STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525242	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Kensington	1810 Kensington Dr Waukesha, WI 53188

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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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and record review, the facility did not ensure accurate reporting of the mandatory submission of staffing information based on payroll data to the Centers for Medicare and Medicaid Services (CMS). The facility failed to enter accurate data in their Payroll Based Journal (PBJ) system which triggered an alert for excessively low weekend staffing. This has the potential to affect all 70 residents residing in the facility. This is evidenced by: Centers for Medicare & Medicaid Services (CMS) Electronic Staffing Data Submission Payroll-Based Journal, Long-term Care Facility Policy Manual, dated June 2022, states in part: Chapter 1: Overview, 1.1 introduction .(U) mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.1.2 Submission Timelines and Accuracy. Direct care staffing and census data will be collected quarterly and is required to be timely and accurate. Report Quarter: staffing and census data will be collected for each fiscal quarter. Staffing data includes the number of hours paid to work by each staff member each day within a quarter. Census data includes the facility's census on the last day of each of the three months in a quarter. The fiscal quarters are as follows: Fiscal Quarter, Date range: 1. October 1 - December 31, (quarter 1) 2. January 1 - March 31, (quarter 2) 3. April 1 - June 30, (quarter 3) 4. July 1 - September 30 (quarter 4) . PBJ Staffing Data Report, CASPER Report (Certification and Survey Provider Enhanced Reports) 1705D for Fiscal year Quarter 1 2026 (October 1 - December 31), run on 4/20/2026, indicates the following: Submitted Weekend Staffing data is excessively low. On 04/28/2026, Surveyor conducted a review of the schedules provided by the facility for the weekends during October- December 2025. It was noted there was a RN (Registered Nurse) or LPN (Licensed Practical nurse) on each shift as well as CNA (Certified Nursing Assistants) designated for each shift and units. If the facility had any unfulfilled hours, they would use agency although this was not frequently a concern. The schedules designated the charge nurse on each shift. Surveyor conducted a review of the Facility Assessment Tool, last reviewed/updated 1/27/26, which documents, Staffing: 7-10 RN providing direct care. 2 RNs with administrative duties. 12-16 LPNs providing direct care. 4-6 Medical Aides/Technicians. 32-38 CNAs. 1 Infection Preventionist. 1 MDS (Minimum Data Set). Direct care staff is calculated based upon acuity of resident needs and ADL (Activities of Daily Living) index scored; flexibility is allowed due to the nature of admissions and discharges for short term and long-term care resident needs reflected in the activities of daily living index reflected on the MDS. Staffing is adjusted based on resident clinical needs. On 04/22/2026 at 9:56 AM, Surveyor interviewed Scheduler-H who has been in this position for approximately 6 weeks. Scheduler-H stated she makes the schedule the same for the weekends as during the week. If there is a call-in, they will send out a message for staff to help. Scheduler-H stated the facility will also use agency staffing for call-ins. Scheduler-H stated she does not know why the staffing data report would indicate there is low weekend staffing and is not sure who submits the report. On 4/28/26, at 1:16 PM, Surveyor interviewed Director of Labor Management-I who stated they are aware of the staffing data report (continued on next page)

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

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	triggering for low weekend staffing and it is something they reviewed. Director of Labor Management-I stated she does not see why it would trigger but then stated facilities struggle with putting agency staff down, especially on the weekend. Director of Labor Management-I stated the office is closed and if the facility does not use good documentation, it is hard to reconcile punches and agency staff are not always counted. Director of Labor Management-I then stated it's a struggle to get the agency staff into the clock and capture those hours. Director of Labor Management-I stated she is new to the position and put a new process in place. As of the time of exit, the facility was not able to provide additional information regarding the inaccurate submission of staffing information, triggering excessively low weekends from October 1- December 31, 2025.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for 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 receive necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 2 of 6 (R14 and R3) residents reviewed for pressure injuries. R14 did not have care plan interventions of a pillow under her legs while in chair implemented during survey. R3 had a delay of comprehensive assessment of her pressure injury upon return from an appointment. Findings include: The facility policy titled Pressure Injury Prevention and Management reviewed/revised 1/2026 documents (in part) . This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries. 2. The facility shall establish and utilize a systemic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate. 3. Assessment of Pressure Injury Risk a. Licenses nurses will conduct a pressure injury risk assessment, using the Braden risk assessment on all residents upon admission/readmission, weekly for 4 weeks, then quarterly or whenever the resident's condition changes significantly. c. Licensed nurses will conduct a full body skin assessment on all residents upon admission/readmission, weekly, and after any newly identified pressure injury. Findings will be documented in the medical record. d. Assessments of pressure injuries will be performed by a licensed nurse. The staging of pressure injuries will be clearly identified to ensure correct coding on the MDS. 4. Interventions for Prevention and to Promote Healing a. After completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions. f. Interventions will be documented in the care plan and communicated to all relevant staff. R14's care plan documents: At risk for impaired skin integrity related to hx (history) of MASD (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(moisture associated skin damage) to sacrum, hx of DTI (deep tissue injury) to right foot and heel, Activity intolerance, cystitis, Alzheimer's, dementia, degenerative disease, anxiety, IBS (irritable bowel syndrome), age related cognitive disorder, reduced mobility, abnormal mobility, sinusitis, meds pain, incontinence, hallucinations , refusals of cares, refusals to turn/reposition, offload, refusals of meds, poor intake, weight loss, HX of sacral excoriation 3/23/26: R (right) calf and R post thigh- DTI 3/25/26: R medial & lateral foot, R first digit DTI - date Initiated 7/5/24, revision on 3/25/26. Interventions include: -Encourage and assist resident to reposition frequently. Encourage and assist to elevate heels off surface of bed. Pressure relieving cushion to wheelchair. Skin inspection: requires a skin inspection weekly and with cares. Observe for redness, open areas, scratches, blisters cuts, bruises – date initiated 7/5/24. -5/18/25 Encourage to off load buttocks when at rest in bed and on chair using wedge or pillow or rolled blanket, also replaced cushion to Broda chair. -Low air loss mattress to bed. Check function q (every) shift. Settings to resident weight or resident comfort - date Initiated 5/19/25. -Ensure she is positioned with BLEs (Bilateral Lower Extremities) away from table during meal to decrease risk of injury and promote skin integrity – date initiated 6/24/25. -8/11/25 encourage to wear boots at rest instead of shoes. -Gentle perineal care after each incontinence episode, application of barrier cream and frequent position changes – date initiated 12/26/25. -Pillow encouraged behind resident's legs while up in Broda chair to keep a barrier between legs and footrest to prevent further skin injury r/t (related to) friction - date initiated 3/24/26. -3/25/26: New heel boots, dietician review, and order for therapy to eval and treat for w/c (wheelchair) positioning. On 4/26/26 at 10:06 AM, Surveyor observed R14 sitting in the dining room in her Broda chair. R14 had grey heel protective boots on both feet extending to her knees. There was no pillow under her legs. On 4/27/26 at 10:05 AM, Surveyor observed R14 lying in her Broda chair, reclined all the way back with her legs elevated. She was wearing grey heel protective boots and there was no pillow under her legs. Surveyor observed R14 to be moving her legs around while in the chair. R14's April 2026 Treatment Administration Record documents: Wound care right lateral foot and heel cleanse with wound cleanser, pat dry, apply xeroform f/b (followed by) bordered gauze in the evening every Monday, Wednesday and Friday. Encourage pillow behind legs when up in Broda chair to prevent skin injury every shift – order date 3/24/26. Surveyor noted this was signed as completed every shift. On 4/28/26 at 7:32 AM, Surveyor observed R14 sitting in her Broda chair in the dining room. Her legs were elevated, and she was wearing grey boots on both feet, but there was no pillow under her legs. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor noted her legs were in a bent position, turned toward the left side with the right knee on top of the left. 4/28/26 at 1:30 PM, Surveyor observed R14 sitting in her Broda chair in the dining room in the same position as previously observed and there was not a pillow under her legs. Surveyor asked the CNA if R14 lays down after meals. Surveyor was told R14 lays down after lunch. Surveyor observed the CNA transfer R14 to bed and visualized her skin. R14's buttocks had no open areas or signs/symptoms of skin breakdown. Surveyor observed a dressing to the lateral side of her right foot dated 4/27. On 4/29/26 at 8:37 AM, Surveyor observed R14 sitting in her Broda chair in the dining room. She was wearing her heel protective boots, but there was no pillow under her legs. 4/29/26 at 10:31 AM, Surveyor asked to view R14's pressure injury. Unit Manager (UM)-G brought R14 to her room. Surveyor observed a pillow under her legs. UM-G removed the dressing from her right foot revealing a small scab-like area to the right lateral foot. The area was dry, and surrounding skin was intact with no redness or signs of skin breakdown. Surveyor and UM-G discussed the evolution of wounds. UM-G reported when the areas were found, it was determined it was likely from squirming/moving around legs in the Broda chair and friction from the leg rest. UM-G reported R14 was provided new protective boots that extend to her knees with sheepskin inside and a pillow under her legs to prevent further rubbing. Surveyor advised UM-G of observations and concern that care plan interventions of a pillow under her legs has not been in place during survey. R14's wound physician note dated 4/22/26 documents: Right lateral foot 1.5 x 1.5 x 0.1 necrotic tissue 100 %. Improved evidenced by decreased surface area. On 4/29/26 at 9:30 AM, Surveyor advised Director of Nursing (DON)-B of concern regarding observations of R14's care plan interventions for pressure injury not in place during survey. No additional information was provided R3 was admitted to the facility on [DATE]. R3's diagnoses include left humerus fracture, hemiplegia, Type 2 Diabetes with polyneuropathy, fall, muscle wasting, lack of coordination and dementia. R3's Significant Change Minimum Data Set (MDS) completed on 2/23/26, documents R3 is dependent on staff for toileting, dressing, rolling left to right and transfers. R3 was documented as having a Brief Interview for Mental Status (BIMS) score of 9, indicating that R3 has moderate cognitive impairment. R3's Care Area Assessment (CAA) documents the following: Cognitive Loss/Dementia CAA: R3 displays some impairments in memory, judgement, safety awareness, and problem solving. A diagnosis of dementia appears to be directly contributing to R3's cognitive deficits. R3 has hearing impairment which affects R3's ability to hear and understand spoken words appropriately. No mood or behavioral issues were reported. Medical problems combined with a diagnosis of dementia may be contributing to cognitive deficits. Medical problems do not appear to be affecting cognitive functioning. R3 needs assistance with ADL's (Activities of Daily Living) due to both diminished cognitive and physical functioning. R3 has hearing impairment which affects R3's ability to hear and understand spoken words appropriately. Cognitive deficits affect R3's ability to safety care for R3's self and/or to appropriately direct R3's own care. Supervision and guidance are indicated. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Visual Function CAA: R3 has a history of corneal erosion, brow ptosis, pseudophakia and retinal hemorrhage. R3 has impaired vision. Care Plan is in place to address visual impairment and complication risk. R3's care plan, documents the following: R3 has a self-care deficit related to activity intolerance, hemiplegia, type 2 diabetes, hyperlipidemia, hypertension, weakness, atrial fibrillation, low back pain, micturition, dementia, pain, medications and decrease in mobility (date initiated 12/20/24). Interventions include: -R3 requires 1 staff member for assistance with bathing/showering. R3 is able to wash R3's face, upper body, peri area and hands (date initiated 12/20/24). -R3 requires assistance of two staff members with Hoyer transfers (date initiated 5/22/25, last revised on 8/15/25). -R3 requires assistance of one staff member with dressing, undressing and bathing (date initiated 12/20/24). -R3 requires assistance of one staff member with toileting needs (date initiated 12/20/24). -R3 requires assistance of one staff member with wheelchair mobility (date initiated 12/20/24, last revised on 8/15/25). -R3 is to wear a brace to the left are at all times for two more weeks (date initiated 4/14/26). -R3 requires assistance of two staff members with bed mobility (date initiated 2/8/26). R3 has an alteration/potential for alteration in skin integrity with history of brief abrasion to the right buttocks, lower extremities, abscess to the left breast, and unstageable left posterior elbow post-surgery, related to activity intolerance, hemiplegia, type 2 diabetes, hyperlipidemia, hypertension, weakness, atrial fibrillation, low back pain, micturition, dementia, pain, medications and decrease in mobility (date initiated 12/20/24, last revised on 4/26/26). Interventions include: -R3 requested the air mattress been removed, risks and benefits discussed (date initiated 4/21/25). -Administer treatments as ordered and monitor effectiveness (date initiated 12/20/24). -Braden assessment on admission and per policy (date initiated 12/20/24). -Skin checks around soft cast to left upper extremity (date initiated 2/20/26). -Monitor/document/report to MD (Medical Doctor) as needed changes in skin status; appearance, color, wound healing, signs/symptoms of infection, wound size and stage (date initiated 12/20/24). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Observe for redness, open areas, scratches, cuts, bruises and report changes to the nurse (date initiated 12/20/24, last revised on 8/15/25). -Observe for redness, open areas, scratches, blisters, cuts and bruises. Report to nurse/MD (date initiated 12/20/24, last revised on 2/20/26). -Turn and reposition every 2-3 hours or as tolerated (date initiated 12/20/24). -Update MD for signs/symptoms of infection or deterioration of wound/skin (date initiated 12/20/24). Surveyor reviewed R3's EMR (Electronic Medical Record) which documents the following: R3 sustained a fall with injury on 2/8/26. R3 had ORIF (open reduction and internal fixation) (surgical repair) of the left humerus (left upper arm) on 2/11/26. R3 was sent back to the facility with a non-removeable splint placed for two weeks. R3 followed up with orthopedic surgery on 2/25/26 with orders to remove the left arm splint and work on passive ROM (range of motion). On 3/25/26, R3 followed up with orthopedic surgeon who placed a long arm fiberglass posterior slab splint, with orders for R3 to wear the splint 24/7 and do not remove. R3 was noted to have wrist drop due to radial nerve palsy which prompted the change for orthopedic surgery to place the non-removeable splint. On 4/1/26, R3 followed up with orthopedic surgeon with orders to continue the non-removable splint. On 4/13/26, R3 followed up with orthopedic surgeon with orders to continue the non-removable splint for 2 more weeks. On 4/27/26, R3 followed up with orthopedic surgeon. R3 was noted to have a healing ulceration of the left elbow, left wrist drop and flexion contracture (chronic joint condition where soft tissues become shortened and stiff, causing the joint to get stuck in a bent position that cannot be fully straightened). R3's non-removable splint was discontinued with recommendations to perform daily dressing changes using Xeroform 4 x 4 gauze and to place an ace wrap. Surveyor reviewed R3's TAR (Treatment Administration Record) which documents the following: -2/8/26 - immobilizer, splints, braces and casts. Skin check every shift. If there are positive findings, contact the MD. Keep left arm elevated every shift for broken left arm. -2/25/26 - Posterior elbow bandage change every day. -2/25/26 - Skin checks to be performed every shift. Splint to LUE (Left Upper Extremity). -3/10/26 - daily skin evaluation; monitor intact skin to identify any new or developing skin impairments, redness or breakdown every shift for skin monitoring. Notify the MD for any alteration in skin integrity. -4/8/26 - complete weekly skin check done by the nurse on bath day in the morning every Monday for (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shower day. On 4/29/26, at 8:30 AM, Surveyor reviewed R3's EMR which documents the facility performed wound care dressing change on 4/28/26. Surveyor notes R3 returned from Orthopedic Surgery with a non-removeable splint that was discontinued on 4/27/26, with orders to perform daily dressing changes to R3's left arm wound. On 4/29/26, Surveyor notes there is no comprehensive wound assessment performed for R3's left arm wound as of 4/29/26, at 8:30 AM. On 4/29/26, at 9:04 AM, Surveyor interviewed UM (Unit Manager)-L who stated R3 had a non-removable plaster cast that was placed by orthopedic surgery on 3/25/26, with orders explicitly stating, do not remove. UM-L stated R3 returned to the facility on 4/27/26, from an orthopedic surgery follow up appointment with the cast removed and an ace wrap and orders for wound care to be performed daily. UM-L stated she took off R3's ace wrap on 4/27/26 to evaluate R3's arm because the facility has not been able to see R3's arm since 3/25/26. UM-L stated the facility wound MD is not currently following R3 due to Orthopedic Surgery managing R3's left arm wound. Once Orthopedic Surgery has signed off, the facility wound MD will follow if appropriate. UM-L stated she will still see R3 weekly on Wednesdays during wound care rounds and perform a skin and wound assessment and will contact the Orthopedic Surgeon with any concerns or updates. Surveyor asked UM-L what the expectation is for a comprehensive wound assessment. UM-L stated normally the expectation is within 24 hours of discovery. UM-L stated she attempted to perform an evaluation on 4/27/26, and R3 declined. Surveyor asked UM-L if this was documented in R3's EMR and UM-L stated she does not think she documented it. Surveyor notified UM-L of concerns with R3 returning from the Orthopedic appointment on 4/27/26 with daily wound care orders with no comprehensive assessment documented as of 4/29/26 at 9:04 AM. On 4/29/26, at 9:21 AM, Surveyor observed wound care with Director of Nursing (DON)-B and UM-L. Surveyor observed DON-B and UM-L perform EBP (Enhanced Barrier Precautions) appropriately wearing a gown and gloves prior to entering R3's room with supplies already on R3's bedside table. R3 was observed laying supine in bed with the head of the bed approximately 45 degrees and R3's left arm elevated on a pillow. R3 was observed wearing a glove on R3's left hand. UM-L removed R3's old dressing dated 4/28. R3's wound was noted to be 100% granulation measuring 1 x 1 cm. UM-L and DON-B applied saline spray and applied Xeroform dressing. UM-L and DON-B then wrapped an ace wrap around R3's left arm and elbow, asking R3 if the ace wrapping was too tight and/or comfortable. Surveyor observed appropriate hand hygiene and EBP throughout the wound care observation. On 4/29/26, at 12:35 PM, Surveyor interviewed DON-B who stated the root cause for R3's wound was due to the medical device placed during surgery. DON-B stated R3's arm was slowly rubbing on the brace which caused the wound to develop. Surveyor asked DON-B what the wound looked like after R3 returned from the Orthopedic Surgeon's office on 4/27/26. DON-B stated a comprehensive assessment will be completed on Wednesday's during wound care rounds. Surveyor asked DON-B what the expectation is on when a comprehensive assessment should be completed now that the facility is able to remove R3's wrapping and noted the facility has not been able to view R3's arm since 3/25/26, when the non-removeable cast was placed. DON-B stated, I see what you're saying, and we completed a comprehensive assessment earlier today on 4/29/26. Surveyor notified DON-B of concerns with R3 returning from the Orthopedic appointment on 4/27/26, with a removeable ace wrap and orders to perform daily wound care dressing changes, with no comprehensive assessment completed until 4/29/26. DON-B acknowledged these concerns. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/29/26, at 12:56 PM, Consultant-C notified Surveyor, today (4/29/26) was the first day the facility completed wound care on R3. Surveyor notified Consultant-C that R3's EMR documents wound care being performed on 4/28/26 and Surveyor observed wound care earlier today (4/29/26), and noted the old dressing being dated 4/28/26.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for 1 of 3 (R76) residents observed during medication pass.R76's prescribed Lorazepam was not available at the facility, and the nurse was unable to remove it from the facility contingency supply because there was no handwritten prescription (script) provided by the physician for the medication. The handwritten script is provided to the pharmacy who in turn supplies the facility with a code which allows the facility to remove the medication from their contingency supply.Findings include:The facility policy titled Unavailable Medications reviewed/revised 1/2026 documents (in part) .This facility shall use uniform guidelines for unavailable medications.1. The facility maintains a contract with a pharmacy provider to supply the facility with routine, PRN (as needed) and emergency medications.2. A STAT (immediate) supply of commonly used medications is maintained in-house for timely initiation of medications.3. The facility shall follow established procedures for ensuring residents have a sufficient supply of medications.4. Medications may be unavailable for a number of reasons. Staff shall take immediate action when it is known that the medication is unavailable.a. Determine reason for unavailability, length of time medication is unavailable, and what efforts have been attempted by the facility of pharmacy provider to obtain the medication.b. Notify physician of inability to obtain medication upon notification or awareness that medication is not available.R76 admitted to the facility on [DATE] with diagnoses that include generalized anxiety disorder.Physician orders upon admission included: Lorazepam 0.5 mg (milligrams), give 1 tablet by mouth two times a day for anxiety and Lorazepam 0.5 mg, give 1 tablet by mouth every 8 hours as needed for anxiety for 14 days. On 4/27/26 at 10:36 AM, Surveyor observed Licensed Practical Nurse (LPN)-E prepare medications for R76. While preparing R76's medications, LPN-E was unable to locate Lorazepam 0.5 mg (milligrams) in the medication cart. LPN-E stated, Maybe it's in the other med (medication) cart. LPN-E prepared the remaining medications, and they were given to R76 with water. LPN-E then walked to the other med cart to look for the Lorazepam; it was not in the med cart. Surveyor asked LPN-E what she would do in this situation. LPN-E reported she would remove the medication from contingency and call the pharmacy. On 4/27/26 at 10:57 AM, Surveyor observed LPN-E on the phone at the nurse's station. Surveyor heard LPN-E say, So it was never shipped out because you need a script for it. OK, I'll call the doctor. LPN-E told Surveyor R76's Lorazepam was never sent because they (pharmacy) didn't have a script. LPN-E stated, I'm going to call the doctor now.Surveyor reviewed R76's April 2026 Medication Administration Record (MAR) which documented: Lorazepam Oral Tablet 0.5 mg. Give 1 tablet by mouth two times a day for anxiety - order Date 4/24/26.The MAR documents 7 = other/see nurses notes on 4/25/26 AM and PM, 4/26 AM and PM and 4/27 AM which indicates 5 doses were not given. R76's EMAR (Electronic Administration Record) notes document:-4/25/26 at 10:48 AM, Lorazepam Oral Tablet 0.5 mg give 1 tablet by mouth two times a day for anxiety - not available.-4/25/26 at 9:28 PM, Lorazepam Oral Tablet 0.5 mg Give 1 tablet by mouth two times a day for anxiety med was not available, called pharm, they said they didn't have a script. HUCU (system for physician notification) the Dr (doctor), got a script. Resident stated she was tired and was going to sleep, if she was asleep when I got everything resolved to just leave it she doesn't want to be woken up.-4/26/26 at 10:26 AM, Lorazepam Oral Tablet 0.5 MG Give 1 tablet by mouth two times a day for anxiety - not available.-4/26/26 at 8:05 PM, Lorazepam Oral Tablet 0.5 MG Give 1 tablet by mouth two times a day for anxiety waiting on pharmacy on PM run.-4/27/26 at 11:47 AM, Lorazepam Oral Tablet 0.5 MG Give 1 tablet by mouth two times a day for anxiety new script needed. Medication was never initiated. APNP (Advanced Practice Nurse Practitioner) put in for a psych consult.Facility progress notes (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525242	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Kensington	1810 Kensington Dr Waukesha, WI 53188

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	document (in part) .On 4/27/26 at 2:45 PM, APNP initial visit: Patient had behavioral concerns overnight on 4/16/2026, including calling the police multiple times. Continue lorazepam 0.5 mg PO (by mouth) BID (twice daily) scheduled with 0.5 mg PO Q8H (every 8 hours) PRN (as needed) breakthrough anxiety.On 4/27/26 at 2:58 PM, F/U (follow up) Recent admit: Resident adjusting to facility well, able to make needs known. Appetite is good, usually asks for extra food with meals. Resident has been requesting Lorazepam 0.5mg tab, no script, NP made aware. Psych consult put in r/t (related to) anxiety/depression. No further concerns at this time.On 4/27/26 at 9:42 PM, F/U Recent admit: Resident adjusting to facility well, able to make needs known. Resident has been requesting Lorazepam 0.5mg tab, script received and given per order with HS (hour of sleep) meds.Surveyor noted R76's scheduled Lorazepam signed as given on 4/27/26 PM and thereafter. On 4/28/26 at 10:25 AM, Surveyor asked Director of Nursing (DON)-B what the procedure is for obtaining medication requiring a handwritten script upon admission. DON-B stated, We need a script, we can't take out anything from contingency until we get an authorization code from pharmacy and for that we need a script. Surveyor advised DON-B of concern R76 was admitted to the facility and missed at least 5 scheduled doses of Lorazepam because a script was not available. Consultant-C stated, There's charting every day about the script, they were calling pharmacy and the doctor to get it. Consultant-C provided Surveyor the HUCU communication between the facility and the Physician Assistant which documented:On 4/25/26, at 7:29 PM, hello I just called [pharmacy name] and they said they don't have a script for lorazepam 0.5 mg and would need it in order to give me a code for RX (perscription).7:40 AM (PA) what is the order.9:04 PM Lorazepam oral tab 0.5 mg, 1 tab po (by mouth) twice daily.9:05 PM (APNP) will send short tx (treatment).4/27/26 at 11:01 AM Lorazepam oral tab 0.5 mg 1 tab po twice daily needs script. Surveyor and Consultant-C reviewed the facility progress notes together. Surveyor advised documentation indicated the medication was not available or waiting on pharmacy run. Surveyor informed Consultant-D of the concern R76 was admitted to the facility on [DATE] with orders for scheduled Lorazepam twice daily and a script was not obtained until 4/27/26 after the facility was advised of Surveyors' concern during med pass. R76 missed at least 5 doses of scheduled Lorazepam.On 4/28/26 at 9:52 AM, Surveyor interviewed R76. Surveyor advised R76 after reviewing her medical record it was noted she has an order for Lorazepam. R76 stated, Yes, for my anxiety. Surveyor asked R76 if she was aware she had not received her Lorazepam for a few days after admission. R76 stated, Oh yes, I can tell. I kept asking for it and they kept telling me they don't have it. It was very frustrating, I figured if I was coming here, they would have all my medications in order. They did finally get it, I got one today and I'm so glad, because I'm having surgery today and I needed it for my anxiety.On 4/28/26 at 10:25 AM, the facility was informed of the above concerns regarding R76's missed doses of scheduled Lorazepam. No additional information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525242	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Kensington	1810 Kensington Dr Waukesha, WI 53188

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The deficient practice had the potential to affect 4 (R3, R18, R24 and R56) of 4 residents residing on the unit that require blood sugar testing.The glucometer that is shared between residents was not cleaned between resident use.Findings include:The facility policy titled Glucometer Disinfection reviewed/revised 1/2026 documents (in part) .The purpose of this procedure is to provide guidelines for the disinfection of capillary-blood glucose sampling devices to prevent transmission of blood borne diseases to residents and employees. Cleaning is the removal of visible soil from objects and surfaces normally accomplished manually or mechanically using water with detergents or enzymatic products. Disinfection is a process that eliminates many or all pathogenic microorganisms except bacterial spores on inanimate objects.The facility will ensure blood glucometers will be cleaned and disinfected after each use and according to manufacturer's instructions for multi-resident use. The glucometers will be disinfected with a wipe pre-saturated with an EPA (environmental protection agency) registered healthcare disinfectant that is effective against HIV (Human Immunodeficiency Virus), Hepatitis C (HVC) and Hepatitis B (HVB) virus. Glucometers will be cleaned and disinfected after each use and according to manufacturer's instructions regardless of whether they are intended for single resident or multiple resident use. Procedure:Retrieve (2) disinfectant wipes from container. Using first wipe, clean first to remove heavy soil, blood and/or other contaminants left on the surface of the glucometer. After cleaning, use second wipe to disinfect the glucometer thoroughly with the disinfectant wipe, following the manufacturer's instructions. All the glucometer to air dry. On 4/28/26 at 7:50 AM, Surveyor asked Licensed Practical Nurse (LPN)-F if she had any blood sugar reading to do. LPN-F stated, Yes. LPN-F gathered supplies of a glucometer, lancet and alcohol wipes in a cup, and entered R24's room. LPN-F washed her hands, applied gloves and obtained R24's blood sugar. LPN-F then wiped the glucometer with an alcohol wipe for approximately 5 seconds. LPN-F then entered R56's room, washed her hands, applied gloves and obtained R56's blood sugar using the same glucometer. After obtaining R56's blood sugar, she wiped the glucometer with an alcohol wipe for approximately 5 seconds, before placing it on the mediation cart. Surveyor asked what is used to clean the glucometer. LPN-F stated, I use an alcohol wipe, but I know there's also bleach wipes in the med cart. Surveyor removed a container labeled Micro kill bleach germicidal bleach wipe from the medication cart. The label on the container documents (in part) .3-minute C diff (Clostridium Difficile) spore kill time. Kills HIV-1, HBV and HCV on precleaned environmental surfaces/objects previously soiled with blood/body fluids. Contact time: Allow surface(s) to remain visibly wet for 30 seconds to kill the bacteria and viruses on the label except a 1-minute contact time is required to kill Candida Albicans and Trichophyton Interdigitale, a 2-minute contact time is required to kill Candida Auris and a 3- minute contact time is required to kill clostridium difficile spores.On 4/28/26 at 8:10 AM, Surveyor advised Director of Nursing (DON)-B of concern the glucometer that is shared and used between residents was not cleaned between resident use. DON-B advised Surveyor the expectation is to use bleach wipes to clean the glucometer and provided Surveyor with a list of residents on the unit that require blood sugar testing and the policy and procedure for glucometer cleaning. Surveyor verified there were no residents on the unit that require blood sugar testing with bloodborne pathogens. No additional information was provided.