STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Maple Grove LLC	3401 Maple Grove Dr. Madison, WI 53719

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 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 that all residents are clinically appropriate to self-administer medications for 1 of 1 residents (R2) observed with medications at bedside out of a sample of 25. R2 was observed on 2 separate occasions to have medications left on her bedside table for her to take independently. R2 does not have an assessment for self-administration of medications indicating that she is safe to administer medications independently.This is evidenced by:The facility's policy, Resident Self-Administration of Medication, dated 1/26, includes: A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely. Each resident is offered the opportunity to self-administer medications during the routine assessment by the facility's interdisciplinary team. The results of the interdisciplinary team assessment are recorded on the Medication Self-Administration Assessment Form, which is placed in the resident's medical record. The care plan must reflect resident self-administration and storage arrangements for such medications.R2 admitted to the facility on [DATE] with diagnoses including polyneuropathy and vitreous degeneration of unspecified eye.R2's quarterly MDS (Minimum Data Set) assessment, accepted date 6/12/26, has a BIMS (Brief Interview for Mental Status) score of 15. This indicates R2 is cognitively intact. On 6/29/26 at 10:33 AM, Surveyor observed two medications in a medication cup on R2's bedside table. R2 indicated the medications were a cranberry and a vitamin. On 7/1/26 at 9:28 AM, Surveyor observed all of R2's morning medications in a medication cup on her bedside table. R2 indicated the nurse brought the medication in but R2 had not taken them yet. On 7/1/26 at 9:37 AM, Surveyor interviewed MT L (Medication Tech). MT L indicated she had left the medications for R2 to take. MT L indicated R2 was able to self-administer medications. MT L indicated staff knows who can self-administer medications because the information is in the resident's medical record. MT L indicated there would be a physician's order on the resident's MAR (Medication Administration Record) and in the resident's care plan. On 7/1/26 at 9:43 AM, Surveyor interviewed RN H (Registered Nurse). RN H stated if a resident can self-administer medications, there would be a physician's order on the resident's MAR and in the resident's care plan. RN H indicated if there is not an order for self-administration of medications the resident should be observed taking their medications. RN H indicated R2 has her own thing going on in regard to taking her medications. RN H indicated resident's do not like the staff standing over top of them while they take their medications. RN H indicated if a resident doesn't want us watching, we just leave the medications and will go back to check on them later to see if they took their medications. RN H indicated R2 is supposed to be watched while taking her medications, but prefers to take them on her own. R2's Quarterly/Annual/Significant Change Assessment, dated 5/27/26, includes: Self Administration of medications a. Does the resident desire to self administer his/her own medications? No. R2's physician orders, printed 7/1/26, does not contain an order for self-administration of medications. R2's comprehensive care plan, printed 7/1/26, does not contain information for self-administration of medications. On 7/1/26 at 10:37 AM, Surveyor interviewed DON B (Director of Nursing) regarding the process for a resident to self-administer medications. DON B indicated the facility will complete a self-administration of medication (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Maple Grove LLC	3401 Maple Grove Dr. Madison, WI 53719

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment, obtain a physician's order and put the information into the resident's care plan. Surveyor shared with DON B the observations of R2's medications being left at bedside. DON B indicated R2 should not have medications left at bedside.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Maple Grove LLC	3401 Maple Grove Dr. Madison, WI 53719

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not make prompt efforts to document, investigate, and resolve grievances a resident may have for 1 of 3 residents (R121) from a total sample of 25 residents reviewed for grievances.R121 voiced a grievance to the facility. Staff did not write his concern up as a grievance, complete an investigation, or follow up with the complainant. This is evidenced by:The facility's policy, titled Resident and Family Grievances, reviewed/revised in 2/2026, states in part: Policy: It is the policy of this facility to support each resident's and family member's right to voice grievances without discrimination, reprisal, or fear of discrimination or reprisal.Policy Explanation and Compliance Guidelines: 1. The Administrator has been designated as the Grievance Official. The Grievance Official or their designee is responsible for overseeing the grievance process; receiving and tracking grievances through to their conclusion; leading any necessary investigations by the facility; maintain the confidentiality of all information associated with grievances; issuing written grievance decisions to the resident. 3. A resident or family member may voice grievances with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and other residents, and other concerns regarding their LTC (long term care) facility stay.6. Grievances may be voiced in the following forums: a. Verbal complaint to a staff member or Grievance Official.8. Procedure: .b. The staff member receiving the grievance will record the nature and specifics of the grievance on the designated grievance form, or assist the resident or family member to complete the form.c. Forward the grievance form to the Grievance Official as soon as practicable. D. The Grievance Official will take steps to resolve the grievance, and record information about the grievance, and those actions, on the grievance form.e. The Grievance Official, or designee, will keep the resident appropriately apprised of progress toward resolution of the grievances.g. In accordance with the resident's right to obtain a written decision regarding his or her grievance, the Grievance Official will issue a written decision on the grievance to the resident or representative at the conclusion of the investigation.R121 was admitted to the facility on [DATE] with diagnoses that include, in part: polyneuropathy, cervical disc disorder with myelopathy, spinal stenosis - lumbar & cervical region with neurogenic claudication, and osteoarthritis of both knees. R121's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/18/26 states that R121 has a BIMS (Brief Interview for Mental Status) of 13 out of 15, indicating he is cognitively intact. R121's care plan, dated 6/24/26, lists the following focus area: The resident was admitted to the facility on [DATE] following a hospital stay. The goal is to return home.upon completion of short-term rehabilitation services.On 6/30/26 at 9:55 AM, Surveyor interviewed R121 about his stay at the facility. R121 expressed frustration with therapy that he's been participating in because they don't schedule therapy appointments at a specific time. R121 said this automatically puts residents who are doing therapy into a state of chaos, and compared it to waiting around all day for a repair person to come to your house to fix an appliance. R121 indicated his goal is to complete therapy and go home, so he puts off other activities during the day because he does not want to miss his therapy appointment. [Of note: R121 was not the only resident who expressed concerns with not having therapy scheduled at specific times during the day. Surveyor reviewed the Grievance Log provided by the facility, dated 4/1/26 to 6/29/26, and there were no grievances listed regarding therapy scheduling.]On 6/30/26 at 2:25 PM, Surveyor spoke with RD W (Rehab Director). RD W indicated there is no set time for therapy appointments due to changing activities and schedules. Therapy does not want to set specific times in case appointments run over the time limit. Therapists try to work with resident preferences for therapy timing (ex: morning vs. afternoon scheduling) and try to give them a time frame (ex: 10 AM-12 PM or between lunch and dinner). Therapists also try to alert staff members to get residents ready for therapy. If a resident isn't in his or her room, the therapist will look in the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Maple Grove LLC	3401 Maple Grove Dr. Madison, WI 53719

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's usual spots to try to find them but may end up moving the appointment time if they can't be located. Surveyor asked if residents have complained about not knowing when they are going to therapy. RD W said yes; many residents do not like not having a set schedule - especially when they first get to the facility, but it is very difficult to have a set time followed.On 7/2/26 at 9:05 AM, Surveyor observed medications being administered with LPN V (Licensed Practical Nurse). LPN V was administering medications to a resident who had been taken to therapy without LPN V's knowledge, so we had to track the resident down and interrupt her therapy session so she could take her medications. LPN V indicated she must often interrupt therapy sessions to administer medications and said it's hard when therapy comes to get residents and she doesn't know when it is scheduled so she must track the resident down.On 7/2/26 at 11:14 AM, Surveyor interviewed PT X (Physical Therapist). PT X indicated therapists are upfront with residents about no set therapy times. Therapists try to accommodate scheduling preferences. Therapists are typically in the building between 7:00 AM and 5:00 PM. They choose their start time and work until the last resident is seen. Surveyor asked if residents ever complain about the scheduling. PT X indicated yes - not everyone, but a small handful. These complaints get passed to RD W. Surveyor asked if these complaints are ever documented as grievances. PT X indicated she wasn't sure. They might be written down as preferences in a note. RD W may put the information in the schedule for future reference to try to accommodate resident wishes.On 7/2/26 at 1:40 PM, Surveyor spoke with DON B (Director of Nursing) about therapy complaints. DON B indicated she was not aware of residents' concerns about therapy scheduling, but could understand where they are coming from. DON B indicated she would reach out to therapy to ensure preferences are being honored.On 7/2/26 at 1:56 PM, Surveyor spoke with SW C (Social Worker) about therapy complaints. SW C indicated residents have voiced concerns about wanting therapy at a certain time. Staff try to inform residents when their therapy appointments are coming up during the day. Some residents end up being okay with the scheduling process and some residents really don't like it. SW C indicated she explains to residents that the facility is not a rehab hospital when they arrive. SW C indicated she has discussed having more specific time frames provided to residents with the therapy department. Surveyor discussed residents expressing experiencing anxiety about missing therapy appointments, feeling like they are waiting around all day, and wanting therapy to feel like a priority. SW C asked Surveyor if she should have logged these concerns as grievances if she keeps hearing them from residents. SW C indicated she would work on a grievance regarding therapy scheduling that she would follow up on. [Of note: Additional information on R121's Care Plan (6/29/26) indicates the following: Focus: Resident exhibits behaviors related to psychosocial distress regarding his immediate environment and daily routines. When expressing concerns or unmet needs, the resident frequently utilizes staff splitting or triangulation techniques to achieve a preferred outcome.Interventions/Tasks: Manage the resident's fixed expectations regarding strict therapy appointment times by providing gentle reality orientation that therapy schedules fluctuate daily rather than operating on fixed hour blocks; if the resident insists he has a specific 10:00 AM session, offer to contact the therapy department directly to verify their projected window for the day, while reinforcing that therapy coordinates directly with nursing staff if specific early mobilization is required, and notify the Therapy team, RN case manager, and Social Worker for interdisciplinary guidance if the fixated behavior or associated agitation persists. This indicates awareness that R121 has expressed concerns with therapy scheduling.]On 7/2/26 at 2:34 PM, Surveyor spoke with NHA A (Nursing Home Administrator). NHA A walked Surveyor through the facility's grievance process. NHA A indicated anyone can fill out a grievance form. They are located throughout the facility. Minor grievances can be reported verbally and staff members know how to complete the forms if a grievance is reported to them. Surveyor asked NHA A if he has received any grievances about therapy scheduling. NHA A indicated RD W had mentioned something about this to him, but said it had been taken care of, so he didn't look into it. Surveyor indicated RD W and SW C had knowledge about residents voicing concerns about therapy schedules, but these concerns were (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Maple Grove LLC	3401 Maple Grove Dr. Madison, WI 53719

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not documented as grievances. NHA A indicted things change with therapy schedules and staffing, so it may difficult to schedule exact therapy times, but if this is an issue, he will address it with RD W to see if any changes need to be implemented.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Maple Grove LLC	3401 Maple Grove Dr. Madison, WI 53719

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not follow through with the appropriate steps of the PASARR (Preadmission Screening and Resident Review) process for 1 of 9 residents (R2) reviewed for PASARR screening out of a sample of 25.R2 did not have a level II PASARR screening completed.This is evidenced by:The facility's policy, Specialized Rehabilitative Services, dated 1/26, includes: It will also ensure that residents with Mental Disorder (MD), Intellectual Disability (ID) or related conditions receive services as determined by their Preadmission Screening and Resident Review (PASARR). R2 admitted to the facility on [DATE] with diagnoses including major depressive disorder.R2's quarterly MDS (Minimum Data Set) assessment, accepted date 6/12/26, has a BIMS (Brief Interview for Mental Status) score of 15. This indicates R2 is cognitively intact. R2's PASARR Level I Screen Summary, undated, includes:Does this person have a major mental disorder? YESScreening Result Resident is suspected of having a serious mental illness. AGREESurveyor reviewed R2's medical record. R2's medical record does not include a PASARR Level II Screen.On 7/1/26 at 2:11 PM, Surveyor interviewed SW C (Social Worker). SW C indicated she is responsible for obtaining the PASARR screenings for residents. SW C indicated R2 did not have a PASARR Level II Screen. SW C indicated R2 should have had a PASARR Level II Screen completed but did not.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Maple Grove LLC	3401 Maple Grove Dr. Madison, WI 53719

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal hygiene for 5 of 21 residents reviewed for accommodation of needs out of a sample of 25. R15 was observed in bed without access to a call light. R41 was observed in bed without access to a call light. Surveyor observed R11 to not have a call light within reach. Surveyor observed R24 to have long facial hair. R75 was observed in bed without access to a call light. Evidenced by: The facility's Call Lights: Accessibility and Timely Response policy, dated 1/26, states, in part: The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. 5. Staff will ensure the call light is within reach of resident and secured, as needed. 6. The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room. Example 1 On 6/29/26 at 11:15 AM, during initial screening, Surveyor observed R15 in bed with call pendant in windowsill, out of R15's reach. There was no call light plugged into the wall. RN D (Registered Nurse) entered R15's room. Surveyor asked RN D how residents contact staff for assistance. RN D stated with the call light. Surveyor asked where R15's call light was located. RN D stated it looks like it is in the windowsill. Surveyor asked if R15 could reach it. RN D stated no, it shouldn't be there. On 7/2/26 at 9:10 AM, Surveyor interviewed DON B (Director of Nursing) about call lights. DON B stated all residents should have access to the bracelet or necklace pendant or the wall call light. Example 2 On 6/29/26 at 2:14 PM, during initial screening, Surveyor observed R41 in bed with call light clipped to the cord hanging from the wall behind R41's bed, out of R41's reach. No pendant noted. CNA E (Certified Nursing Assistant) entered R41's room. Surveyor asked CNA E how residents call for assistance. CNA E stated with the call light, R41 doesn't have a pendant. Surveyor asked if R41's call light was within reach. CNA E stated no, R41 should have access to the call light. On 6/29/26 at 2:19 PM, Surveyor interviewed LPN F (Licensed Practical Nurse) and asked how residents call for assistance. LPN F stated they use the call light or pendant. Surveyor asked LPN F about R41. LPN F went to R41's room asked CNA E about R41's pendant. CNA E stated that R41 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Maple Grove LLC	3401 Maple Grove Dr. Madison, WI 53719

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	doesn't currently have a pendant. LPN F stated I will check about getting one, everyone needs to be able to call for assist. On 7/2/26 at 9:10 AM, Surveyor interviewed DON B (Director of Nursing) about call lights. DON B stated all residents should have access to the bracelet or necklace pendant or the wall call light. Example 3 The facility policy, Activities of Daily Living, dated, 1/26, states, in part;.Care and services will be provided for the following activities of daily living: Bathing, dressing, grooming and oral care.A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. R24 was admitted to the facility on [DATE] with a diagnoses including dementia and neurocognitive disorder with lewy bodies. R24's most recent care plan, states, in part;.the resident has an ADL self-care performance deficit.PERSONAL HYGIENE/ORAL CARE: 1 Assist. On 6/29/26 at 11:14 AM, Surveyor met R24. R24 had long facial hair. R24 indicated R24 would like to be cleaned shaved. On 6/30/26 at 10:20 AM, Surveyor observed R24. R24 had long facial hair. Certified Nursing Assistant BB (CNA) indicated R24 has never declined a shower or to be assisted with shaving when she assists R24. CNA BB indicated R24 prefers to be clean shaved and can utilize electric razor with the assistance of staff. CNA BB indicated R24 needs staff assistance for all ADL's. CNA BB and Surveyor observed R24 and CNA BB indicated that R24 does need to be shaved. CNA BB indicated staff assist residents with shaving on shower days and as needed. CNA BB indicated R24 had a shower this morning. CNA BB indicated she knows there was a cord missing from R24's electric razor and perhaps that is why R24 hasn't been shaved. On 7/2/26 at 1:20PM, Director of Nursing B (DON) indicated she would expect residents to receive assistance with shaving if they need assistance. Example 4 On 6/30/26 at 12:44PM, Surveyor observed R111's call light wrapped around bed. R111 was sitting in wheelchair and unable to reach call light. On 6/30/26 at 12:45PM, Certified Nursing Assistant CC (CNA) indicated R111's call light should be within reach of resident. CNA CC placed call light near resident, so resident had access to call light. Example 5 On 6/29/26 between 10:36 AM and 11:26 AM during initial screening, Surveyor overheard R75 yelling out for help from his room several times with staff responding. Surveyor entered R75's room at 11:30 AM. R75 indicated that he waits a long time for his call light to be answered. Surveyor looked around R75's room but did not see a call light or call light pendant near him. Surveyor asked R75 where his call light was, but he did not know. At 11:37 AM, HD U (Housekeeping Director) entered R75's room (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Maple Grove LLC	3401 Maple Grove Dr. Madison, WI 53719

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with a call light pendant and put it around his neck so it was within reach for him. On 7/1/26 at 2:48 PM, Surveyor interviewed HD U and asked what had been going on with R75's call light on 6/29. HD U indicated maintenance had been fixing his call light pendant and asked her to bring it back up to R75. HD U was unsure how long it took to be fixed. On 7/2/26 at 8:32 AM, Surveyor interviewed MD T (Maintenance Director) about R75's call light. MD T indicated he had a bunch of call lights (13) to fix on 6/29. MD T indicated SW C (Social Worker) had emailed him at approximately 9:00 AM that morning to let him know that R75 needed a call light. MD T indicated his priority is to get them fixed and working, so he addressed this immediately. On 7/2/26 at 1:56, Surveyor spoke with SW C (Social Worker). SW C provided a copy of the email that she sent to MD T. The email was sent at 10:59 AM on 6/29/26 and asked MD T if he could get R75 a call light because he did not have one in his room. On 7/2/26 at 1:40 PM, Surveyor interviewed DON B (Director of Nursing) about R75's missing call light. DON B indicated residents should always have access to a call light and said a building audit was just done to ensure all call lights are in working order.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Maple Grove LLC	3401 Maple Grove Dr. Madison, WI 53719

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 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 ensure that Residents receive treatment and care in accordance with professional standards of practice for 1 (R5) of 6 residents reviewed for assessments out of a sample of 25 residents.R5 fell and facility did not complete on-going monitoring and assessments, and the following evening R5 went to ER by ambulance.The facility policy, Fall Prevention Program, dated 1/25, states, in part;.monitor for changes in resident's cognition, gait, ability to rise/sit, and balance.monitor vital signs in accordance with facility policy.document all assessments and actions.R5 was admitted to the facility on [DATE], with a diagnoses including stroke, difficulty in walking, and unspecified fall.R5's most recent MDS (Minimum Data Set) indicates R5 has a BIMS (Brief Interview for Mental Status) score of 8 indicating R5 is moderately cognitively impaired.R5's most recent care plan states, in part;.resident is at risk for falls and history of falls.R5 experienced a fall on 3/21/26 around 7:45PM. The fall report states, in part;.writer went to answer resident's call light. Found resident in bathroom on the floor on knees with arms up on grab bars beside toilet, trying to get up.At a standing position, resident able to march both feet with more difficulty on the right side. Resident rating pain immediately after fall a 10/10 on the right side. Nonverbal signs of pain with movement include facial grimacing.On call MD notified- gave orders to treat skin tear left wrist. States that further evaluation may be needed if resident becomes unable to bear weight.Facility completed Post Fall Assessment and Head to Toe checklist form at the time of R5's fall. Facility completed Follow up post fall document on 3/22/26 at 5:24am.On 3/22/26 at 8:37AM, documentation shows that R5 indicated pain was at an 8/10. Facility staff provided a PRN (as needed medication) which was effective. The facility did not notify primary of increase in pain.Surveyor was unable to locate follow up assessments for R5 or provider notification. It is important to note, through record review, R5 does not typically have pain at an 8/10.Facility did not complete any nursing assessments until the evening of 3/22/26 at 5:01 PM in which R5 went to ER by ambulance.On 7/2/26 at 1:20 PM, Director of Nursing B (DON) indicated nursing should provide on-going monitoring and assessment after someone experiences a fall. DON B indicated she would expect staff to notify primary physician if a resident is experiencing an increase in pain after a fall.The facility did not complete on-going nursing assessments after a resident experienced a fall.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Maple Grove LLC	3401 Maple Grove Dr. Madison, WI 53719

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 - 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 each resident received care, consistent with professional standards of practice (SOP), to prevent pressure injuries (PI) for 1 of 1 residents (R1) reviewed for pressure injuries of a total of 25 sampled residents.R1 is at risk for PI (pressure injury) development and has a history of pressure injuries. Staff did not obtain measurements for two weeks of a newly developed pressure injury, and failed to ensure that care planned interventions were in place to prevent worsening of the pressure injury.Evidenced by:The AMDA (American Medical Directors Association) clinical practice guideline titled, 'Pressure Ulcers and Other Wounds,' dated 2017, states in part: .A pressure ulcer (Injury) is localized damage to the skin or underlying soft tissue, usually over a bony prominence or related to a medical or other device. The ulcer may present as intact skin or as an open ulcer and may be painful. The ulcer occurs as a result of intense or prolonged pressure or pressure in combination with shear .Recognition: Early recognition of pressure ulcers and of any risk associated with the development of pressure ulcers and other wounds is critical to their successful prevention and management .Assessment: The purpose of the assessment is to collect enough information to evaluate the patient's general condition, characterize a pressure ulcer, and identify related causes and complications. The National Pressure Injury Advisory Panel (NPIAP) at www.NPIAP.com defines PIs in the following categories:Category/Stage II: Partial thickness loss - Partial thickness loss of dermis presenting as a shallow open ulcer with a red, pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled or serosanguineous filled blister.Category/Stage III: Full thickness skin loss - Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/Stage III pressure ulcer varies by anatomical location.Unstageable/Unclassified: Full thickness skin or tissue loss - depth unknown. Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined; but it will be either a Category/Stage III or IV.The facility's policy titled Pressure Injury Prevention and Management, dated 3/25, with last revision date of 3/26, states in part, Policy Explanation and Compliance Guidelines: . 2. The facility shall establish and utilize a systematic 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. 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. Findings should include type of wound, wound measurements (measured upon discovery and at least weekly thereafter), other wound characteristics (color, exudate, odor, pain, tissue type in wound bed), and treatment and interventions implemented. 4. Interventions for Prevention and to Promote Healing. c. Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include, but are not limited to: i. Redistribute pressure (such as repositioning, protecting and/or offloading heels, etc.). f. Interventions will be documented in the care plan and communicated to all relevant staff.R1 was admitted to the facility on [DATE] with diagnoses that include Type 2 Diabetes Mellitus with diabetic chronic kidney disease, Peripheral Vascular Disease unspecified, and Other skin changes.R1's Comprehensive Care Plan, states in part:Focus: Skin Integrity: At Risk/ and/or Potential for complications with impaired skin integrity including skin tears, bruising, history of blisters AND/OR pressure R/T (related to) current medical/physical status. Has meds/dx (medications/diagnoses) that can/may affect skin integrity. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Maple Grove LLC	3401 Maple Grove Dr. Madison, WI 53719

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 - Minimal harm or potential for actual harm Residents Affected - Few	Right heel pressure wound. Date Initiated: 2/7/23. Revision on: 6/2/26.Goal: Will have clean, dry, intact skin through next review date. Date Initiated: 2/7/23. Revision on: 5/18/26. Target Date: 12/16/26.Interventions: Medications/Labs. Treatments as ordered per provider/accepted. Date Initiated: 2/7/23. Revision on: 2/2/26. Assist/encourage pressure relief as needed/accepted. Date Initiated: 2/7/23. Follow community skin protocol. Date Initiated: 2/7/23. Reposition per standards of care and as accepted/requested. Date Initiated: 4/5/23. Revision on: 5/5/26. Observe skin with AM/PM cares and with toileting for redness, rashes, open areas, pain, swelling and report them to team leader. Weekly skin check. Lotion to dry skin. Review skin concerns with MD. Date Initiated: 5/17/23. Offloading boots to bilateral feet when in bed and recliner at ALL TIMES. Date Initiated: 5/17/23. Revision on: 5/13/26.Focus: Actual/at risk / and/or potential for complications with Diabetes. Concern of DMII (Diabetes Mellitus Type 2), INSULIN DEPENDENT - daily and/or sliding scale. Takes hypoglycemic medication. Date Initiated: 4/4/23. Revision on: 10/31/25.Interventions: Monitor bilateral feet daily for any skin issues. Date Initiated: 4/17/24. Revision on: 2/28/25.Of note, R1's last Braden Scale assessment was completed on 1/29/25 with a score of 13, indicating R1 had a moderate risk for developing pressure injuries.On 4/1/26, R1 was seen by NP O (Nurse Practitioner), whose visit notes indicate, in part: Chief Complaint: ?I found a wound to the right heel during her skin assessment'. Removed Mepilex that nursing applied this AM after finding wound. Objective: Nontender with palpation. Surrounding tissue without erythema or warmth. Wound with surrounding dark tissue. Sanguineous drainage to Mepilex.Assessment and Plan: Pressure Injury of deep tissue of right heel (primary encounter diagnosis). Comment: Discussed with nursing who notes that [Resident Name] has a history of skin blisters that open and turn into ulcers. They wonder if that is the case today. Reviewed history of bullous pemphigoid with previous NP who noted presentation was more widespread and bilateral to feet/shins in 2024. I do not see evidence of blistering anywhere else to legs at this time. Rather, wound is localized to bony prominence of heel with surrounding tissue darker in color as well as deeper/discolored injury to center of wound bed. Wound is also non-itching. Given the above, more likely a deep tissue injury that opened. Plan: Heels in offloading boots at all times in recliner and bed. Visit Diagnoses: Pressure injury of deep tissue of right heel.On 4/1/26 the following physician orders were initiated for R1:-Offloading boots to bilateral feet when in bed and recliner at ALL TIMES every shift for offloading to BL (bilateral) feet. Order Date: 4/1/26. Start Date: 4/1/26. End Date: 7/2/26.-Wound care: Location: RIGHT Heel: Rinse with saline, pat dry. Apply Calcium Alginate with silver to wound bed. Cover with Mepilex. Change daily and PRN (as needed) if soiled, loose, or dislodged, as needed for right heel wound care. May change PRN if soiled, loose, or dislodged, AND every day shift for right heel wound care. Order Date: 4/1/26. Start Date: 4/1/26. End Date: 4/17/26.On 4/2/26 R1's Weekly Skin Review indicated, Right heel has an open area that was addressed when found 4/1/26. Treatment orders are in place and completed per orders. Resident has green booties to wear to aid in healing and protection. No other new skin concerns noted at this time. Site: Right Heel. Description: Open area - Not newOf note, there are no wound measurements or wound characteristics.On 4/3/26 an IDT (Interdisciplinary Team) Skin/Wound Follow up note indicates the following: IDT review of left heel wound noted 4/1/26. [Resident Name] has a history of significant PVD (peripheral vascular disease) and her diabetes was uncontrolled for several years before being admitted to the SNF. She suffers many complications related to these two disease processes. She has a documented history of bullae spontaneously forming on her BLE (bilateral lower extremities) resulting in wounds that can take several months to heal. Per her care plan her heels are off-loaded with heel boots when in bed and her heels hang off the end of her reclining chair when she spends time in it. Her heel boots were in place per care plan prior to discovery of left heel wound. Right heel assessed by writer with scar tissue present and no skin breakdown noted.On 4/9/26 R1's Weekly Skin Review indicates the following: Right heel with open area - treatment orders in plave (sic). Dressing is clean dry and intact at this time. Site: Right heel. Description: Current wound - treatment orders in placeOf note, there are no wound measurements or wound characteristics.On (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Maple Grove LLC	3401 Maple Grove Dr. Madison, WI 53719

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 - Minimal harm or potential for actual harm Residents Affected - Few	4/9/26 the following physician orders were initiated for R1:-Juven one time a day for pressure wound/risk of malnutrition. Order Date: 4/10/26. Start Date: 4/11/26. No end date.On 4/14/26, R1's Skin and Wound Evaluation indicates the following: 2.9 cm length; 3.0 cm width; 0.2 cm depth. In-house acquired. Type: Stage 2: Partial-thickness skin loss with exposed dermis. Wound bed: 100% granulation tissue. Moderate serosanguineous exudate. Edges: Attached: Edge appears flush with wound bed or as a sloping edge.Of note, these are the first measurements that are taken of the wound that was discovered on 4/1/26.On 4/17/26 the following physician orders were initiated for R1:-Wound Care: Location: RIGHT Heel. Rinse with wound cleanser, pat dry. Cut Hydrofera Blue to fit wound bed. Wet with saline and squeeze out excess saline. Apply to wound bed. Cover with ABD (abdominal pad) and Kerlix. Change daily and PRN if soiled, loose, or dislodged, as needed for right heel wound care. May change PRN if soiled, loose or dislodged AND every day shift for right heel wound care. Order Date: 4/17/26. Start Date: 4/17/26. End Date: 5/5/26.On 4/21/26, R1's Skin and Wound Evaluation indicates the following: 2.8 cm length; 3.5 cm width, 0.2 cm depth. In-house acquired. Type: Stage 2: Partial-thickness skin loss with exposed dermis. Wound bed: 100% granulation tissue. Moderate serosanguineous exudate. Faint odor. Edges: Attached: Edge appears flush with wound bed or as a sloping edge.On 4/21/26 the following physician orders were initiated for R1:-R (right) heel ulcer Cleanse with Saline and wipe debris away from ulcer, pat dry. Apply Medi-honey to bandage and apply to R (right) heel ulcer, wrap with Kerlix one time a day for wound ulcer. Order Date: 4/22/26. Start Date: 4/23/26. End Date: 5/5/26.On 4/23/26, R1's Weekly Skin Review indicates the following: Tight (sic) heel open area - treatment in place.R1 was discharged to the hospital on 4/23/26 and returned to the facility on 5/5/26. R1's Admit/Readmit Assessment, dated 5/5/26, indicates the following, in part: Section C: Skin Integrity/Braden Score of 15: Low Risk.Skin condition: Right heel has an open area that was addressed when found 4/1/26. Treatment orders are in place and completed per orders. Skin Integrity: Deep tissue injury to right heel, plantar aspect. 4 cm by 6 cm. Eschar covers about 95% of wound base. Eschar feels hard, thick and non-tender to touch. No active drainage and no odor. No granulation tissue noted. [NAME] pink tissue noted around the edges of the eschar. Surrounding skin appears darkened and dry and feels like callus. Right heel does not have any open areas but appears dry and calloused as well.On 5/5/26 the following physician orders were initiated for R1:-Wound Care: Location: RIGHT Heel. Cleanse daily with normal saline or soap and water, pat dry. Paint with betadine. Cover with dry gauze. Change daily and PRN if soiled, loose or dislodged, as needed for right heel wound care. May change PRN if soiled, loose or dislodged AND every day shift for right heel wound care. Order Date: 5/5/26. Start Date: 5/5/26. End Date: 5/14/26.-Apply Heel Medix Boots for off-loading every shift for heel boots. Order Date: 5/5/26. Start Date: 5/5/26. End Date: 7/2/26.R1's Skin and Wound Evaluations and Weekly Skin Reviews indicate the following measurements:On 5/12/26: 4.3 cm length, 6.5 cm width, 100% eschar. Stage: Unstageable: Obscured full-thickness skin and tissue [NAME] 5/13/26, R1's care plan was updated to include the following intervention: Check feet for any skin issues daily.On 5/14/26 the following physician orders were initiated for R1:-Right Heel Treatment: Wash with soap and water, apply Silvadene cream to right heel eschar, cover with gauze every other day, as needed for right heel wound care. May change PRN if soiled, loose or dislodged AND one time a day for right heel wound care. Order Date: 5/14/26. Start Date: 5/15/26. End Date: 5/24/26.R1's Skin and Wound Evaluations and Weekly Skin Reviews indicate the following measurements:On 5/19/26: 4.5 cm length, 6.4 cm width, 100% eschar. Stage: Unstageable: Obscured full-thickness skin and tissue [NAME] 5/24/26 the following physician orders were initiated for R1:-Right Heel Treatment: Wash with soap and water, apply Silvadene cream to right heel eschar, cover with gauze every other day, one time a day for right heel wound care AND as needed for right heel wound care. May change PRN if soiled, loose or dislodged. Order Date: 5/24/26. Start Date: 5/25/26. End Date: 6/11/26.R1's Skin and Wound Evaluations and Weekly Skin Reviews indicate the following measurements:On 5/26/26: 5.0 cm length, 5.6 cm width, 90% eschar. Stage: Unstageable: Obscured full-thickness skin and tissue (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Maple Grove LLC	3401 Maple Grove Dr. Madison, WI 53719

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 - Minimal harm or potential for actual harm Residents Affected - Few	[NAME] 6/2/26: Right heel. 4.5 cm x 6 cm. No description of wound bed or characteristics of wound.On 6/9/26: Right heel. 4.5 cm x 5.5 cm. No description of wound bed or characteristics of wound.On 6/11/26 the following physician orders were initiated for R1:-Silvadene External Cream 1% (Silver Sulfadiazine). Apply to R (right) heel topically every day shift for skin integrity maintenance until healed. Silvadene (sic) Cream 90 gm tube. Order Date: 6/11/26. Start Date: 6/11/26. No end date.R1's Skin and Wound Evaluations and Weekly Skin Reviews indicate the following measurements:On 6/16/26: 4.5 cm x 6.5 cm. No description of wound bed or characteristics of wound.Of note, on 6/23/26 there was no skin assessment or wound measurements taken.On 6/30/26: Right heel. 4.5 cm x 6.0 cm. No description of wound bed or characteristics of wound.R1's CNA (Certified Nursing Assistant) Kardex states the following, in part: Offloading boots to bilateral feet when in bed and recliner at ALL TIMES.On 6/29/26 at 10:43 AM, Surveyor observed R1 in her room asleep in her recliner. R1 was wearing gripper socks but not offloading boots. Surveyor observed that the offloading boots were sitting in the windowsill next to the bed. On 6/29/26 at 4:19 PM, Surveyor observed R1 in her room sitting in the wheelchair with the foot pedals on. R1 was wearing gripper socks but not offloading boots. Surveyor observed that the offloading boots were still sitting in the windowsill next to the bed. 7/1/26 at 8:04 AM, Surveyor interviewed RN/UM M (Registered Nurse/Unit Manager) about R1's right heel wound. RN/UM M stated that she called the provider about it yesterday because the measurements were stable but not improving. RN/UM M stated that at that time the provider didn't want to make any changes because R1 is scheduled to see podiatry today. RN/UM M indicated that R1 has a history of getting areas that bubble up and blister so initially they did not label it as a pressure ulcer but because of the location it was changed to a pressure ulcer. RN/UM M stated that R1 has offloading boots for when she lays down. RN/UM M indicated that R1 does not refuse to wear the offloading boots that she is aware of, but that will refuse the foot cradle when she is in bed because she is often cold and wants to feel the blankets on her feet.On 7/1/26 at 1:38 PM, Surveyor interviewed IP/ADON N (Infection Preventionist/Assistant Director of Nursing) about R1's right heel wound. IP/ADON N stated that the pressure injury was discovered on 4/1/26 as an open area and the NP was contacted at that time. IP/ADON N stated that the wound on the right heel was in the exact same spot as a wound a couple years ago that she admitted with. IP/ADON N stated that R1 would get spontaneous blisters on top and bottom of her feet and shins. IP/ADON N stated that it looked like exactly that last time with the blistering started again so she didn't feel like it was pressure and didn't end up staging it at that time. IP/ADON N indicated that after she had further discussions with NP O and the doctor, they felt it was pressure, so they classified it as stage two. IP/ADON N indicated that when R1 went out to the hospital and then returned back to the facility, the entire wound had eschar and was much larger and was classified as unstageable at that time. At this time, IP/ADON N asked RN/UM M to join the interview. RN/UM M reiterated that some of R1's pressure interventions included foot boots when R1 is in the recliner or bed. Surveyor asked when R1 was supposed to be wearing the off-loading boots. Both RN/UM M and IP/ADON N stated R1 was to be wearing the off-loading boots at all times. Surveyor asked how often wound assessments and measurements should be taken. RN/UM M stated weekly. Surveyor asked why no measurements were taken until 4/14/26. IP/ADON N stated that NP O saw R1 on 4/1/26 but that it was not classified as a pressure ulcer until 4/14/26.On 7/1/26 at 3:47 PM, Surveyor interviewed NP O (Nurse Practitioner) via telephone about R1's right heel wound. NP O stated that she had conversations with the facility about it because she felt it was a pressure injury instead of a diabetic foot ulcer because of the location of on a bony prominence. NP O indicated that when the doctor came to see R1 she agreed it was a pressure injury. NP O stated that the facility asked her about them being the bullous blisters that she had in the past, but NP O stated those would be all over and not in just one location. Surveyor asked NP O what her expectation for R1 was regarding the off-loading boots. NP O indicated that she expected R1 to be wearing the off-loading boots at all times, including in the bed, recliner or wheelchair to protect her heels.On 7/2/26 at 8:01 AM, Surveyor interviewed DON B (Director of (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Maple Grove LLC	3401 Maple Grove Dr. Madison, WI 53719

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 - Minimal harm or potential for actual harm Residents Affected - Few	Nursing) about R1's right heel wound. DON B indicated that R1 had those wounds in the past and they've been healed since 2022. DON B indicated that R1 would get these blisters on her feet and the one on the left heel had osteomyelitis, so they just thought it was another one of those ulcers that started out as a blister. DON B stated that IP/ADON N and NP O had back and forth discussions trying to decide what it was and because it was on the heel they went with a pressure ulcer. DON B stated that then R1 went out to the hospital and when she came back it was covered with necrotic tissue. Surveyor asked DON B how often wound assessments and measurements were completed. DON B stated it was her expectation that wounds be measured weekly. DON B stated that they started measuring R1's wound when it was declared a pressure injury on 4/14/26.The facility did not ensure complete and accurate documentation of the wound including weekly measurements and did not ensure that care planned interventions were being followed to prevent worsening or additional pressure injuries.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Maple Grove LLC	3401 Maple Grove Dr. Madison, WI 53719

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 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 each resident receives adequate supervision and assistance devices to prevent accidents from occurring for 1 of 4 residents (R31) of 25 sampled residents reviewed for safety concerns.R31's Care Plan instructed that he was to be given plastic silverware at meals; however, he was repeatedly observed to be given regular silverware at meals.This is evidenced by:The facility's policy, titled Accidents and Supervision, reviewed/revised in 3/2026, states in part: Policy: The resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes: 1. Identifying hazard(s) and risk(s). 2. Evaluating and analyzing hazard(s) and risk(s). 3. Implementing interventions to reduce hazard(s) and risk(s). 4. Monitoring for effectiveness and modifying interventions when necessary.Policy Explanation and Compliance Guidelines: The facility shall establish and utilize a systematic approach to address resident risk and environmental hazards to minimize the likelihood of accidents. 1. Identification of Hazards and Risks - the process through which the facility becomes aware of potential hazards in the resident environment and the risk of a resident having an avoidable accident.3. Implementation of Interventions - using specific interventions to try to reduce a resident's risks from hazards in the environment. The process includes: a. Communicating the interventions to all relevant staff b. Assigning responsibility c. Providing training as needed d. Documenting interventions (e.g., plans of action developed through the QAA (Quality Assessment and Assurance) Committee or care plans for the individual resident) e. Ensuring that the interventions are put into action.R31 was admitted to the facility on [DATE] with diagnoses that include the following, in part: dementia - mild with anxiety, bipolar disorder, personality disorder, impulse disorder, and anxiety disorder. R31's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/22/26 states that R31 has a BIMS (Brief Interview for Mental Status) of 3 out of 15, indicating he is severely cognitively impaired. R31 has an activated HCPOA (Health Care Power of Attorney). On 6/29/26 at 12:24 PM, Surveyor was observing residents dining for lunch. Surveyor noted R31 sits at a table by himself in the dining room. Surveyor observed CNA R (Certified Nursing Assistant) approach R31 and take his metal fork and knife away from him. CNA R approached MT S (Med Tech) and informed her that R31 had asked CNA R to take away his fork and knife because he was going to stick them in his throat. MT S called the charge nurse immediately and then informed the unit nurse, LPN Q (Licensed Practical Nurse) about the incident. CNA R gave R31 a plastic spoon to use to finish eating his meal.Surveyor reviewed R31's Care Plan. R31's Care Plan states in a banner at the top of the page, in part: Special Instructions: Plastic silverware to be used for meals.Surveyor reviewed R31's progress notes and noted the following: -5/2/26 at 7:38 PM: During suppertime meal resident was [sic] had aggressive outburst towards another resident, screaming vulgar slurs, leaping up out of their wheelchair with their fork in their hand pointed at resident. Resident was removed from dining room and taken to their room to finish their supper with CNA staff staying with resident. Writer notified charge nurse.-5/28/26 at 7:15 AM - Psychiatry Follow Up: .History of Present Illness: .On 5/14/26, nurse.reported worsening outburst behaviors including spitting on staff members, verbal threats to other resident, and throwing utensils at other residents, primarily in the evening.-6/11/26 at 1:58 PM: Resident blurted out 'I am going to kill you' while sitting in the dining room. Behavior was not directed at any specific person. Resident removed immediately from dining room and placed in room with call light within reach.-6/17/26 at 6:58 PM: Resident had aggressive outburst at dinner table in general dining room at supper time. Resident, unprovoked by anything, began yelling vulgar obscenities, raising their fists in the air and spitting while yelling. CNA staff made attempt to speak to resident and resident picked up their glass of juice and with throwing motion made threat to hit CNA staff with glass of juice. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Maple Grove LLC	3401 Maple Grove Dr. Madison, WI 53719

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident was removed from the dining room by CNA staff and taken to their room to have a moment to cool down.-6/27/26 at 9:42 PM: Resident had difficult time during breakfast meal in general dining room with disruptive behaviors that included swearing, making very loud inappropriate noises and slamming their hands off the table numerous times however, resident redirectable after discussion. On 6/29/26 at 2:00 PM, Surveyor interviewed CNA R about R31's behaviors. CNA R indicated R31 acts out when he is not getting attention. He makes threats often but then says he won't actually do anything. CNA R indicated she had to treat the silverware incident as a real threat and report it. Surveyor asked if R31 can use regular silverware for meals and CNA R said yes but indicated she would ask the kitchen to send plastic silverware for now. On 6/29/26 at 2:05 PM, Surveyor spoke with LPN Q and informed her that R31's care plan instructs that he should use plastic silverware for meals. LPN Q said she is still training but will look into that and will report this incident during shift change.On 6/30/26 at 8:43 AM, Surveyor observed R31 eating breakfast using metal silverware. On 6/30/26 at 8:52 AM, Surveyor interviewed CNA Z and asked if R31 should be using plastic silverware for meals. CNA Z said yes and told kitchen staff serving breakfast about using plastic silverware for R31 going forward. CNA Z indicated she had been told about the plastic silverware during shift change this morning but had forgotten about it. Of Note: CNA Z did not take the metal silverware away from R31.On 7/1/26 at 8:39 AM, Surveyor observed R31 eating breakfast using metal silverware. On 7/1/26 at 8:41 AM, Surveyor interviewed CNA P and asked if R31 should be using plastic silverware for meals. CNA P indicated she just realized R31 had metal silverware and told another CNA that he was not supposed to have that. CNA P then walked over to R31 and switched the metal silverware out with plastic silverware.On 7/1/26 at 9:09 AM, Surveyor informed RN Y (Registered Nurse) about R31's metal silverware being used.On 7/2/26 at 1:40 PM, Surveyor spoke with DON B (Director of Nursing) about R31's dining utensils and behaviors. DON B indicated that staff typically keep R31 separated from other residents in the dining room because of his behaviors and they are supposed to be monitoring him more closely right now due to a medication change. DON B made note of the plastic silverware intervention not being followed and said she would address it with staff members. Additionally, DON B spoke with DM AA (Dietary Manager), who indicated R31 does not have plastic silverware use instructions listed on his kitchen meal tickets.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Maple Grove LLC	3401 Maple Grove Dr. Madison, WI 53719

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that residents with an indwelling catheter received the appropriate care and services to prevent infections or complications for 1 of 1 resident (R95) reviewed for catheters out of 25 sampled residents.Surveyor observed R95's suprapubic indwelling catheter bag to be resting in direct contact with the floor.This is evidenced by:The facility's policy, titled Catheter Care, implemented 11/2025, states in part: Policy: It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy while indwelling catheters are in use. Policy Explanation: .2. Privacy bags will be available and catheter drainage bags will be covered at all times while in use.The CDC (Centers for Disease Control and Prevention) lists the following recommendation from the Guideline for Prevention of Catheter-Associated Urinary Tract Infections (2009): Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor (https://www.cdc.gov/infection-control/hcp/cauti/summary-of-recommendations.html). R95 initially admitted to the facility on [DATE] with diagnoses that include, in part: neuromuscular dysfunction of the bladder, presence of urogenital implants, and retention of urine.R95's physician orders include the following, in part: May change.suprapubic catheter every 4 weeks. Every 6th catheter change, resident must be seen by urology to evaluate SP (suprapubic) tract - Order date: 5/7/26. R95's care plan, revised on 1/19/26, includes the following information related to catheter care, in part: Focus: Actual / at risk / and/or potential for complications with use of suprapubic catheter. Goal: Will be free of serious complications r/t (related to) device use through next review. Interventions/Tasks: Dignity bag for foley when not in room.Of note: Review of R95's progress notes indicated that she was treated for a UTI (urinary tract infection) in 5/2026.On 6/29/26 at 12:24 PM, Surveyor observed R95 eating lunch in the dining room. R95 was sitting in her wheelchair with her catheter bag hooked on the bottom of the wheelchair and resting in direct contact with the floor. At 12:30 PM, Surveyor notified CNA P (Certified Nursing Assistant) about the catheter bag touching the floor. CNA P notified another CNA who was working that the bag should not be touching the floor. They took R95 back to her room, placed a dignity bag over the catheter bag, and hung it on R95's wheelchair so it was below her bladder but not in contact with the floor. At 12:46 PM, Surveyor notified LPN Q (Licensed Practical Nurse) about R95's catheter bag. LPN Q said the catheter bag should not have been in contact with the floor. On 7/1/26 at 8:17 AM, Surveyor observed R95 eating breakfast in the dining room. R95 was sitting in her wheelchair with her catheter bag hooked on the bottom of the wheelchair and resting in direct contact with the floor. Surveyor notified CNA P about the catheter bag touching the floor. CNA P indicated that she would address this with the CNA working with R95. At 9:09 AM, Surveyor informed RN Y (Registered Nurse) about R95's catheter bag being on the floor. On 7/2/26 at 1:40 PM, Surveyor reviewed findings of R95's catheter bag being on the floor with DON B (Director of Nursing). DON B indicated catheter bags should not be touching the floor and said this would be addressed with staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Maple Grove LLC	3401 Maple Grove Dr. Madison, WI 53719

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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for resident's experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident for 1 of 3 residents (R102) reviewed for trauma informed care out of a sample of 25 residents.R102 disclosed trauma and does not have a complete trauma assessment or a care plan addressing triggers, resident specific approaches, or interventions.This is evidenced by:The facility's policy, Trauma Informed Care, dated 1/26, includes: It is the policy of this facility to provide care and services. and address the needs of trauma survivors by minimizing triggers and/or re-traumatization. The facility will use a multi-pronged approach to identifying a resident's history of trauma. This will include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event, as well as screening and assessment tools. Trigger-specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident, and will be added to the residents care plan. R102 admitted to the facility on [DATE] with diagnoses including depression, anxiety, and skin-picking disorder.R102's BIMS (Brief Interview for Mental Status), dated 6/8/26, has a score of 14, indicating R102 is cognitively intact. On 6/30/26 at 8:38 AM, Surveyor interviewed R102. R102 disclosed sexual assault in her past. R102's Trauma Informed Care Assessment, dated 6/8/26, includes:1. Part 1Listed below are a number of difficult or stressful things that sometimes happen to people. For each event choose one or more of the options.4. Serious accident at work, home or recreational activity. Answer was left blank6. Physical assault. Answer is blank12. Life threatening illness or injury. Answer is blank.13. Severe human suffering. Answer is blank. 17. Any other very stressful event or experience. 1. Happened to me. 2. Part 2A. If you select numbers 1-4 as an answer to any of the above questions, briefly identify the event(s) you were thinking of: Answer is blank.3. PC-PTSD-5The PC-PTSD-5 screening is designed to identify individuals with probable PTSD (Post Traumatic Stress Disorder). Those screening positive require further assessment. Resident will answer yes or no to the following 5 questions.All 5 questions are left blank. R102's comprehensive care plan, printed 7/1/26, does not include trauma specific focus, goals or interventions. On 7/1/26 at 10:09 AM, Surveyor interviewed SW C (Social Worker) regarding the process of Trauma Informed Care Assessments in the facility. SW C indicated she completes a Trauma Informed Care Assessment soon after a resident is admitted to the facility. SW C indicated if a resident indicates a history of trauma, SW C will care plan the trauma along with known triggers. Surveyor asked SW C about R102's trauma. SW C indicated on 6/25/26 or 6/26/26, R102 informed SW C about a traumatic sexual incident that occurred when R102 was a teenager. SW C indicated a new Trauma Informed Care Assessment should have been completed and R102's care plan should have been updated. SW C indicated she did not complete a new assessment nor did she update R102's care plan but should have.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Maple Grove LLC	3401 Maple Grove Dr. Madison, WI 53719

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 maintain a safe and sanitary environment in which food is prepared, stored, and distributed. This has the potential to affect all 103 residents who reside in the facility.Surveyor observed food not properly covered in the walk-in refrigerator.Surveyor observed a scoop left in the flour bin.Surveyor observed a kitchen staff with facial hair not wearing a beard restraint.Surveyor observed food brought in by family members not properly labeled and dated.Evidenced by:The facility policy, Food Safety requirements, dated 1/26, states, in part;.labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use-by date.keeping foods covered or in tight containers.Dietary staff must wear hair restraints (e.g., hairnet, hat, and/or beard restraint) to prevent hair from contacting food.The facility policy, Use and Storage of Food Brought in by Family or Visitors, dated, 3/26, states, in part.All food items that are already prepared by the family or visitor brought in must be labeled with content and dated.On 6/29/26 at 9:00 AM, during the initial walk through of the kitchen, Surveyor observed a scoop left in the flour bin. Surveyor observed bacon and pie crusts uncovered with no label and date in the walk-in refrigerator. Dietary Manager AA (DM) indicated the scoop should not be left in the bin and DM AA would provide staff education. DM AA indicated food items should be covered, labeled, and dated.On 6/30/26 at 1:08PM, Surveyor observed staff with facial hair, not wearing a beard restraint.On 6/30/26 at 2:40PM, Surveyor observed items in the 100-hallway refrigerator to not be labeled and dated. Dietary Manager AA (DM) indicated the two items were some sort of fruit that was brought in by a family. DM AA indicated these items should be labeled and dated. DM AA indicated staff should be wearing a beard restraint if staff has facial hair and that he has talked to this staff regarding this concern.On 7/2/26 at 3:15 PM, Nursing Home Administrator A (NHA) indicated understanding of the above concerns.The facility did not maintain a safe and sanitary environment in which food is prepared, stored, and distributed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Maple Grove LLC	3401 Maple Grove Dr. Madison, WI 53719

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility for 1 of 1 resident (R44) reviewed for hospice services out of sample of 25 residents. R44 was receiving hospice services and the facility failed to obtain hospice care plan and notes. Evidenced by: The facility policy titled Coordination of Hospice Services, dated 1/26, states, in part: Policy: When a resident chooses to receive hospice care and services, the facility will coordinate and provide care in cooperation with hospice staff in order to promote the resident's highest practicable physical, mental, and psychosocial well-being. Policy Explanations and Compliance Guidelines: . 2. The facility and hospice provider will coordinate a plan of care and will implement interventions in accordance with the resident's needs, goals, and recognized standards of practice. 3. The plan of care will identify the care and services that each entity will provide in order to meet the needs of the resident and his/her expressed desire for hospice care. The Hospice-Nursing Facility Services Agreement states, in part, . Agreements. the parties agree to the following terms and conditions: 1. Definitions:. (e) Hospice Plan of Care means a written care plan established, maintained, reviewed, and modified, if necessary, at intervals identified by the Hospice IDT (Interdisciplinary Team) in coordination with Facility and each Hospice Patient's attending physician. The Hospice Plan of Care must reflect goals of each Hospice Patient and his or her family and interventions. Specifically, the Hospice Plan of Care includes: (i) identification of the Hospice Services. and Facility Services needed to meet a Hospice Patient's needs and the related needs of his or her family. 2. Responsibilities of Facility. (i) Facility Services. Facility shall comply with each Hospice Patient's Hospice Plan of Care. and ensure that the level of care provided is appropriate based on the individual Hospice Patient's needs. (ii) Design of Hospice Plan of Care. Facility shall coordinate with Hospice in developing a Hospice Plan of Care for each Hospice Patient that is consistent with the hospice philosophy and is responsive to the unique needs of each Hospice Patient and his or her expressed desire for hospice care. The Hospice Plan of Care will identify which provider is responsible for performing the respective functions that have been agreed upon and included in the Hospice Plan of Care. R44 was admitted to the facility on [DATE] with diagnoses that include, in part: Malignant neoplasm of connective and soft tissue of right lower limb including hip, Non-pressure chronic ulcer of other part of right foot with unspecified severity, Non-pressure chronic ulcer of other part of right lower leg with fat layer exposed, Other chronic pain, and Pain in right leg. R44 was admitted to hospice services on 1/13/26 with primary hospice diagnosis of Primary angiosarcoma of right lower extremity. R44's Comprehensive Care Plan states, in part: Focus: Dignity/Alteration in Body Image and Social Isolation r/t (related to) Fungating Tumor Malodor: Resident presents with a malignant, malodorous fungating tumor of the right lower extremity (RLE). resident is currently monitored by Nursing and Hospice services for targeted wound palliation.Date Initiated: 4/27/26. Revision on 6/30/26.Interventions: . Refer directly to hospice protocols, guidelines, and directives to safely implement alternative and advanced interventions for the mitigation and management of right lower extremity (RLE) wound malodor. Date Initiated: 4/27/26.Focus: Patient is on Hospice care related to: End of life care for malignant neoplasm of connective tissue of rt (right) lower limb/hip. Date Initiated: 5/1/26. Revision on 7/1/26.Interventions: . Allow patient to verbalize fears and concerns about dying process. Date Initiated: 5/1/26. Keep family informed of change in condition. Date Initiated: 5/1/26. Notify hospice of any change in condition or medication changes. Date Initiated: 5/1/26. Provide emotional support to patient and family during decline in the dying process. Date Initiated: 5/1/26. Provide for any patient request within reason such as any food (including fast food), flowers, music, special pictures, church on DVD, pets, etc. Date Initiated: 5/1/26. Revision on: 5/4/26. Meds/Labs/Treatments as ordered per (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525276	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Maple Grove LLC	3401 Maple Grove Dr. Madison, WI 53719

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provider/accepted. Date Initiated: 7/1/26. On 7/1/26 at 2:51 PM, Surveyor interviewed CNA J (Certified Nursing Assistant) about R44's hospice services. CNA J indicated that hospice manages R44's wound and pain medications. Surveyor asked where R44's hospice care plan was located. CNA J stated there is a care plan located in the bathroom. On 7/1/26 at 3:01 PM, Surveyor interviewed LPN K (Licensed Practical Nurse) about R44's hospice services. LPN K stated that hospice comes out and addresses R44's pain and leg treatments. Surveyor asked where R44's hospice care plan was located. LPN K indicated that it was included in PCC (Point Click Care) electronic health record. On 7/2/26 at 8:00 AM, Surveyor interviewed DON B (Director of Nursing) and asked where R44's hospice care plan was located. DON B indicated that hospice notebooks were at the nurse's station. On 7/2/26 at 9:59 AM, Surveyor interviewed LPN G while at the nurse's station and asked to review R44's hospice binder. LPN G looked and stated that she couldn't find R44's hospice binder. On 7/2/26 at 10:08 AM, Surveyor interviewed RN H (Registered Nurse) while at the nurse's station and asked to review R44's hospice binder. RN H could not locate a hospice binder. RN H stated that usually hospice fills it out and brings it back to the nurse's station, but it was not there today. RN H stated he would look around for the binder and get back to Surveyor. On 7/2/26 at 1:50 PM, Surveyor interviewed LPN G about R44's hospice care plan and binder. LPN G stated that the unit manager brought it back earlier today. LPN G stated that if a resident is on hospice, their care plan is also posted in their bathroom. LPN G took Surveyor to R44's room and showed her what she was referring to. One page of the CNA Kardex was posted on R44's bathroom wall with information on R44's ADLs (Activities of Daily Living) such as transfer status. On 7/2/26 at 1:51 PM, Surveyor interviewed MT I (Medication Technician) and asked to review R44's hospice binder with her. MT I showed Surveyor a binder with three sheets of paper that had hospice contact information on them, but no plan of care. MT I then obtained R44's paper chart and showed Surveyor that the plan of care from hospice was in the paper chart under the hospice tab. Surveyor pointed out the date in the corner of the hospice care plan, and MT I stated yes, it was just printed today. Surveyor pointed out that the hospice plan of care in R44's paper chart indicated that R44 was still living at home with home health services. MT I stated that it needed to be updated. MT I indicated that the hospice providers also print up their notes and they are included in the paper chart, but MT I stated that she did not see any evidence of those visit notes in R44's chart. On 7/2/26 at 2:26 PM, Surveyor interviewed DON B about how the facility coordinates care with hospice for R44. DON B indicated that the hospice providers will check in with facility staff when they visit and if there is any problems or changes the staff will notify hospice with updates and get their input on R44's care. Surveyor asked DON B how often the IDT team meets with hospice. DON B stated that the IDT team meets with hospice and the resident and family when they are admitted to hospice and then monthly after that. Surveyor asked DON B if there was documentation of these meetings. DON B stated that the facility gets hospice notes every time they come to visit. Surveyor asked DON B who was responsible for obtaining these notes and keeping the hospice care plan updated. DON B indicated that it was the floor nurses and unit managers who do that. Surveyor asked DON B where this information was kept. DON B stated that the hospice care plans are kept in binders on the unit, but that she was aware that R44's was printed today because it wasn't there. Surveyor asked DON B how she ensures coordination with the hospice plan of care if there was no hospice documentation in the facility. DON B stated that in R44's case it was a fluke, and she should have had a binder with all that information in it, but it just happened to be missing. The facility did not ensure collaboration and coordination with hospice for a complete plan of care for a resident in their facility who was receiving hospice services.