STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525493	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Health Services	3540 S 43rd St Milwaukee, WI 53220

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview and record review, the facility did not ensure menu items were followed. This was observed with 7 (R31, R16, R54, R88, R50, R26 and R10) of 7 residents receiving an altered textured diet. * R31, R16, R54, R88, R50, R26 and R10 have altered textured diets and did not receive a dinner roll with their lunch meal as stated on the menu.Findings include:The facility's policy and procedure titled, Menus dated 9/2017, documents, . The menus will be served as written, unless a substitution is provided in response to preference, unavailability of an item, or a special meal.On 7/21/2025, at 12:06 PM, Surveyor observed the serving of the lunch meal on the 1st floor by Dietary Aide (DA)-M. The menu documented for lunch: Turkey Alfredo, parslied fettuccini, Tuscany blend vegetables, garlic dinner roll and strawberry shortcake for dessert. Surveyor observed DA-M assemble the food into a steam table and take temperatures of the food. Surveyor noted there was not a puree or mechanically altered dinner roll option available. The DA-M used divided plates for R31, R16, R54, R88, R50, R26 and R10. Surveyor observed these residents did not receive a garlic dinner roll or substitution. DA-M did provide a dinner roll with butter to all resident that received regular textured diets. On 7/22/2025, at 9:51 AM, Surveyor interviewed Dietary Manager (DM)-K. DM-K stated the usual staff was not serving the noon meal yesterday. DM-K stated they do have textured consistency options for dinner rolls. DM-K stated they forgot to make the altered textured dinner rolls. DM-K stated all residents get all the same menu items. On 7/22/2025, at 10:18 AM, Surveyor shared the menu concerns with Director of Nurses (DON)-B and Senior [NAME] President of Success (SVPOS) -C. On 7/22/2025, at 12:48 PM, Regional Director (RD)-L and DM-K provided Surveyor with policy and procedures related to concerns in the kitchen meal service. RD-L stated they have started education for the kitchen staff.

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

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility did not ensure food and beverages were maintained in a sanitary manner. This was observed with 2 of 2 kitchenette serving areas. *The lunch meal food temperatures were not obtained in a sanitary manner. * The coolers and freezers in the 1st and 2nd floor kitchenettes were not maintained in a sanitary manner. Findings include:The facility's policy and procedure for Food Storage, dated 9/2017, documented, . 5. All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. The facility's policy and procedure for Food Preparation dated 9/2017, documented, . 3. All utensils, food contact equipment, and food contact surfaces will be cleaned and sanitized after every use.On 7/21/2025, at 11:54 AM, Surveyor observed the 1st floor kitchenette refrigerator. The freezer has undated, and opened, popsicles. An unlabeled Styrofoam container. The fridge section has a deli container of a brownish-green substance with no labeling. There were 2 plastic bagged containers with no labeling. There was an open jar of queso with no label. There was a Styrofoam drink with a straw with no labeling. There was a sliced raw onion in loose saran wrap with no label. There was a brown bag with purple grapes inside with no labeling.On 7/21/2025, at 12:06 PM, Surveyor observed food temperatures by Dietary Aide (DA)-M on 1st floor kitchenette. The DA-M placed all the hot food in a steam table and removed the foil covering. The DA-M obtained a food thermometer and placed it into the turkey alfredo. The DA-M then wiped off the thermometer with a paper towel. The DA-M then placed the thermometer into the mechanical soft turkey alfredo. The DA-M then wiped off the thermometer with the same paper towel. The DA-M then placed the thermometer into puree noodles. The DA-M wiped off the thermometer with the same paper towel. Surveyor observed DA-M did not sanitize the thermometer between foods. DA-M then placed the thermometer into puree carrots. DA-M wiped off the thermometer with the same paper towel. The DA-M did not sanitize the thermometer between foods. The DA-M then placed the thermometer into mechanical soft carrots. The DA-M then wiped off the thermometer with the same paper towels. Surveyor observed DA-M did not sanitize the thermometer. DA-M then placed the thermometer into a carrot and cauliflower mix and DA-M wiped the thermometer with the same paper towel. Surveyor observed DA-M did not sanitize the thermometer between foods. DA-M then placed the thermometer into puree strawberry shortcake. Surveyor observed DA-M did not sanitize the thermometer between foods.On 7/21/2025, at 1:25 PM, Surveyor observed the 2nd floor kitchenette. The freezer has an opened fast-food container with no label, a large frozen red colored Styrofoam drinking cup with lid and no label, a frozen, used dessert icing bag with no label, a frozen Italian Ice pop box with no label, a yellow tied up grocery bag with frozen items in it unlabeled. The fridge section has 1 opened honey container with no label, a quart of opened chocolate milk with no open date, one loose apple, a gray tied up bag of 2 small oranges with no label.On 7/22/202, at 9:51 AM, Surveyor interviewed Dietary Manager (DM) - K. DM-K stated they do check the kitchenette refrigerators every day. DM-K stated they have been busy cooking lately. DM-K stated their process is to sanitize the food thermometer between foods when taking food temperatures.On 7/22/2025, at 10:18 AM, Surveyor shared the menu concerns with Director of Nurses (DON)-B and Senior [NAME] President of Success (SVPOS) -C. On 7/22/2025, at 12:48 PM, DM-K and Regional Director (RD)-L, provided Surveyor with policy and procedures related to food preparation and storage. RD-L stated they have started training the kitchen staff on these procedures.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility did not ensure residents right to formulate an advance directive for do not resuscitate (DNR) was implemented for 1 of 18 (R8) residents advanced directives reviewed.R8 electronic health record indicated full code, CPR preference form date [DATE] indicated R8 was a DNRFindings include: The facility Policy titled Cardiopulmonary Resuscitation (CPR) dated [DATE] documents (in part) . It is the policy of this facility to adhere to residents' rights to formulate advance directives. In accordance to these rights, this facility will implement guidelines regarding cardiopulmonary resuscitation (CPR). 2. If a resident experiences a cardiac arrest, facility staff will provide basic life support, including CPR, prior to the arrival of emergency medical services, and: a. In accordance with the resident's advance directives, orb. In the absence of advance directives or a Do Not Resuscitate order. R8's Care plan dated [DATE] documents: Resident has an advanced directive in place. Follow advanced directive per MD (Medical Doctor) orders. Follow facility protocol for identification of code status. On [DATE], at 10:44 AM, while reviewing R8's electronic health record (EHR), Surveyor noted R8's code status was listed as Full Code. R8's Physician order dated [DATE] documents Full Code. Surveyor located a CPR (Cardiopulmonary Resuscitation)/DNR (Do Not Resuscitate) preference form signed by R8's Guardian/legal decision maker dated [DATE] which documents an X next to I do NOT want CPR attempted (DNR order). On [DATE], at 11:57 AM, Surveyor interviewed Registered Nurse (RN)-F. Surveyor asked if RN-F if he observed a resident not breathing/without a pulse or if he was advised by a CNA (Certified Nursing Assistant) that a resident was coding, where would he look to find their code status? RN-F showed Surveyor on the computer/EHR and stated, I would look right here, on their dashboard it lists their advanced directive, it's the same place for every resident. Surveyor asked to view R8's code status. RN-F brought up R8's dashboard on the computer. RN-F pointed to the advanced directives section and stated, It says it right here, she's a full code. Surveyor asked RN-F if there was anywhere else, he would look to find R8's code status. RN-F stated, No, this is where I would look. Surveyor verified with RN-F that R8 is a full code. Surveyor asked RN-F if residents wear DNR bracelets at the facility. RN-F reported he did not think so. Surveyor verified with RN-F, if a resident coded, he would look at the computer dashboard to verify their code status. RN-F stated, yes. On [DATE] at 12:10 PM, Surveyor spoke with Licensed Practical Nurse (LPN)-G and asked if residents wear DNR bracelets. LPN-F stated, No, maybe some of them do but mostly no. Surveyor asked what he would do if a resident coded. LPN-G stated, I would look at the computer, it says their code status on the main screen. Surveyor asked if he meant the dashboard, LPN-G stated, Yes, if I saw a resident with a DNR bracelet on, I would still come look at the computer to make sure, because you never know - sometimes things get messed up. Surveyor asked which location he would trust as accurate. LPN-G stated, The computer. On [DATE], at 12:15 PM, Surveyor observed R8 seated in the dining room. R8 had an allergy bracelet on her left wrist and was not wearing a DNR bracelet. On [DATE], at 9:13 AM, Surveyor noted R8's code status on the EHR dashboard was changed to DNR. On [DATE], at 11:33 AM, Director of Nursing (DON)-B was advised of concern R8's Guardian signed the CPR/DNR preference form on [DATE] indicating DNR. R8's EHR was not revised to include the DNR order. As of [DATE] (1 week later) R8's code status indicated Full Code and was not changed to DNR until notified by Surveyor. On [DATE] at 3:43 PM, the facility was notified of the above concerns. No additional information was provided.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure 1 (R2) of 18 residents care plans reviewed were revised after each assessment or determined by resident's needs.R2' care plan was not revised to indicate R2 did not require the use of an abdominal protector with monitoring and need to release the binder due to the need for the use of a gastrointestinal (G-tube) tube. Findings include:The facility policy titled Comprehensive Care Plan with a reviewed/revision date of 9/23/2022 documents: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a residents medical, nursing, and mental and psychological needs that are identified in the residents comprehensive assessment. 5. The comprehensive care plan will be reviewed and revised as appropriate by the interdisciplinary team after each comprehensive and quarterly minimum data set (MDS) assessment, and as needed with changes in condition.R2 was admitted to the facility on [DATE] and has diagnoses that include hemiplegia/ hemiparesis following cerebral infarction affecting right dominant side (Stroke with right sided paralysis), dysphagia (difficulty swallowing), aphasia (difficulty communicating), type 2 diabetes mellitus, protein-calorie malnutrition, Alzheimer's disease, and Dementia.R2's admission Minimum Data Set (MDS) dated [DATE] indicated R2 had severely impaired cognition with a Brief Interview for Mental Status (BIMS) score of 0. R2 was assessed to require total assistance with one staff member for all activities of daily living (ADL) care. R2 was admitted with a gastrointestinal (G-tube) tube that delivered continuous feedings and a foley catheter. R2 has an activated power of attorney (POA).R2's care plan documented a need for a feeding tube/potential for complications of feeding tube use related to swallowing impairment initiated 5/2/2025 documents that R2 pulls at G-tube at times and has the following intervention:-Abdominal binder to keep G-tube from being pulled out.On 5/2/2025 R2 had a physical restraint assessment completed which documented: .- Abdominal binder to be worn at all times to prevent dislodgement of G-tube.- Frequent monitoring has been performed, continues to pull at G-tube between checks.- For safety and nutritional purposes decision was made to have abdominal binder in place.- Monitor and open abdominal binder every 2 (two) hours.R2 has the following order implemented on 5/2/2025:- Abdominal binder to be released for 15 minutes every 2 hours while being utilized. Check for any skin irritation/ impairment and proper circulation, if any changes noted notify medical doctor/nurse practitioner (MD/NP) every 2 hours for monitoring. Start date: 5/2/2025.On 7/22/2025, at 1:20 PM, Surveyor interviewed certified nursing assistant (CNA)-H who stated R2 was not wearing an abdominal binder this morning. Surveyor asked who was responsible for putting on the abdominal binder and checking the abdominal binder for R2. CNA-H stated R2 does not wear an abdominal binder, and CNA-H did not see one in R2's room. CNA-H stated CNA-H does not work with R2 often but never has seen an abdominal binder on R2. On 7/22/2025, at 1:23 PM, Surveyor interviewed licensed practical nurse (LPN)-F who stated R2 does not have an abdominal binder on and R2 does not wear an abdominal binder. Surveyor asked if R2 pulls at the g-tubing or if there is concern of the tubing being pulled out. LPN-F stated R2 has never pulled at the tubing or attempted to pull the tubing out. Surveyor reviewed R2's May, June, and July 2025 medication administration/ treatment administration records (MAR/TARs) and noted nursing initialing R2's abdominal binder being taken off 15 minutes every two hours per physician order. On 7/23/2025, at 8:58 AM, Surveyor observed CNA-I assisting R2 with getting up for the day. Surveyor asked if R2 was to get an abdominal binder in place to prevent pulling on R2's G-tube. CNA-I stated R2 had an abdominal binder in the past but not sure if R2 ever wore it and no longer wears it currently.On 7/23/2025, at 8:50 AM, Surveyor interviewed LPN-G who stated R2 came from the hospital with an abdominal binder and may have worn it in the beginning but then did not because R2 never pulled or tried to take tubing out. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN-G stated LPN-G checks to make sure R2 is not starting to pull on tubing and R2's hands are visible but R2 does not move much so staff just monitor.On 7/23/2025, at 10:42 AM, Surveyor interviewed LPN Unit Manager (LPNUM)-D and Director of Nursing (DON)-B who stated R2 never came to the facility with an order to wear an abdominal binder. LPNUM-D stated it was brought up in a care conference from R2's activated POA. DON-B stated R2's POA wanted R2 to wear one because R2 got it from the hospital. DON-B stated everyone that comes to the facility from the hospital is provided an abdominal binder from the hospital in the event the resident would start to pull at the tubing. LPNUM-D and DON-B stated they got the order to appease R2's POA because the POA was worried R2 would start pulling the G-tube out. Surveyor shared concern staff was documenting in the MAR/TAR that they were checking every 2 hours and releasing the abdominal binder for 15 minutes however surveyor could not see any documentation R2 was not wearing a binder or t R2 was pulling at the tubing. DON-B and LPNUM-D stated they would check into the concern as to why staff were documenting on an order that was not being followed through.On 7/23/2025, at 4:16 PM, DON-B stated that staff were documenting on R2's MAR/TAR and singing out every two hours because the order states if R2 would utilize the abdominal binder and that staff were checking to make sure R2 as not pulling on tubing. Surveyor informed DON-B the order and care plan imply R2 pulls at R2's G-tube site and R2 should be wearing the abdominal binder with 2-hour checks with 15 minutes release of the binder. Surveyor stated the care plan was not revised to indicate if R2 were to start pulling at the tubing or that there is an abdominal binder in the event R2 starts to pull at the tubing. DON-B understood concern and how it was not clear and would look to revise the care plan or discontinue the order to prevent further confusion to staff. No further information was provided at the time of this write up.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure 1 (R2) of 1 resident reviewed for indwelling catheters received appropriate treatment and services.R2's catheter collection bag and tubing were observed during multiple observations to be laying directly on the floor with no barrier.Findings include:R2 was admitted to the facility on [DATE] and has diagnoses that include hemiplegia/ hemiparesis following cerebral infarction affecting right dominant side (Stroke with right sided paralysis), dysphagia (difficulty swallowing), aphasia (difficulty communicating), type 2 diabetes mellitus, Spinal stenosis, presence of urogenital implants, and Alzheimer's disease, and Dementia. R2's admission Minimum Data Set (MDS) dated [DATE] indicated R2 had severely impaired cognition with a Brief Interview for Mental Status (BIMS) score of 0 and the facility assessed R2 requiring total assist with one staff member for all activities of daily living (ADL) care. R2 was admitted with a foley catheter. R2 has an activated power of attorney (POA).R2's care plan documents the use of indwelling urinary catheter- Foley needed due to disease process recent stroke with deficits was initiated on 4/29/2025 with the following interventions:-Catheter care .On 7/22/2025, at 7:46 AM, Surveyor observed R2 lying in bed sleeping. R2's catheter bag was lying on the right side of the bed directly on the floor. Surveyor did not observe any barrier between the catheter drainage system and the floor.On 7/23/2025, at 7:50 AM, Surveyor observed R2 lying in bed sleeping. R2's catheter bag was hooked onto the right side of R2's bed the bottoms half of the catheter bag that included the catheter drainage system was observed touching the floor. Surveyor did not observe a barrier between the catheter drainage system and the floor. On 7/23/2025, at 10:45 AM, Surveyor interviewed director of nursing (DON)-B and licensed practical nurse unit manager (LPNUM)-D. Surveyor asked what intervention of catheter care means on a resident's care plan. LPNUM-D stated staff are made aware a resident has a catheter and to provide cares, emptying the catheter, making sure the catheter bag has a privacy cover, and that the catheter bag does not touch the floor, etc. Surveyor shared concerns with DON-B and LPNUM-D that R2's catheter bag was observed lying on the floor and touching the floor without a barrier between the catheter drainage system and the floor the mornings of 7/22/2025 and 7/23/2025. DON-B stated that should not have happened, and education will be started with facility staff.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure drugs and biologicals used in the facility were be labeled in accordance with currently accepted professional principles and include the expiration date when applicable for 1 of 2 medication carts observed. Insulin in the medication cart was not labeled and/or was expired. Findings include:The facility policy titled Medication Administration Injectable Vials and Ampules dated 01/23 documents (in part) .Vials and ampules of injectable medications are used in accordance with the manufacturer's recommendations or the providers pharmacy's directions for storage, use and disposal. 3. The date opened and the initials of the first person to use the vial are recorded on multi-dose vials (on the vial label or an accessory label affixed for that purpose).9. Discard multi-dose vials when empty, when suspected or visible contamination occurs or when the manufacturer's stated expiration date is reached, providing the manufacturer's storage conditions have been maintained. Expiration dating not specifically referenced in the manufacturer's package insert should not exceed 28 days once the vial has been opened. Medications with shortened expiration dates:Humalog (Lispro) insulin: Vial and Kwik pen - once opened, product expires 28 days. Aspart (Novolog): Vial and Flex pen - product expires 28 days after first use. On [DATE], at 2:43 PM, Surveyor observed the 2nd floor medication cart B. In the right middle drawer, Surveyor located the following:-Aspart insulin pen labeled with R3's first name. The insulin pen was open and used, dated opened [DATE]. Surveyor noted another date written in black marker [DATE]. Licensed Practical Nurse (LPN)-G reported the insulin belonged to R3 and he was not sure why there were 2 dates written or which one is correct. -Humalog insulin pen not labeled with a resident name. The insulin pen was open and used, dated opened [DATE]. LPN-G was not sure why the insulin was not labeled with a resident name. -Lispro insulin vial labeled with R1's name. The insulin vial was open and used, dated opened [DATE]. Surveyor asked LPN-G how long insulin is good for once opened. LPN-G stated, 30 days. I think almost all insulins are good for only 30 days. Surveyor showed LPN-G the above insulins and the dates opened. LPN-G stated, I guess they're expired.On [DATE], at 3:42 PM, Surveyor shared concerns with Nursing Home Administrator-A and Director of Nursing-B regarding the above insulins that were not labeled and/or were expired. No additional information was provided.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the Facility did not ensure a resident's hospice notes were readily available for communication and collaboration of care in accordance with professional standards of practice for 1 (R88) of 3 residents reviewed for hospice services. Hospice visit notes were not updated in R88's medical record or in R88's hospice binder until Surveyor requested the information.R88 was admitted to the facility on [DATE] with pertinent diagnoses that include type 2 diabetes mellitus (happens when the body cannot use insulin correctly and sugar builds up in the blood), dementia (a syndrome that can be caused by a number of diseases which over time destroy nerve cells and damage the brain, typically leading to deterioration in cognitive function (i.e. the ability to process thought) beyond what might be expected from the usual consequences of biological ageing), and hypertensive chronic kidney disease (kidney damage caused by long-term high blood pressure (hypertension)).R88's Quarterly Minimum Data Set (MDS) with an assessment reference date of 6/8/25 documents a Brief Interview for Mental Status (BIMS) score of 00, indicating R88 has severe cognitive impairment. The MDS documents R88 rarely or never makes self-understood or has ability to understand others. No behavior concerns were exhibited during the 7 day look back period; always incontinent of bowel and bladder; has range of motion impairment on both sides of upper and lower extremities. R88 is documented to receive hospice care.R88 has a care plan for hospice care needs due to end of life, initiated on 1/10/2023. Interventions include: -Allow resident/family to discuss feelings, etc.-Assist with ADL (activities of daily living) care and pain management as needed-Encourage to participate in activities as able-Honor advanced directives-Hospice staff to visit to provide care, assistance, and/or evaluation On 07/23/2025, at 9:20 am, Surveyor observed the hospice binders for residents within the facility. Surveyor was unable to locate a binder for R88.On 7/23/25, at 9:27 am, Surveyor interviewed Unit Manager (UM)-D regarding R88's hospice binder not being with the other residents. UM-D stated another resident from the facility is not at the facility anymore and hospice picked up the binder, UM-D thinks they may have taken the wrong one. UM-D will follow up and find out.On 7/23/25, at 1:01 pm, Surveyor interviewed Certified Nursing Assistant (CNA)-J and asked how CNA-J communicates with R88's hospice provider and was told if the hospice staff have questions about cares CNA-J answers them, otherwise they ask nurses their questions.On 7/23/25, at 1:16 pm, Surveyor interviewed Licensed Practical Nurse (LPN)-G about how they communicate with R88's hospice provider and was told there is a phone number in R88's hospice binder otherwise when hospice staff are here, they talk to in person.On 7/23/25, at 1:30 pm, Surveyor followed up with UM-D regarding the location of R88's hospice communication binder and was told that UM-D had not received a call back.On 7/23/25, at 3:09 pm, during the end of day meeting, with Director of Nursing (DON)-B, 1st and 2nd floor Unit Managers and Senior [NAME] President of Success-C, Surveyor relayed concern of R88's missing hospice communication binder.On 7/24/25, at 8:36 am, Surveyor observed the hospice binder for R88 with the other hospice binders. Surveyor noted the last visit logged for R88 was a CNA visit on 7/7/25. Surveyor was unable to locate documented nursing visit notes.On 7/24/25, at 8:40 am, Surveyor interviewed UM -D regarding the hospice binder lacking communication information from nurses visiting R88. Surveyor gave UM-D the binder and pointed out it contained another resident's records in R88's binder which UM-D removed. UM-D told Surveyor to ask DON-B if there's more documentation as DON-B requested hospice email it last night.On 7/24/25, at 8:58 am, Surveyor interviewed DON-B and Senior [NAME] President of Success-C regarding the concern R88's binder did not have nurse visit notes documented as they occurred and R88's binder was not available for staff review for continued communication and coordination of care with hospice until surveyor requested such. Per DON-B they let the hospice service know that last night.Surveyor noted before exiting the facility nurse visit notes were provided (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525493	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Health Services	3540 S 43rd St Milwaukee, WI 53220

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	and DON-B stated they would be added to R88's hospice binder.Surveyor noted no further information regarding R88's hospice visit notes not being updated in R88's medical record or in R88's hospice binder was provided.