bed dry. No drainage. Induration of peri-wound tissue with well-defined wound edges and shape. No inflammation. R38 complaining of pain during assessment to left heel. No changes noted.Care plan revision -Observed R38 propel self in wheelchair using feet or heel, resident encouraged to refrain using heels to propel self, and use hands to propel self, also encouraged to avoid wearing leather shoes. Risk and benefits res states, oh well, I try, I think its fine, it does not hurt when I use my feet to move my chair, ok, ok Initiated 1/26/26Right Heel data:12/31/251.3 x 1.0 x 1-Unstageable100% necrosis and/or slough in the wound bed. Tissue type not specified (ie: eschar or slough or combination).No exudate, no odor. Full thickness tissue loss in which the base of the ulcer's is covered by brown, tan, blackish discoloration in wound bed, wound bed dry. No drainage. Induration of peri-wound tissue with well-defined wound edges and shape. No inflammation. R38 complaining of pain during assessment to left heel. No changes noted.Left Heel data: 12/31/250.9 x 1 x 1-Unstageable100% necrosis and/or slough in the wound bed. Tissue type not specified (ie: eschar or slough or combination).No exudate, no odor. Full thickness tissue loss in which the base of the ulcer's is covered by brown, tan, blackish discoloration in wound bed, wound bed dry. No drainage. Induration of peri-wound tissue with well-defined wound edges and shape. No inflammation. R38 complaining of pain during assessment to left heel. No changes noted.On 12/31/2025 R38's skin care plan was revised to include documentation indicating: Risk and benefits provided to R38 and HCPOA (healthcare power of attorney), refusing non pharmacological intervention blue boots to feet while in bed, will increase risk of skin breakdown and or worsen the current pressure ulcer's to bilateral heels, R38 states well, my feet gets hot, then it gets uncomfortable staff to encourage res to wear blue boots or offer alternative which is elevating legs with pillow. HCPOA states well, just encourage, I'm sorry Initiated 1/3/26Surveyor noted there are no wound assessments for both the right and left heel pressure injuries for the week of 1/5/26Right Heel data: 1/13/261.3 x 1.0 x 1-Unstageable100% necrosis and/or slough in the wound bed. Tissue type not specified (ie: eschar or slough or combination).No exudate, no odor. Full thickness tissue loss in which the base of the ulcer's is covered by brown, tan, blackish discoloration in wound bed, wound bed dry. No drainage. Induration of peri-wound tissue with well-defined wound edges and shape. No inflammation. Complaints of tenderness to area. R38 complaining of pain during assessment to left heel. No changes noted.Left Heel data 1/13/260.9 x 1 x 1-Unstageable100% necrosis and/or slough in the wound bed. Tissue type not specified (ie: eschar or slough or combination).No exudate, no odor. Full thickness tissue loss in which the base of the ulcer's is covered by brown, tan, blackish discoloration in wound bed, wound bed dry. No drainage. Induration of peri-wound tissue with well-defined wound edges and shape. No inflammation. R38 complaining of pain during assessment to left heel. No changes noted.Surveyor noted R38 initially complained of pain during the wound assessment on 12/31/25. There is no indication additional assessments of the pain was completed or addressed leading to R38 to continue to experience pain during additional assessments.R38's previous treatment to the right heel was discontinued on 1/13/26. The new treatment order starting 1/14/26 indicates: Clean wound to Right heel w/ wound cleanser, pat dry, skin prep peri wound. Apply quarter thick of Santyl to wound bed. Cover w/ Optifoam dressing. Change QD/PRN if soiled. Monitor signs of infection at bedtime.Right Heel data: 1/20/261.3 x 1.0 x 1-Unstageable100% necrosis and/or slough in the wound bed. Tissue type not specified (ie: eschar or slough or combination).No exudate, no odor. Full thickness tissue (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	loss in which the base of the ulcer's is covered by brown, tan, blackish discoloration in wound bed, wound bed dry. No drainage. Induration of peri-wound tissue with well-defined wound edges and shape. No inflammation. Complaints of slight tenderness to touch. R38 complaining of pain during assessment to left heel. No changes noted. New treatment.Left Heel data: 1/20/260.9 x 1 x 1 -Unstageable100% necrosis and/or slough in the wound bed. Tissue type not specified (ie: eschar or slough or combination).No exudate, no odor. Full thickness tissue loss in which the base of the ulcer's is covered by brown, tan, blackish discoloration in wound bed, wound bed dry. No drainage. Induration of peri-wound tissue with well-defined wound edges and shape. No inflammation. R38 complaining of pain during assessment to left heel. No changes noted. New treatment.Surveyor noted R38 continues to complain of pain during the assessment that is not addressed and now is indicating the right heel is also tender to the touch in addition to being painful during assessment.Right Heel data: 1/27/261.3 x 1.0 x 1- Unstageable90% necrosis and/or slough in the wound bed.No exudate, no odor. Full thickness tissue loss in which the base of the ulcer's is covered by brown, tan, blackish discoloration in wound bed, wound bed dry. No drainage. Induration of peri-wound tissue with well-defined wound edges and shape. No inflammation. Complaints of slight tenderness to touch. R38 complaining of pain during assessment to left heel. Improving, no change with measurement, wound bed 10% red, 90% light brown brownish color resembles scab thinning, moist to exudate.Surveyor noted R38 continues to express pain with the right heel.Left Heel data: 1/27/260 x 0 x 0- UnstageableHealed. New treatment to cover left heel with optifoam dressing for protection. Change every 3 days and as needed. Left heel wound bed 100% epithelization.Right Heel data: 2/3/261.3 x 1.0 x 1-Unstageable90% of necrosis and/or slough in the wound bed.No exudate, no odor. Full thickness tissue loss in which the base of the ulcer's is covered by brown, tan, blackish discoloration in wound bed, wound bed dry. No drainage. Induration of peri-wound tissue with well-defined wound edges and shape. No inflammation. Complaints of slight tenderness to touch. R38 complaining of pain during assessment to left heel. Improving, no change with measurement, wound bed 10% red, 90% light brown brownish color resembles scab thinning, moist to exudate.Left Heel data: 2/3/260 x 0 x 0-UnstageableHealed.Right Heel data: 2/10/260.9 x 0.8 x < (less than) 0.1 wound bed pinkish red moist, callused peri wound, no complaints of pain. No signs of infection.100% pinkish red wound bedNo exudate, no odor. Full thickness tissue loss in which the base of the ulcer's is covered by brown, tan, blackish discoloration in wound bed, wound bed dry. No drainage. Induration of peri-wound tissue with well-defined wound edges and shape. No inflammation.Surveyor noted conflicting details in the data documentation regarding the details of the tissue type with statements indicating pinkish, red, moist wound bed and brown, tan, blackish discoloration in wound bed, wound bed dry.A new treatment order initiated 2/10/26 indicates: Clean wound to Right heel w/ wound cleanser, pat dry, skin prep peri wound. Apply Xeroform dressing. Cover w/ Optifoam dressing. Change QOD (every other day)/PRN if soiled or offRight Heel data: 2/18/260.6 x 0.7 x < 0.1 wound bed pinkish red moist, callused peri wound, no complaints of pain to surrounding area during palpation, slightly red. R38 complaint of pain to wound area itself during dressing change. New order.100% pinkish red wound bed, peri wound surrounded with thick callusNo exudate, no odor. Full thickness tissue loss in which the base of the ulcer's is covered by brown, tan, blackish discoloration in wound bed, wound bed dry. No drainage. Induration of peri-wound tissue with well-defined wound edges and shape. No inflammation.Surveyor noted conflicting details in the data documentation regarding the details of the tissue type with statements indicating pinkish, red, moist wound bed and brown, tan, blackish discoloration in wound bed, wound bed dry. R38 again is experiencing pain related to the wound that is not assessed.Observations of heels not floated/blue boots not on - expression of pain:R38's certified nursing assistant (CNA) care card reviewed by Surveyor during the survey instructing CNAs on the care of R38 documents R38 is to have blue boots on while in bed. Surveyor noted the alterative of offloading R38's heels with pillows is not included as directions for the CNAs for caring for R38.On 2/16/26, at 10:55 AM, Surveyor observed R38 in bed with no heel boots on and heels were observed to not be floated/offloaded of (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	pressure.On 2/16/2026, at 12:12 PM, Surveyor observed the lunch meal in the dining room. Surveyor heard R38 inform Wound LPN -I that R38's right heel really hurts. Wound LPN-I informed R38 that Wound LPN-I will look at it after lunch. On 2/16/26, at 2:25 PM, Surveyor observed R38 in bed with no bilateral blue boots on.On 2/17/2026, at 6:59 AM, Surveyor observed R38's bilateral heels not floated or offloaded with boots or a pillow. Surveyor observed both heels on the bed.On 2/17/26, at 11:09 AM, Surveyor observed R38 in a low bed, gripper socks on, no bilateral heel boots on and no pillow floating/offloading pressure on R28's heels.On 2/17/2026, at 11:27 AM, Surveyor observed Wound LPN-I complete a treatment to R38's right heel. R38 stated no pain or discomfort this morning. Wound LPN-I explained the area around the wound bed was inflamed red on 2/16/26. Surveyor observed the area to be pinkish around the wound bed during the treatment. Wound bed present, area around is callous. Wound LPN-I informed Surveyor at this time that Wound LPN-I wanted to send R38 to a wound clinic for debridement, but HCPOA has refused and only wants treatments to be done at the facility. Wound LPN-I believes it will not heal without debridement. Wound LPN-I placed a pillow under R38's heels after completing the treatment. R38 has no problem with the pillow underneath R38's heels. Wound LPN-I did not complete any measurements.On 2/17/2026, at 12:19 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-N. CNA-N confirmed CNA-N is assigned to R38 today. CNA-N informed Surveyor that R38 does not like R38's bilateral heel boots on. Surveyor asked CNA-N what CNA-N would do if R38 refused to wear the bilateral heel boots. CNA-N stated that CNA-N will offer a pillow which R38 will allow. CNA-N will re-approach R38 several times and then tell the nurse R38 is refusing.On 2/17/2026, at 1:23 PM, Surveyor interviewed Wound LPN-I. Surveyor asked Wound LPN-I why R38's bilateral heel pressure ulcers were not assessed until 2 days after admission. Wound LPN-I stated it was because R38 came in on the weekend. Surveyor asked Wound LPN-I if R38 refuses the heel boots what staff should do. Wound LPN-I stated staff should encourage R38 to wear the bilateral heel boots and if R38 continues to refuse, staff should float R38's heels with a pillow.Surveyor noted that R38's Medication/Treatment Assessment Records (MARS/TARS) document R38 frequently refuses to wear heel boots. Surveyor noted R38's CNA care card do not indicate an alternative to the blue heel boots to offload pressure to R38's heels.On 2/17/26 (during the survey) R38's care plan for skin was resolved. A revised care plan dated 2/16/26 (during the survey) includes the revisions: addressing the continued unstageable pressure injury to the right heel; indicating the left heel had resolved. Surveyor noted the revised care plan included the same, previous interventions as R38's care plan initiated 12/8/25 but now with an initiated date of 2/16/26 (the first day of the survey).Possible Right Heel Osteomyelitis:On 2/16/26, the facility obtained an x-ray of the right heel. Results: Subtle heterogeneity of the calcaneus. Soft tissues appear swollen with ulceration.Conclusion: Findings suspicious for calcaneal osteomyelitis. Recommend MRI.On 2/18/26, The following was initiated and documented in R38's physician orders: Peripheral IV administration Cefepime via Peripheral IV (intravenous).On 2/18/2026, at 10:23 AM, Surveyor interviewed Wound LPN-I. Wound LPN-I informed Surveyor that Wound LPN-I believes R38's right heel is not healing due to non-compliance. Wound LPN-I shared R38 was wearing leather shoes at admission, Wound LPN-I asked family to bring soft shoes in. R38 agreed to wear softer shoes and most recently gripper socks. R38's HCPOA does not want aggressive treatment. Wound LPN-I shared they had a conversation with HCPOA, sometime in first week of January, but failed to document the conversation. Wound LPN-I had informed family that it is not healing due to the heel pressure ulcer needing debridement. Wound LPN-I shared R38 likes to hang right leg off the bed. Surveyor noted the possible risks for pressure and/or injury by wearing leather shoes, was not addressed in the care plan until 1/26/26. Surveyor also noted that the care plan does not address the risk factor of R38 using his feet/pressure on heels to self-propel their wheelchair. Regarding R38's pain, Wound LPN-I assessed R38's pain on Monday (2/16/26) and obtained an x-ray. Surveyor asked Wound LPN-I about R38's missing wound assessments of both the right and left heel pressure ulcers for the week of 12/15/25 and 1/5/26. Wound LPN-I stated, may have gotten away from me, I get a lot of admissions that have to be (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 0686 Level of Harm - Actual harm Residents Affected - Few	completed. Surveyor shared the concern that R38's bilateral right and left heel scabbed areas did not have data collected regarding the areas until 2 days after admission. Surveyor noted the areas have not been comprehensively assessed by an RN. Surveyor shared a care plan (baseline or comprehensive) to address R38's skin risks was not initiated until 12/8/25 and physician orders with a treatment were not initiated until 12/8/25.On 2/18/2026, at 1:20 PM, Surveyor spoke with Wound LPN-I regarding the timing of the data collection/assessment of #38's skin. Wound LPN-I stated, you can't expect me to complete assessments on the weekend. Wound LPN-I insisted an assessment was completed by RN-X. Surveyor shared there is no measurements, no characteristics until 2 days after admission with no treatment in place until 12/8/25.On 2/18/2026, at 1:27 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A regarding R38's pressure injury care. NHA-A stated they understood the concerns.On 2/18/2026, at 2:20 PM, NHA-A shared with Surveyor R38's baseline care plan has circles on the body image indicating R38 had pressure areas. Surveyor explained the circles are on the front body image and not on the back body image where the scabbed/unstageable bilateral heel pressure injuries would have been documented. NHA-A also stated Wound LPN-I documented the missing wound assessments (12/15/25 and 1/5/26) in Wound LPN-I's tracker but did not transfer to the formal wound assessment. NHA-A provided the tracker at this time.Surveyor reviewed the tracker and noted the details in the tracker indicate need to document.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525085	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eastcastle Pl Bradford Ter Conv Ctr	2505 E Bradford Ave Milwaukee, WI 53211

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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 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. Based on observation, interview and record review, the facility did not ensure food was served in accordance with professional standards for food service safety.* The 5th floor kitchen server for lunch was observed. The Cook-E used gloves for multiple tasks, including handling ready-to-eat foods. The food thermometer had a tethered string that was not maintained to prevent food contamination. This had the potential to affect all 20 residents on the 5th floor.Findings include:The facility policy and procedure Hospitality Department-Attendance, Conduct, and Safety Policy dated 9/12/2025 documents: The purpose of this policy is to give a hospitality employees clear direction regarding attendance, time-off requests, food handling, glove usage guidelines, kitchen safety, and grooming standards. Adherence to these guidelines protects employees, residents, and the reputation of [facility name].Procedures and Guidelines:5. Glove Usage documents under Changing Gloves:Gloves must be changed when switching tasks or workstations, after touching non-food surfaces (equipment handles, doors, trash lids, etc.).The following are not permitted: Wearing the same glove for multiple tasks.1.) On 2/16/2026, at 12:36 PM, Surveyor observed food service on the 5th floor with Cook-E. Cook-E removed the prepared food from the hot cart and placed items in the steam table. Cook-E washed their hands and donned gloves. Cook-E had a clipboard with a tethered thermometer on a string. Cook-E used the thermometer to take the temperature of the ravioli. During the observation, Surveyor observed the string was resting against the cooked ravioli.After Cook-E used the thermometer in the ravioli they used their gloved hand to mix cooked green beans. Surveyor noted that Cook-E did not wash their hands or changed gloves before touching and mixing the ready to eat cooked green beans with their gloves. Surveyor then observed Cook-E finish taking temperatures of the cooked food and then removed their gloves and washed their hands.Cook-E with their gloves, place bottom plate warmers on the device. The Cook-E took a plate from the plate warmer. The Cook-E used their gloved hand to place the cooked ravioli on it. The Cook-E used the same gloved hand for the tongs to serve cooked green beans. The Cook-E used the same glove to touch cooked ravioli, serving utensils and plates. This was observed with 2 plate services.Surveyor noted that Cook-E did not wash their hands or changed gloves before touching ready to eat food. Cook-E then removed their gloves and donned new gloves. Cook-E did not wash hands between glove changes. Cook-E then took a plate and a heated plate warmer. Cook-E used the same gloved hand to place the ravioli on the plate, used tongs for the green beans and pasta sauce ladle. Cook-E used their gloved hand to obtain 2 cooked raviolis. Cook-E placed the Ravioli on the server board. This board was used to place non-food items on. Cook-E used a knife to cut the ravioli and placed it on a plate. Cook-E used the same gloved hand to grab green beans and placed them on the same plate.Surveyor noted that Cook-E did not wash their hands or changed gloves before touching ready to eat food. On 2/16/26, at 12:56 PM, Surveyor interviewed Cook-E after observing several plates being served in a unsanitary manner. Cook-E stated they were aware of using food barriers however, the ravioli is sticky. Cook-E stated they were aware of glove use and did not have a response for touching multiple items with their gloves without washing their hands or changing gloves before touching ready to eat food. On 2/17/2026, at 10:22 AM, Surveyor interviewed Director of Hospitality (DOH) -D. The DOH-D stated that staff are aware of glove use with food handling. DOH-D did not have a response for the thermometer string being in the food or why Cook-E did not wash their hands or changed gloves before touching ready to eat food. On 2/17/26, at 3:03 PM, at the facility exit meeting, with Nursing Home Administrator (NHA)- A and Director of Nurses (DON) -B, Surveyor shared the kitchen sanitation concerns. No additional information was provided.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility did not ensure 1 (R2) of 1 resident received the necessary assessment to self-administer medications. On 2/16/26 at 9:44 a.m. Surveyor interviewed R2. Surveyor observed an Advair inhaler on the table beside the bed. Surveyor asked R2 if she uses the inhaler independently. R2 stated she does and has been using that inhaler for many years. Surveyor asked R2 if the nurses leave the inhaler in R2 possession and R2 stated yes. Surveyor reviewed R2 assessments, and a self-administration of medications assessment was not completed.Findings include:The facility's self-administration of medications policy dated December 2016 documents1. As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident.2. In addition to general evaluation of decision-making capacity, the staff and practitioner will perform a more specific skill assessment, including (but not limited to) the resident's: a. Ability to read and understand medication labels.b. Comprehension of the purpose and proper dosage and administration time for his or her medicationsc. Ability to remove medications from a container and to ingest and swallow (or otherwise administer) the medication andd. Ability to recognize risks and major adverse consequences of his or her medications.6. For self-administering residents, the nursing staff will determine who will be responsible (the resident or the nursing staff) for documenting that medications were taken.8. Self-administered medications must be stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in the resident's room, the medications of residents permitted to self-administer will be stored on a central medication cart or in the medication room. Nursing will transfer the unopened medication to the resident when the resident requests them. R2 was admitted to the facility on [DATE] with diagnoses of right lower leg fracture, asthma, hypertension and atrial fibrillation. The admission Minimum Data Set (MDS) dated [DATE] documents R2 has moderate cognitive impairment and is independent with eating. On 2/16/26 at 9:44 a.m., Surveyor interviewed R2. Surveyor observed an Advair inhaler on the table beside the bed. Surveyor asked R2 if she uses the inhaler independently. R2 stated she does and has been using an inhaler for many years. Surveyor asked R2 if the nurses leave the inhaler in R2's possession and R2 stated yes. Surveyor reviewed R2's medical record and there wasn't an assessment to determine if R2 is safe to self-administer the inhaler. R2's care plan does not address R2's self-administering the inhaler. On 2/17/26 at 3:00 p.m., during the daily exit meeting with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B, Surveyor requested to see R2's self-administration of medication assessment.On 2/18/26 at 10:06 a.m., DON-B gave Surveyor a self-administration of medication assessment for R2. The assessment was dated 2/17/26. Surveyor asked DON-B why the assessment was not completed prior to 2/17/26. DON-B stated she wasn't sure why because she remembers having a conversation with nursing regarding R2 self-administering the inhaler. Surveyor explained the concern R2's inhaler is not secured somewhere that other residents don't have access to. DON-B understood the concern.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not ensure a resident with psychotropic medications was comprehensively assessed for their use. This was observed with 1 (R38) of 5 resident medication reviews.* R38 was admitted [DATE] with Duloxetine (antidepressant), Bupropion (antidepressant) and Trazadone (antidepressant). The diagnosis for Duloxetine is for depression, Bupropion for dysthymia and Trazadone for insomnia. The medical record does not have documentation of a comprehensive assessment for the use of these medications. Findings include:The facility's policy and procedure Psychotropic Medication Use dated July 2022. Policy Interpretation and Implementation:1. A psychotropic medication is any medication that affects brain activity associated with mental processes and behavior.2. Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: b. Anti-depressants .3. Residents, families and/or the representative are involved in the medication management process. Medication management includes:a. indications for use;b. dose (including duplicate therapy);c. duration;d. adequate monitoring for efficacy and adverse consequences; ande. preventing, identifying and responding to adverse consequences.R38 was admitted to the facility on [DATE] with an activated Power of Attorney for Healthcare (POAHC). R38 has diagnosis of unspecified insomnia, unspecified depression and unspecified anxiety disorder. R38's medications upon admission to the facility are Duloxetine (antidepressant), Bupropion (antidepressant) and Trazadone (antidepressant). The diagnosis for Duloxetine is for depression, Bupropion for dysthymia and Trazadone for insomniaR38's admission Minimum Data Set (MDS) was completed on 12/12/25 and documents R38 is receiving antidepressant and antianxiety medications. The MDS Care Area Assessment (CAA) for Psychotropic Drug Use does not document a comprehensive assessment for depression, anxiety and insomnia. Surveyor notes R38's medical record does not have documentation of a comprehensive assessment related to depression medication indications for use and adequate monitoring.R38 Treatment Administration Record (TAR) for December 2025 documents a sleep study every hour for 12/8/25 - 12/10/25. This indicates yes or no for sleeping. The TAR for January 2026 documents a sleep study every hour for 1/1/26 - 1/3/26. This indicates yes or no for sleeping. There is no documentation related to this sleep study sleeping information. The sleep study documented if R38 was asleep or awake. There is no additional documentation related to a comprehensive assessment for insomnia including the sleep study information.On 2/18/2026, at 9:14 AM, Surveyor interviewed Director of Nurses (DON)-B. Surveyor reviewed R38's sleep study and psychotropic medications with DON-B. DON-B stated they were aware the MDS CAAs summary assessment is blank (no documentation of a comprehensive assessment). DON-B stated they will look for any additional assessments. DON-B stated there was no additional facility staff with information related to the assessment. R38's medical record was reviewed at this time. Surveyor notes there was no documentation of a comprehensive assessment for R38 3 antidepressant medications.On 2/18/2026, at 2:46 PM, at the facility exit meeting with Nursing Home Administrator (NHA) -A and DON-B, no further information was provided for R38's psychotropic medications.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not document additional assessments for the Care Area Assessment (CAA) triggered by the Minimum Data Set (MDS) assessment information. This would include a summary of the information to complete a comprehensive assessment. This was observed with 3 (R38, R23, and R62) of 12 resident reviews. * R38 had an admission MDS assessment completed on 12/12/25. The MDS triggered CAAs for Falls, Pressure Injury, Psychotropic Drug Use, Psychosocial Well-Being and Behavioral Symptoms. The CAAs did not have an additional assessment summary analyzing the MDS data and need for an individualized care plan. * R23 had a Significant Change in Status (SCS) MDS assessment completed on 11/19/25. The MDS triggered a CAA for Falls. The CAA did not have an additional assessment summary analyzing the MDS data and need for an individualized care plan. * R62 had an admission MDS assessment completed on 11/16/25. The MDS triggered a CAA for Falls. The CAA did not have an additional assessment summary analyzing the MDS data and need for an individualized care plan . Findings include: The facility policy and procedure Care Area Assessments undated documents Policy: Care Area Assessments (CAAs) will be used to help analyze data obtained from the MDS and to develop individualized care plans. CAAs are the link between the assessment and care planning.Policy Interpretation and Implementation:5. CAA documentation explains the basis for the care plan. This documentation should include:a. Causes and contributing factors for the triggered care areas; b. The nature of the condition or issue (i.e., What exactly is the problem and why is it a problem?);c. Complications contributing to (or caused by) the care area;d. Risk factors related to the condition;e. Factors that should be considering in developing the care plan (including reasons to care plan or not to care plan particular findings);f. Any need for further evaluation by the physician or other health care provider;g. Resources and tools used for decision making;h. Conclusions that arise from the care area assessment process; [NAME]. Completion of section V of the MDS. On 2/18/2026, at 10:02 AM, Surveyor interviewed MDS Nurse-K via phone. MDS Nurse-K stated they do not write a long narrative in the CAA Summary. The electronic medical record Point Click Care (PCC) triggers the CAA by checked boxes. The PCC system triggers the areas of concern, and they check the boxes. MDS Nurse-K stated the residents are discussed and the care plan is an interdisciplinary development. MDS Nurse-K stated she does not document a summary of the triggered CAAs from the MDS assessment. 1.) R38 was admitted to the facility on [DATE] with an activated Power of Attorney for Healthcare (POAHC). R38 has diagnosis of unspecified insomnia, unspecified depression and unspecified anxiety disorder. R38's medications upon admission are Duloxetine (antidepressant), Bupropion (antidepressant) and Trazadone (antidepressant). The diagnosis for Duloxetine is for depression, Bupropion for dysthymia and Trazadone for insomnia The admission Minimum Data Set (MDS) was completed on 12/12/25 which documents R38 is receiving antidepressant and antianxiety (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications. R38 has range of motion (ROM) impairment on one side of upper extremity. No ROM impairment on lower extremities. R38's MDS R38 requires partial/moderate assistance for transfers, substantial/maximum assistance for upper dressing and mobility, and is dependent for showers and lower dressing. R38's MDS documents R38 has a pressure injury, currently has two unstageable pressure injuries, and is at risk for developing pressure injury. R38 has had 2 or more falls since admission or previous assessment. R38's MDS Care Area Assessment (CAA) triggered additional assessment information for Psychotropic Drug Use, Psychosocial Well-Being, Behavioral Symptoms, Pressure Injuries and Falls. Surveyor notes these CAAs do not have documentation of an assessment summary analyzing the MDS data and need for an individualized care plan. Surveyor notes boxes that are checked on the CAAs, however, there is no narrative describing the impact of the problem/need and the rationale for a care plan decision. On 2/18/2026, at 9:14 AM, Surveyor interviewed Director of Nurses (DON)-B who stated R38's sleep study and psychotropic medications were reviewed. DON-B stated they were aware the MDS CAAs did not have a comprehensive assessment. On 2/18/2026, at 2:46 PM, at the facility exit meeting with Nursing Home Administrator (NHA) -A and DON-B, no further information was provided as to why the facility did not complete a summary analyzing R38's assessment information in the CAA. 2) R38 was admitted to the facility on [DATE] with diagnoses of Fracture of One Rib, Right Side, Vascular Dementia(brain damage caused by multiple strokes), Atherosclerotic Heart Disease of the Native Coronary Artery(plaque buildup narrows the arteries that supply blood to the heart), Essential Hypertension(chronic condition of persistently high blood pressure), Insomnia(sleep disorder characterized by difficulty falling asleep), Anxiety Disorder(mental health disorder characterized by feelings of worry, fear that interfere with daily activities), and Depression(mood disorder that causes persistent feelings of sadness and loss of interest). R38 has an activated Health Care Power of Attorney(HCPOA). R38's admission Minimum Data Set(MDS) completed 12/12/25 documents R38's Brief Interview for Mental Status(BIMS) score to be 0, indicating R38 demonstrates severely impaired skills for daily decision making. R38 has no depressive symptoms. R38 has range of motion(ROM) impairment on one side of upper extremity. No ROM impairment on lower extremities. R38's MDS documents R38 demonstrates physical and other behaviors 1-3 days. R38 requires supervision for eating. R38 requires partial/moderate assistance for transfers, substantial/maximum assistance for upper dressing and mobility, and is dependent for showers and lower dressing. R38's MDS documents R38 has a pressure injury, currently has two unstageable, and is at risk for developing pressure injury. R38 has had 2 or more falls since admission or previous assessment. Surveyor reviewed R38's pressure injury and falls care area assessment(CAA). There are boxes that are checked, however, there is no narrative describing the impact of the problem/need and the rationale for a care plan decision. 3) R23 was admitted to the facility on [DATE] with diagnoses of Paroxysmal Atrial Fibrillation(irregular heartbeats occur intermittently and spontaneously resolve within 7 days), (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Essential Hypertension(chronic condition of persistently high blood pressure), Hyperlipidemia(high levels of fat particles in blood), Protein-Calorie Malnutrition Moderate(significant, but not severe, deficiency in nutrient intake), Gastro-Esophageal Reflux Disease(stomach contents leak backward from stomach into the esophagus(food pipe), Dementia(loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life), and Anxiety Disorder(mental health disorder characterized by feelings of worry, fear that interfere with daily activities). R23 has activated Health Care Power of Attorney(HCPOA). R23's Significant Change MDS completed 11/19/25 documents R23's BIMS score is 0, indicating R23 demonstrates severely impaired skills for daily decision making. R23 has no depressive symptoms. R23 demonstrates verbal and other behaviors 1-3 days. R23 has ROM impairment on one side of lower extremity and has no upper ROM impairment. R23 requires partial/moderate assistance for eating. R23's MDS also documents R23 requires substantial/maximum assistance for showers and upper dressing, and is dependent for lower body dressing, transfers, and mobility. R23's is dependent for sit to stand-the ability to come to a standing position from sitting on the bed. R23's MDS also documents that R23 has minimal difficulty for hearing and has hearing aides. R23 has had 2 or more falls since admission or previous assessment. Surveyor reviewed R23's falls care area assessment(CAA). There are boxes that are checked, however, there is no narrative describing the impact of the problem/need and the rationale for a care plan decision. On 2/18/2026, at 10:02 AM, Minimum Data Set (MDS)-K was interviewed by Surveyor on the team. MDS-K confirmed MDS-K is responsible for each residents' CAA. MDS-K does not write much because the boxes are checked to identify areas. MDS-K stated MDS-K does not write long narratives due to the residents' electronic medical record(EMR) which pulls in information. MDS-K stated that MDS-K will start completing CAA narratives effective today. On 2/18/2026, at 1:27 PM, Surveyor shared with Nursing Home Administrator (NHA)-A the concern that both R38 and R23 did not have triggered care area assessemts(CAA) completed for falls and R38 did not have a CAA completed for pressure injury. No further information has been provided by the facility as to why CAAs triggered have not been completed with a thorough narrative describing the impact of the problem, rationale for a care plan decision, and interventions implemented. 3) R62 was admitted to the facility on [DATE] with diagnoses of parkinsonism, anxiety and hypertension. The fall risk assessment dated [DATE] documents R62 is high risk for potential falls. The admission Minimum Data Set (MDS) dated [DATE] documents R62 has severe cognitive impairment and is dependent for bathing and rolling in bed. It also documents R62 had a fall prior to admission. The Care Assessment Area (CAA) dated 11/16/25 documents history of falls, confusion and weakness. The CAAs did not have an additional assessment summary analyzing the MDS data and need for an individualized care plan. On 2/18/2026, at 10:02 AM, Surveyor interviewed MDS Nurse-K via phone. MDS Nurse-K stated they (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	do not write a long narrative in the CAA Summary. The electronic medical record Point Click Care (PCC) triggers the CAA by checked boxes. The PCC system triggers the areas of concern, and they check the boxes. MDS Nurse-K stated the residents are discussed and the care plan is an interdisciplinary development. MDS Nurse-K stated she does not document a summary of the triggered CAAs from the MDS assessment. On 2/18/2026, at 2:46 PM, at the facility exit meeting with Nursing Home Administrator (NHA) -A and Direction of Nursing (DON)-B, no further information was provided as to why the facility did not complete a summary analyzing R62's assessment information in the CAA.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure 1 (R52) of 12 residents reviewed received a completed Minimum Data Set (MDS). R52 was discharged to the hospital on 9/10/25 due to a change in condition. A discharge MDS was not completed.Findings include:R52 was admitted to the facility on [DATE] with diagnoses of metabolic encephalopathy, pneumonia and hypertension. On 9/10/25 R52 was discharged to the hospital due to a change in condition. The MDS information reveals a discharge MDS was not completed on 9/10/25. The medical record reveals the MDS is late.On 2/17/26 at 12:52 p.m., Surveyor interviewed MDS Coordinator-Q. Surveyor explained R52 was discharged to the hospital on 9/10/25 and a discharged MDS was not completed. MDS Coordinator-Q stated she was hired in October to be the MDS Coordinator but hasn't done much with MDSs because she's been training. Surveyor asked MDS Coordinator-Q if she knew why the discharge MDS wasn't completed. MDS Coordinator-Q stated she would investigate it.On 2/18/26 at 9:30 a.m. MDS Coordinator-Q stated an MDS correction was completed to document R52's discharge MDS. MDS Coordinator-Q stated it was an oversight.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility did not ensure 1 (R2) of 12 residents reviewed received an accurate comprehensive Minimum Data Set (MDS) assessment. R2 was admitted on [DATE] and the admission MDS dated [DATE] assess R2 with the need for tracheostomy care. Surveyor notes R2 does not have a tracheostomy.Findings include:R2 was admitted to the facility on [DATE] with diagnoses of right lower leg fracture, asthma, hypertension and atrial fibrillation. The admission MDS dated [DATE] documents R2 has moderate cognitive impairment and is independent with eating. Section O0110 Special Treatments Procedures and Programs documents while a resident R2 was receiving tracheostomy care. On 2/16/26 at 9:44 a.m. Surveyor interviewed R2. Surveyor observed R2 did not have a tracheostomy.On 2/17/26 at 12:52 p.m. Surveyor interviewed MDS Coordinator-Q. Surveyor explained the concern the admission MDS dated [DATE] documents R2 is receiving tracheostomy care. MDS Coordinator-Q stated the facility does not accept residents with tracheostomy. Surveyor explained R2 was observed by Surveyor and does not have a tracheostomy. MDS Coordinator-Q agreed R2 does not have a tracheostomy. MDS Coordinator-Q stated this was a mistake.

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	525085	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eastcastle Pl Bradford Ter Conv Ctr	2505 E Bradford Ave Milwaukee, WI 53211

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure a baseline care plan was developed and implemented within 48 hours of a resident's admission for 1 (R38) of 12 sampled residents reviewed for baseline care plans.*R38's baseline care plan was not thoroughly completed as every section of R38's baseline care plan was not completed. Findings Include:The facility did not provide a baseline care plan policy and procedure for review.R38 was admitted to the facility on [DATE] with diagnoses of Fracture of One Rib, Right Side, Vascular Dementia (brain damage caused by multiple strokes), Atherosclerotic Heart Disease of the Native Coronary Artery (plaque buildup narrows the arteries that supply blood to the heart), Essential Hypertension (chronic condition of persistently high blood pressure), Insomnia (sleep disorder characterized by difficulty falling asleep), Anxiety Disorder (mental health disorder characterized by feelings of worry, fear that interfere with daily activities), and Depression (mood disorder that causes persistent feelings of sadness and loss of interest). R38 has an activated Health Care Power of Attorney (HCPOA).R38's admission Minimum Data Set (MDS) completed 12/12/25 documents R38's Brief Interview for Mental Status (BIMS) score to be 0, indicating R38 demonstrates severely impaired cognitive skills for daily decision making. R38 has no depressive symptoms. R38 has range of motion (ROM) impairment on one side of upper extremity. No ROM impairment on lower extremities. R38's MDS documents R38 demonstrates physical and other behaviors for 1-3 days of the last 7 days. R38 requires supervision for eating. R38 requires partial/moderate assistance for transfers, substantial/maximum assistance for upper body dressing and mobility and is dependent for showers and lower body dressing. R38's MDS documents R38 has a pressure injury, currently has two unstageable areas, and is at risk for developing pressure injuries. R38 has had 2 or more falls since admission or previous assessment. Surveyor reviewed R38's undated baseline care plan provided by the facility. Surveyor notes the following sections of R38's baseline care plan contains no documentation:-admitted for :-Disease/Illness Management including interventions-Assistance of Daily Living (ADL)-Psychosocial well/Ill being care: including interventions-Other special care instructions-Physician order for therapy-Activity/mobility-Labs-There is no physician order for medication/treatment documentationSurveyor notes the front and back pictures of the body figures located under wound and/or pressure injury are circled on the front of the body figure. No further documentation on specific details of R38's skin impairment.Surveyor notes R38 had skin impairment on the back of the right and left heels on admission.R38's 12/5/25 hospital record documents R38 had frequent falls and potential for impact trauma. R38's hospital record documents R38 had up to 15 falls in the past 2 weeks prior to admission to the hospital.Surveyor notes both R38's pressure injuries and high risk for falls are not documented on R38's baseline care plan with person-centered interventions on admission.Surveyor notes R38's physician orders document to verify baseline care plan is complete and signed per responsible party one time only for one day filed under care plan tab in chart-leave open until complete. Start date of 12/6/25 and end date of 12/7/25.On 2/18/2026, at 12:44 PM, Surveyor interviewed Director of Nursing (DON)-B regarding the facility procedure for resident baseline care plans. DON-B explained the baseline care plans are completed on a separate individualized care plan and are not included in the comprehensive care plan. Surveyor reviewed R38's incomplete baseline care plan with DON-B who agreed R38's baseline care plan was not complete, and all areas should have been addressed with immediate interventions on admission. DON-B understands the concern R38's baseline care plan was not thoroughly completed on admission.On 2/18/2026, at 1:27 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A that R38's baseline care plan was not thoroughly completed, and two significant areas of pressure injury/wound, and falls was not completed and did not include person-centered interventions. NHA-A acknowledged the concern.

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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** Based on interview and record review, the facility did not complete neurological (neuro) checks in accordance with policy and procedure for 1 (R38) of 4 residents reviewed for unwitnessed falls.*R38 did not receive neurological checks in accordance with facility's policy and procedure for 1 of 3 unwitnessed falls.Findings Include:The facility's Falls policy and procedure revised 12/25 documents:2. In addition, the nurse shall assess and document/report the following:e. Neurological statusThe facility's process for completing neurological assessment is the following:-Time of incident-30 min post incident check-60 min post incident check-Following shifts for 72 hoursR38 was admitted to the facility on [DATE] with diagnoses of Fracture of One Rib, Right Side, Vascular Dementia(brain damage caused by multiple strokes), Atherosclerotic Heart Disease of the Native Coronary Artery(plaque buildup narrows the arteries that supply blood to the heart), Essential Hypertension(chronic condition of persistently high blood pressure), Insomnia(sleep disorder characterized by difficulty falling asleep), Anxiety Disorder(mental health disorder characterized by feelings of worry, fear that interfere with daily activities), and Depression(mood disorder that causes persistent feelings of sadness and loss of interest). R38's admission Minimum Data Set(MDS) completed 12/12/25 documents a Brief Interview for Mental Status(BIMS) score to be 0, indicating R38 demonstrates severely impaired skills for daily decision making. The MDS documents that: R38 has no depressive symptoms; R38 has range of motion (ROM) impairment on one side of upper extremity; No ROM impairment on lower extremities; R38 demonstrates physical and other behaviors for 1-3 days; R38 requires supervision for eating; R38 requires partial/moderate assistance for transfers, substantial/maximum assistance for upper dressing and mobility, and is dependent for showers and lower dressing; R38 has a pressure injury, currently has two unstageable, and is at risk for developing pressure injury and that R38 has had 2 or more falls since admission or previous assessment.Surveyor reviewed R38's three unwitnessed falls.R38 had an unwitnessed fall on 1/18/26 and there is no documentation that neuro-checks were completed per facility policy and process.On 2/18/2026, at 11:00 AM, Surveyor interviewed Director of Nursing (DON)- B in regard to the facility process for neurological checks to be completed. DON-B informed Surveyor that neuro-checks should be completed for any unwitnessed fall. Surveyor shared that R38 is missing a shift for R38's 1/17/26 unwitnessed fall and there are no documented neuro-checks for R38's 1/18/26 unwitnessed fall.On 2/18/2026, at 1:27 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A that R38 was missing a neuro-check for a shift following R38's 1/17/26 unwitnessed fall and that there are no documented neuro-checks following R38's unwitnessed fall on 1/18/26.No additional information has been provided by the facility at this time as to why R38 has missing documented neuro-checks following R38's unwitnessed falls.

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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** Based on observation, interviews, and record review, the facility did not ensure a resident (R23) with hearing and vision impairment received proper treatment and assistive devices to maintain vision and hearing abilities.*Surveyor observed R23 to not be wearing R23's bilateral hearing aids and glasses during the survey process.Findings Include:The facility's Hearing Impaired Resident, Care of policy and procedure revised 2/18 documents:Policy Statement:Staff will assist hearing impaired residents to main effective communication with clinicians, caregivers, other residents and visitors.Policy Interpretation and Implementation:3. Staff will assist residents with care and maintenance of hearing devices.4. Staff will help residents who have lost or damaged hearing devices in obtaining services to replace the devices.j. Evaluate resident's adaptive needs and progress at regular intervals.R23 was admitted to the facility on [DATE] with diagnoses of Paroxysmal Atrial Fibrillation (irregular heartbeats occur intermittently and spontaneously resolve within 7 days), Essential Hypertension (chronic condition of persistently high blood pressure), Hyperlipidemia (high levels of fat particles in blood), Protein-Calorie Malnutrition Moderate (significant, but not severe, deficiency in nutrient intake), Gastro-Esophageal Reflux Disease (stomach contents leak backward from stomach into the esophagus (food pipe), Dementia (loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life), and Anxiety Disorder (mental health disorder characterized by feelings of worry, fear that interfere with daily activities).R23's Significant Change MDS completed 11/19/25 documents a BIMS (Brief Interview for Mental Status) score of 0, indicating R23 demonstrates severely impaired skills for daily decision making. The MDS documents: R23 has no depressive symptoms; R23 demonstrates verbal and other behaviors 1-3 days; R23 has ROM impairment on one side of lower extremity and has no upper ROM impairment; R23 requires partial/moderate assistance for eating; R23's MDS also documents R23 requires substantial/maximum assistance for showers and upper dressing, and is dependent for lower body dressing, transfers, and mobility; R23's is dependent for sit to stand-the ability to come to a standing position from sitting on the bed; R23's MDS also documents that R23 has minimal difficulty for hearing and has hearing aids and that R23 has had 2 or more falls since admission or previous assessment.R23's current physician orders document to assist R23 with hearing aids' placement-on AM (morning) and off HS (hour of sleep), Effective 1/7/26. R23's certified nursing assistant (CNA) care card documents to offer assistance with bilateral hearing aids in AM or HS. Charge hearing aids in medication room. R23's comprehensive care plan documents to provide bilateral hearing aids and glasses. Initiated 12/2/25. Surveyor noted R23's comprehensive care plan does not address R23's vision and hearing loss including R23 wearing glasses and bilateral hearing aides. R23's care plan does not address if R23 refuses to wear R23's glasses and hearing aides and interventions to address refusals.On 2/16/2026, at 10:06 AM, Surveyor observed R23's purple glasses on the window ledge in R23's room. Surveyor observed R23 in a broda chair located at the nurse's station. Surveyor observed R23 not wearing glasses and bilateral hearing aides. On 2/17/26, the facility updated R23's physician orders to document if R23 refused hearing aid placement or takes them off and/or throws them two times a day.On 2/17/2026, at 3:39 PM, Surveyor observed R23 up in R23's broda chair not wearing glasses or bilateral hearing aides. On 2/17/2026, at 9:54 AM, Surveyor observed R23 in a broda chair located at the nurse's station. Surveyor observed R23 not wearing glasses and bilateral hearing aides. On 2/17/2026, at 12:12 PM, Surveyor interviewed both Certified Nursing Assistants (CNA)-M and CNA-N in regard to R23. Both CNA-M and CNA-N informed Surveyor that R23's hearing aides have been missing for awhile but does not know how long the hearing aides have been missing.On 2/17/2026, at 1:39 PM, Surveyor interviewed Nurse Manager (NM)-I regarding R23. NM-I stated that R23 does not wear glasses as much anymore and R23 wears R23's hearing aides on a regular consistent basis. NM-I explained the bilateral hearing aides are kept at the nurse's station and the (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurse should be validating that R23 is wearing them. Surveyor shared the concern to NM-I that R23's glasses and hearing aides have not been in place. On 2/17/2026, at 1:52 PM, Surveyor confirmed that the bilateral hearing aides are not in and R23 is not wearing glasses. R23 is sitting in the broda chair in the dining room.On 2/17/2026, at 3:13 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B that R23 has not had R23's glasses on and bilateral hearing aides in during the survey process.On 2/17/2026, at 3:36 PM, at Licensed Practical Nurse (LPN)-L informed Surveyor that LPN-L attempted to place R23's bilateral hearing aides in, but R23 kept pulling at R23's ears and grabbing at them, so LPN-L had the CNA put back the bilateral hearing aides on the charger because R23 wouldn't wear the hearing aides. LPN-L stated LPN-L wrote a note but then struck it out. DON-B was present with LPN-L. Surveyor shared the concern that there is no documentation that R23 is refusing to wear the hearing aides or glasses. Surveyor shared that there are no interventions in place when R23 refuses to wear bilateral hearing aides and glasses documented on R23's comprehensive care plan. Surveyor shared the bilateral hearing aides are to be placed in, remains documented on R23's care card. Surveyor noted there is no documentation in R23's progress notes located in R23's electronic medical record(EMR) that R23's glasses and bilateral hearing aides were attempted to be placed on/in and interventions attempted.Surveyor reviewed R23's medication administration records(MARS) for January and February.January: There is 7 days with documentation that R23 was not wearing bilateral hearing aides.February: There is 10 days with documentation that R23 was not wearing bilateral hearing aides.Surveyor reviewed R23's progress notes and LPN-L did not document on 2/17/26 that R23 refused to wear R23's bilateral hearing aides. On 1/31/2026, LPN-R documented: Hearing Aides located and charged in 4th floor medication room. Document if R23 refused hearing aids placement two times a day. Hearing aids not working.Surveyor notes the 1/31/26 progress note is the only documented note in regards to R23's hearing aides. There is no documented follow-up to R23's hearing aides not working at this time.On 2/18/2026, at 10:08 AM, the facility did not provide any additional information in regards to R23 not wearing bilateral hearing aides and or glasses on during the survey process.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview and record review, the facility did not ensure 3 (R23, R38 and R62) of 4 sampled residents received adequate supervision and assistance devices to prevent and be free of accidents. * On 2/2/26 R23 was evaluated by physical therapy, after the facility risk management team determined R23 was doing better, to assess changing R23's transfer status from the use of a mechanical lift to being transferred with a sit to stand or through a stand-pivot transfer. Following the evaluation R23 was upgraded to transfer with the assist of two staff using a sit to stand. R23's power of attorney for healthcare was not consulted with or notified of this change in care for R23. On 2/14/26 two Certified Nursing Assistants (CNAs) proceeded with transferring R23 using a sit to stand despite R23 showing resistance to sitting upright to position the sling and releasing staffs hand to hold onto the bar. The CNAs (U and V) proceeded with raising R23 up using the lift and discovered a cord was in the way of the lift impeding moving the lift. They turned their attention to move the cord and R23 slipped from the sling/lift hitting their head on the bed. R23 sustained an injury requiring transfer to the hospital to have staples placed related to the head injury. R38's assessments and facility care plans did not address all of R23's possible risk factors. Multiple staff indicated R23 should not have had their transfer modality changed as it was unsafe. * R38 sustained 3 avoidable falls following admission to the facility. The facility did not ensure post fall investigations were comprehensive to help determine a root cause analysis to determine effective interventions to prevent falls and possible injuries. During the survey, R38 was observed to not have safety interventions implemented. * On 11/27/25, R62 was found on the floor next to his bed. The fall investigation reveals R62's bed was left in a high position (a position higher than the baseline height of the average bed/height for caregivers to provide cares). The staff involved provided a statement post fall indicating the plan of care was not followed. The standard of practice for Nurse Aides was not followed prior to the fall. Findings include: The facility's Falls-Clinical Protocol dated September 2012 documents1. As part of the initial assessment, the Interdisciplinary team (IDT) will help identify individuals with a history of falls and risk factors for subsequent falling. a. Staff will ask the resident and caregiver or family about a history of falling.b. Staff to complete Fall risk EvaluationTreatment/Management1. Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risk of serious consequences of falling.a. Examples of such interventions may include calcium and vitamin D supplementation to address osteoporosis, addressing medical issues such as hypotension and dizziness and tapering, discontinuing, or changing problematic medications (for example, those that could make the resident dizzy or cause blood pressure to drop significantly on standing). Change to add fall mat, bed in lowest position, visual cue for call light etc. 1.) R23 was admitted to the facility on [DATE] with diagnoses of Paroxysmal Atrial Fibrillation (irregular heartbeats occur intermittently and spontaneously resolve within 7 days), Essential Hypertension (chronic condition of persistently high blood pressure), Hyperlipidemia (high levels of fat (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	particles in blood), Protein-Calorie Malnutrition Moderate (significant, but not severe, deficiency in nutrient intake), Gastro-Esophageal Reflux Disease (stomach contents leak backward from stomach into the esophagus (food pipe), Dementia (loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life), and Anxiety Disorder (mental health disorder characterized by feelings of worry, fear that interfere with daily activities). R23's Significant Change Minimum Data Set (MDS) completed 11/19/25 assesses R23 with a BIMS (Brief Interview for Mental Status) score of 0, indicating R23 demonstrates severely impaired skills for daily decision making. The MDS documents: R23 has no depressive symptoms; R23 demonstrates verbal and other behaviors 1-3 days; R23 has Range of Motion (ROM) impairment on one side of lower extremity and has no upper ROM impairment; R23 requires partial/moderate assistance for eating; R23's MDS also documents R23 requires substantial/maximum assistance for showers and upper dressing, and is dependent for lower body dressing, transfers, and mobility; R23's is dependent for sitting to standing-the ability to come to a standing position from sitting on the bed; R23's MDS also assesses R23 a having minimal difficulty for hearing and has hearing aids and that R23 has had 2 or more falls since admission or previous assessment. Surveyor noted that R23's dependency on assistance for transfers and mobility established R23 requires substantial staff intervention for safe repositioning and movement, increasing the risk of injury if equipment selection for transfers was inconsistent or improperly implemented. Surveyor noted R23's Care Area Assessment (CAA) for falls was triggered as requiring further review and to proceed to a plan of care. The CAA did not include the details to demonstrate R23's risk factors and the details considered to develop a plan of care related to falls for R23. R23's Fall Risk Evaluation completed 11/19/25 documents R23 is high risk for falls with a score of 17. Surveyor noted that a high risk fall score, combined with cognitive impairment and mobility dependence, required staff to adhere to transfer protocols and verify safe transfers to prevent accidents for R23. R23's current certified nursing assistant (CNA) care card documents R23 is to be transferred using a mechanical lift with assistance of two staff. R23's comprehensive care plan documents R23 is at risk for falls due to deconditioning, and pain; secondary to L3 compression fracture. Dementia. No safety awareness. Initiated 9/19/25 Revised 12/2/25 Interventions: -Anticipate and meet (R23's) needs. Initiated 9/19/25 -Be sure (R23's) call light is within reach and encourage (R23) to use it for assistance as needed. (R23) needs prompt response to all requests for assistance. Initiated 9/19/25 -Educate (R23)/family/caregivers about safety reminders and what to do if a fall occurs. Initiated 9/19/25 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Ensure phone and items are close to (R23) for easy access. Initiated 10/29/25 -Physical Therapy evaluate and treat as ordered or as needed. Initiated 9/19/25 -(R23) needs a safe environment with: floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, personal items with reach. Initiated 9/19/25 -11/14/25 Staff re-education on rounding and incontinence care. Initiated 11/14/25 Revised 11/17/25 Surveyor reviewed R23's hospice care plan which documents: Hospice nurse to assess for fall risk factors: Abnormal gait/balance, Muscle weakness, Taking 4 or more medications, Vision deficits (poor visual acuity, reduced contrast sensitivity, decreased visual field, cataracts, glaucoma, macular degeneration, etc), Certain chronic diseases, such as Parkinson's Disease, arthritis, stroke, cognitive impairment, osteoporosis, etc., History of previous falls, Postural hypotension (dizziness, syncope), Cardiac arrhythmia, Use of restraints, Sleep problems, Alcohol consumption, Presence of pain, Peripheral neuropathy, Urinary frequency, urgency, incontinence, nocturia. -Hospice nurse to instruct facility on R23 and caregiver on safe and appropriate use of assistive devices.-Hospice nurse to instruct facility, patient/caregiver on fall prevention strategies.-Hospice nurse to instruct facility, patient/caregiver on safe transfers.-Hospice nurse to review care plan with facility, patient/family/caregiver. Surveyor noted the facility care plan for falls does include R23's diagnoses of postural hypotension as a possible risk factor during transfers as referenced in the hospice plan of care. MDS Coordinator (MDS)-Q documented the following: Initiated 11/13/25 TRANSFER: (R23) requires mechanical lift 11/28/2025 TRANSFER: (R23) requires sit to stand Assistance of two for transfers 2/2/2026 TRANSFER: (R23) requires mechanical lift assistance of two for transfers 2/16/2026 On 2/17/2026, at 1:46 PM, Surveyor asked LPN Wound Nurse-I about the changes in R23's transfer status. LPN Wound Nurse-I informed Surveyor that therapy would have made the decision to change R23's transfer status to a sit to stand. On 2/2/26, Physical Therapist (PT)-O documented: PT evaluation completed this date. R23 is being referred to therapy services to evaluate R23's transfer status. Sit to stand lift trialed with CNA present in room. R23 was able to complete 3 stands, each lasting about 30-45 seconds. Transfer completed to Broda chair with assist of two. Sit to stand trialed from Broda with R23 holding onto writer, maximum assistance of one required. R23 tolerated standing for about 15 seconds and then let go of writer to try and sit. Pivot transfer not safe to trial at this time. R23 is upgraded to use of sit to stand lift with assist of two on unit. Further skilled therapy is not warranted at this time due to R23 being on hospice care. Surveyor noted R23's care plan adjusting R23 to being able to transfer using a sit to stand with assist of two did not include factors to monitor for such as the length of time it may take to transfer R23 given R23 was only able to stand and hold on for limited lengths of time versus and extended period that may be required to complete a full transfer. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/14/26, at 8:50 AM, R23 was assisted by two CNAs utilizing the sit to stand. The fall investigation, with a statement written by Certified Nursing Assistant (CNA)-U, states when CNA-U was first trying to put the sling on R23, R23 was resisting sitting up straight but eventually got R23 to sit up straight. R23 also would not loosen up R23's hands to hold on to the bars, eventually getting R23 to loosen up and hold on. CNA-U's statement documents R23 let go of the handlebars on the sit to stand and fell out of the sling into a fetal position, hitting R23's head and both CNA-U and CNA-V noticed blood coming out. CNA-V stated R23 was up in the air when the pathway was unclear. With one hand on R23's back, CNA-V bent down to clear the way of the cords in the way, CNA-U began to pull out the sit to stand and R23 fell out of the sling. CNA-U's statement documents that R23 should never have been made a sit to stand transfer as it was not a good idea. Surveyor noted prior to initiating the transfer CNA-V and U did not ensure the pathway to complete the transfer in was clear and safe requiring them to turn their attention away from R23. On 2/14/2026, at 9:28 AM, Registered Nurse (RN)-T documented: Writer made aware by aides that they were attempting to transfer R23 to wheelchair with sit to stand at 8:50 AM. Aides reported that R23 was secured tightly in sling. One aide began to lift R23 by remote while the other removed a cord that was blocking the machine's pathway. Aides also reported that R23 held a tight grip before trying to have her hold the safety bars and that assisted R23 with loosen (sic) hands for proper placement. Once R23 was raised from bed, R23 released hands from safety bars and slipped out of the sling. Aides stated R23 hit head on foot of bed. Upon observation, R23's head was bleeding. Writer immediately called 911 for assistance and took vitals. R23 was awake and moaning in pain. R23 did not lose consciousness at any time while with R23. Writer kept talking to R23 and noted R23 squeezing writer's hand. Writer remained bedside with R23 until paramedics arrived to evaluate. Upon evaluation, it was determined that R23 should be sent to emergency room to evaluate head laceration. Ambulance arrived at 9:20 AM to transfer R23 to emergency room. Call to HCPOA (healthcare power of attorney) attempted with no success, callback number provided on voice mail. R23's fall documents that R23 became unstable while elevated in the sit to stand, resulting in an unprotected fall from the sling with an injury requiring staples to the head. On 2/14/2026, at 12:00 PM RN-T documented: Writer explained the fall and transfer to emergency room to HCPOA. HCPOA had questions about transfer status as she believed R23 was a mechanical lift. Writer explained that R23 was a mechanical lift transfer and writer was made aware that status was upgraded to sit-to-stand recently. HCPOA made writer aware that R23 is getting stitches and should be coming back to facility at some point. Surveyor reviewed R23's emergency room documentation dated 2/14/26. A CT (computed tomography scan) of head without contrast was completed and R23 sustained a laceration of scalp due to a fall and received staples to the back of R23's head. On 2/16/26 R23's falls care plan was revised stating: - 2/14/26 (R23) sent to (initials of hospital) for evaluation. (R23) downgraded to mechanical lift assistance of two. Initiated 2/16/26. On 2/16/2026, at 12:07 PM, Surveyor interviewed Anonymous individual (ANON)-P via telephone. Anon-P shared it was understood R23 was to be transferred with a mechanical lift but R23 was transferred with the use of a sit to stand. Anon-P expressed concern regarding why the change was made and that not everyone was aware of the change. Anon-P expressed concern that R23 was unnecessarily injured because of the unsafe change in transfers. (continued on next page)

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	525085	A. Building B. Wing	02/18/2026

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Eastcastle Pl Bradford Ter Conv Ctr	2505 E Bradford Ave Milwaukee, WI 53211

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/16/2026, at 4:06 PM, Licensed Practical Nurse (LPN) Wound Nurse-I documented: IDT (interdisciplinary team) team (sic) met and discussed R23's witnessed fall, R23's plan of care was followed, including transfer status. The correct size sling was used for transfer. R23 was sent to the hospital. Upon return, R23 downgraded to mechanical lift transfer. Surveyor noted upon review of the interdisciplinary team note related to the fall the team did not take into consideration the CNAs initiated use of the lift despite resistance/reluctance from R23. CNA-U and V did not seek out guidance from a nurse prior to proceeding with the transfer to ensure R23's safety. Surveyor also noted the interdisciplinary team did not take into consideration the CNA did not ensure the pathway was clear of obstacles that required turning their attention away from R23 during the transfer leading to an unsafe transfer. On 2/18/2026, at 7:29 AM, Surveyor asked CNA-G about transferring R23. CNA-G informed Surveyor that CNA-G knows R23 very well. CNA-G stated that CNA-G used their judgment with R23 to continue to use the mechanical lift when R23 was changed to transfer with a sit to stand. CNA-G explained that R23 had good days and bad days where R23 appears to be weaker and more disoriented so CNA-G would use the mechanical lift to transfer R23. When asked about R23'a 2/14/26 fall. Both CNA-G and CNA-H shared that they both believe there was a lack of judgement due to R23 not being able to stand well that day contributed to R23 slipping out of the sling. CNA-G stated R23 will buckle R23's legs. Surveyor noted there are multiple indicators from staff presently and at the time of the fall that questioned the decision to change how R23 was to be transferred. Surveyor noted the assessment to change R23's transfer status did not seem to include facts from staff that work with R23 on a routine basis and assist R23 with transfers. On 2/18/2026, at 8:59 AM, Surveyor interviewed Physical Therapist (PT)-O who evaluated R23 and upgraded R23 to the sit to stand. PT-O was informed by nursing they wanted to do an evaluation because R23 was doing better. PT-O completed a couple of transfers with the sit to stand, and it went well so PT-O upgraded R23 to the sit to stand. PT-O stated R23 did not have any buckling of legs when the transfer was completed and R23 could tolerate standing for a period of time. PT-O stated the size of the sling is based on weight. PT-O stated something didn't go right, maybe they used the wrong size sling or it was too loose. On 2/18/2026, at 11:06 AM, Surveyor interviewed Director of Nursing (DON)-B regarding R23's fall out of the sit to stand sling. DON-B explained that at the weekly risk meeting, it was discussed that R23 was stronger and that is how the upgrade from mechanical lift to sit to stand occurred. DON-B shared that both agency CNAs and new CNAs are provided education and policies on safe transfers. Surveyor shared the concern with DON-B that R23 slipped out the sling resulting in 4 staples. Surveyor shared that 'something' with the transfer process of R23 did not go according to facility procedure for a safe transfer. The facility's failure to ensure the real time clinical appropriateness of the sit to stand transfer resulted in the resident becoming unstable while elevated, slipping from the sling and sustaining actual harm in the form of scalp laceration requiring emergency treatment and staples. 2.) R38 was admitted to the facility on [DATE] with diagnoses of Fracture of One Rib, Right Side, Vascular Dementia (brain damage caused by multiple strokes), Atherosclerotic Heart Disease of the Native Coronary Artery (plaque buildup narrows the arteries that supply blood to the heart), Essential (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hypertension (chronic condition of persistently high blood pressure), Insomnia (sleep disorder characterized by difficulty falling asleep), Anxiety Disorder (mental health disorder characterized by feelings of worry, fear that interfere with daily activities), and Depression (mood disorder that causes persistent feelings of sadness and loss of interest). R38's admission Minimum Data Set (MDS) completed 12/12/25 assesses a Brief Interview for Mental Status (BIMS) score to be 0, indicating R38 demonstrates severely impaired skills for daily decision making. The MDS documents: R38 has no depressive symptoms; R38 has range of motion(ROM) impairment on one side of upper extremity; No ROM impairment on lower extremities; R38's MDS documents R38 demonstrates physical and other behaviors for 1-3 days; R38 requires supervision for eating; R38 requires partial/moderate assistance for transfers, substantial/maximum assistance for upper dressing and mobility, and is dependent for showers and lower dressing; R38's MDS documents R38 has a pressure injury, currently has two unstageable, and is at risk for developing pressure injury and that R38 has had 2 or more falls since admission or previous assessment. Surveyor notes that R38's Care Area Assessment (CAA) for falls was triggered and not thoroughly completed to include a narrative describing the impact of the problem/need and the rationale for a care plan decision. R38's 12/5/25 hospital record documents: R38 with frequent falls and potential for impact trauma. R38's hospital record documents R38 had up to 15 falls in the past 2 weeks prior to admission to the hospital. Surveyor notes R38's high risk for falls are not documented on R38's baseline care plan with person-centered interventions upon admission. R38's Fall Risk Evaluation completed 12/6/25 documents a score of 11, indicating R38 is at high risk for falls. R38's Certified Nursing Assistant (CNA) care card documents R38 is to have bed in lowest position and a fall mat. R38's comprehensive care plan documents: R38 is at risk for falls due to weakness, confusion, gait/balance problems. History of falls. Initiated 12/6/25 Revised 12/18/25 Interventions: -1/16/26 Environmental assessment, provide education to staff member regarding proper positioning during cares. Initiated 1/16/26 Revised 1/21/26-1/18/26 Continence evaluation assessment to be completed. Initiated 1/21/26-1/19/26 Encourage R38 to be up for meals in dining room. Initiated 1/19/25 Revised 1/21/26-Bed in lowest position. Initiated 12/8/25-Encourage R38 to be up for meals in dining room. Initiated 1/19/26-Ensure that R38 is wearing appropriate footwear when ambulating or mobilizing in w/c. Initiated 12/8/25-Fall mat next to bed. Initiated 12/6/25 Revised 2/16/26-Medication review from pharmacy consultant. Initiated 12/8/25-R38 needs a safe environment with: floors free from spills and/or clutter a working and reachable call light. Initiated 12/8/25 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/8/25, Nurse Practitioner (NP)-S documented in R38's history and physical: R38 is here for a new patient history and physical for skilled rehabilitation, with the primary goal of strengthening. R38 has experienced 15 falls in the past two weeks and is described as alert and oriented to two spheres. Assessment: 1. Impaired mobility and frequent falls- R38 has reported multiple falls due to muscle weakness and impulsivity, requiring further strengthening and monitoring. 3. Cognitive impairment- Alert and oriented to two spheres, indicating potential cognitive challenges that need addressing. Plan 1. Impaired mobility and frequent falls -Proceed with strengthening therapies to enhance muscle function and reduce fall risk. -Implement close monitoring for safety due to impulsivity and mobility issues. 3. Cognitive impairment -Maintain regular assessment of cognitive status and adjust care plans as needed. -Ensure staff is aware of and accommodates cognitive deficits. On 2/17/2026, at 10:37 AM, Surveyor reviewed the investigations into R38's three unwitnessed falls. Fall 1. 1/15/26 at 6:20 PM. R38 was found lying on R38's back next to the wall. The CNA was changing the bed after the bed bath. The bed was pulled away from the wall and elevated to allow CNA to give a bed bath and change the sheets. Per CNA, R38 abruptly turned to R38's left side. The mattress was not properly placed on the bed frame, leaving the mattress unsupported from the bed frame and R38 rolled off the bed on to the floor. R38 sustained an abrasion to the right elbow. Per investigation, the CNA involved was re-educated on making sure the mattress is secured on the bedframe, make sure the resident is lying flat on the bed with weight evenly dispersed and CNA should be on the side the resident is lying and facing to act as a barrier from rolling off the bed. Surveyor noted R38's care plan documents R38 requires moderate assistance of one to turn and reposition in bed. Fall 2. 1/17/26 at 12:14 PM. R38 was found on the floor by family in a sitting position on the fall mat bedside. R38 stated, I was sitting at the edge of the bed and slipped to the floor about two feet onto the mat. R38 indicated R38 wasn't going anywhere when R38 slipped. The investigation does not document if the fall interventions of gripper socks and low bed was implemented. R38's continence status is not documented. The fall investigation does not have documented statements from possible witnesses or staff responsible for R38. Fall 3. 1/18/26 at 2:08 AM.R38 was found on the floor by CNA. R38 was wrapped in bed sheet. Bed (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the State of Wisconsin Nurse Aide Candidate Handbook date November 2025 Version 74: all nurse aide competencies for providing care in bed include the expectations: .Leave the resident in a position of safety and .Lower the bed. On 2/18/26 at 10:00 a.m. Surveyor interviewed Director of Nursing (DON)-B regarding R62 fall. Surveyor explained the concern the investigation reveals R62 was left in a high bed and fell out of bed. Surveyor explained the concern R62 was dependent in bed. Surveyor explained the investigation doesn't reveal how R62 fell or if R62 is dependent for moving in bed. Surveyor asked if there is additional information to this fall investigation and if any education provided. DON-B stated she understood the concern and will asked NHA-A if there is any additional pieces to the investigation for R62. On 2/18/26 at 12:55 p.m. Surveyor interviewed Nursing Home Administrator (NHA)-A. Surveyor explained to NHA-A the concern R62 was left in a high bed and fell out of bed. Surveyor explained R62 was dependent for bed mobility and the investigation doesn't reveal how R62 fell out of bed. Surveyor asked if there is additional information to the investigation and if any education was provided to staff. NHA-A stated she thinks there is more information to the investigation. On 2/18/26 at 1:35 p.m. NHA-A stated to Surveyor she did not have any additional information regarding the investigation. NHA-A stated education was provided to nursing staff. No additional information was provided.

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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. Based on observation, interview and record review the facility did not ensure 1 (R6) of 3 residents observed during medication pass received medications without errors or that the medication error rate was not 5 percent or greater. The medication error rate was 33.33%.*On 2/17/26 at 9:00 a.m., Surveyor observed R6 receive his medications through his G (gastrointestinal) tube. Surveyor observed RN (Registered Nurse)- F dispense R6's morning medications into individual medication cups and then crush them individually. RN-F instilled all the medications at the same time without water flushes in between each medication. Findings include:The facility's Administering Medications through an Enteral Tube policy dated March 2015 documents: 3. Do not mix medications together prior to administering through an enteral tube. Administer each medication separately. 23. Dilute the crushed or split medications with 15-30 milliliter (ml) sterile or purified water (or prescribed amount).26. If administering more than one medication, flush with 15 ml (or prescribed amount) warm sterile or purified water between medications27. When the last of the medication begins to drain from the tubing, flush the tubing with 15 ml of warm or purified water (or prescribed amount).On 2/17/26 at 9:00 a.m. Surveyor observed RN-F prepare R6 medications to be administered through G tube. RN-F dispensed each medication, which was ten medications in total, into individual cups. RN-F crushed nine tablets separately and poured one liquid medication. RN-F poured water into each crushed medication separately. RN-F checked placement then administered the water flush per facility policy. R6's family member explained to RN-F that it was easier to administer all the meds at the same time. RN-F then proceeded to mix all the medication in the same syringe and instill the medications into R6's G-tube. RN-F then flushed the G tube with water as per facility policy. On 2/18/26 at 10:08 a.m. Surveyor interviewed Director of Nursing (DON)-B. Surveyor explained the concern RN-F administered R6 medications through the G tube and did not follow the facility's policy. Surveyor explained RN-F carefully crushed all the tablet medications separately but when it came time to administer the medications, she instilled all the medications at the same time. Surveyor explained that R6 family member directed RN-F to administer the medications in this manner. DON-B stated R6 family member is particular when it comes to the care of R6. DON-B stated she agreed RN-F did not follow the facility's policy in regards to administering R6 medications through the G tube. No additional information was provided.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on record review, observation and interviews, the facility did not ensure the required nurse staff posting information was posted. The facility did not document the total amount of hours for Certified Nursing Assistants (CNAs). This had the potential to affect all 39 residents in the facility.Findings include:The policy Titled Staffing Hours Posting Procedure, created 1/2020 documented:ResponsibilityThe nursing Scheduler creates/posts weekday BIPA sheets.Designee acts if scheduler is absent.Required informationNursing staff hours based on position for all 3 shifts.Compliance MonitoringNurse Manager/DON (director of nursing) and/or verifies presence and accuracy.Surveyor reviewed January 2026 and February 2026 nurse staff schedules along with the nurse staff posting information. The nurse staff posting did not document the total number of hours for CNAs.On 2/17/2026, at 2:05 PM, Surveyor spoke with Staffing Specialist (SS)-C who has been in the role for over a year. SS-C admitted they are responsible for filling out the staff posting information. SS-C was not aware that the required CNA staffing hours were not posted. SS-C stated it was an oversight.On 2/17/26, at 2:27 PM, Surveyor spoke with Nursing Home Administrator (NHA)-A who indicated the SS-C fills out the nurse staffing information. NHA-A was not aware of the missing CNA posting information. NHA-A stated the staff postings are made by hand and the CNA hours were missing. NHA-A stated either NHA-A or Director of Nursing (DON)-B are responsible for the daily postings if SS-C is absent.On 2/17/26, at 3:03 PM, Surveyor shared the concern of information missing from the nurse staff posting with NHA- A and DON- B. No additional information was provided.