STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525547	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Glendale West	6263 N Green Bay Ave Glendale, WI 53209

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews, the facility did not ensure each Resident is treated with dignity and respect that promoted maintenance or enhancement of quality of life. This occurred for 4 (R65, R68, R173, and R174) of 10 Residents reviewed for dignity. *R65 was observed to be in a gown during 3 days of the survey process and prefers to be dressed. *R68 was observed to be in the hallway by the nurse's station in a gown during the survey process. *R173 was observed to be in the dining room eating lunch in a gown. *R174 was observed walking down the hallway with therapy in a gown. Findings Include: The facility's Accommodation of Needs policy implemented 2/25 documents: .The facility will treat each Resident with respect and dignity and will evaluate and make reasonable accommodations for the individual needs and preferences of a Resident, except when the health and safety of the individual or other Residents would be endangered. Policy Explanation and Compliance Guidelines: 3. Facility staff shall make efforts to reasonably accommodate the needs and preferences of the Resident as they make sue of their physical environment. 4. Based on individual needs and preferences, the facility will assist the Resident in maintaining and/or achieving independent functioning, dignity, and well being to the extent possible. 1.) R65 was admitted to the facility on [DATE] and is their own decision maker. (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
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R65's admission Minimum Data Set (MDS) completed 4/16/25 documents R65's Brief Interview for Mental Status(BIMS) score to be 12, indicating R65 demonstrates moderately impaired skills for daily decision making. R65's MDS documents R65 has no mood or behavior symptoms. R65 has range of motion(ROM) impairment on 1 side of both upper and lower extremity, R65 requires substantial/maximum assistance for showers, upper and lower dressing and transfers. R65's MDS documents that it is somewhat important for R65 to choose clothes to wear. On 5/19/25, at 9:59 AM, R65 is observed wearing a gown. R65 informed Surveyor that R65 does not think R65 has any clothes in the closet. On 5/19/25, at 1:21 PM, R65 is still in a gown. On 5/19/25, at 3:37 PM, R65 is sitting in R65's wheelchair in a gown. On 5/20/25, at 10:26 AM, R65 is in bed, with a gown on. On 5/21/25, at 11:42 AM, Surveyor observed R65 sitting in R65's wheelchair with a gown on. Surveyor interviewed R65 who stated that at home R65 always got dressed. R65 stated R65 wants to be in clothes, and prefers to be in clothes. R65 stated that R65 has been telling facility staff since R65 got here that R65 wants to be dressed. Surveyor notes R65 engages in conversation, but appears with a flat affect, disheveled hair, with full growth beard. On 5/22/25, at 10:06 AM, Surveyor observed R65 wearing a black sweatshirt and blue pants. R65 started singing to Surveyor and expressed how happy R65 was to be wearing clothes and was excited. Surveyor also observed R65 had a significant haircut and received a shave. R65 stated R65's son came in and brought clothes, gave a haircut and a shave. Surveyor observed R65 had a big smile when talking about being dressed and gave Surveyor a high five in thanks for obtaining clothes. 2.) R68 was admitted to the facility on [DATE] and is their own decision maker. R68's admission Minimum Data Set (MDS) completed 5/3/25 documents R68's Brief Interview for Mental Status(BIMS) score to be 12 indicating R68 demonstrates moderately impaired skills for daily decision making. There are no documented mood or behavior symptoms for R68. R68 requires partial/moderate assistance for showers, supervision for upper dressing, substantial/maximum assistance for lower dressing and mobility and is dependent for transfers. R68 stated it is very important to choose what clothes to wear. On 5/21/25, at 11:50 AM, Surveyor observed R68 sitting at the nurse's station in just a gown. On 5/21/25, at 1:07 PM, Surveyor interviewed R68 who stated R68 would prefer to be dressed and is usually cold in the gown. On 5/22/25, at 10:14 AM, Surveyor observed R68 in bed with clothes on. 3.) R173 was admitted to the facility on [DATE]. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R173's admission Minimum Data Set (MDS) completed 5/6/25 documents R173's Brief Interview for Mental Status(BIMS) score to be 3 indicating R173 demonstrates severely impaired skills for daily decision making. There are no documented mood or behavior symptoms for R173. R173 has range of motion (ROM) impairment on both upper and lower extremities on both sides. R173 requires partial/moderate assistance for upper and lower dressing, and substantial/maximum assistance for mobility and transfers. R173 stated it is somewhat important to choose what clothes to wear. On 5/21/25, at 11:50 AM, Surveyor observed R173 in a gown with red gripper socks in a wheelchair located in the hallway by the nurse's station. Surveyor observed Certified Nursing Assistant (CNA)-I take R173 to the main dining room. On 5/21/25, at 12:34 PM, Surveyor observed R173 in the dining room with a gown on. On 5/21/25, at 12:43 PM, CNA-I confirmed to Surveyor that R173 was in the main dining room eating lunch and CNA-I brought R173 back by the nurse's station and placed in the hallway with just a gown on. On 5/22/25, at 10:21 AM, Surveyor observed R173 in bed sleeping and has clothes on. 4.) R174 was admitted to the facility on [DATE]. R174's admission Minimum Data Set (MDS) completed 5/16/25 documents R174's Brief Interview for Mental Status (BIMS) score to be 11 indicating R174 demonstrates moderately impaired skills for daily decision making. There are no documented mood or behavior symptoms for R174. R174 requires substantial/maximum assistance for upper and lower dressing, showers, and partial/moderate assistance for mobility and transfers. R174 stated it is very important to choose what clothes to wear. On 5/21/25, at 11:50 AM, Surveyor observed R174 walking down the hallway with the assistance of therapy wearing a gown and black shoes. R174 had a gait belt around R174's waist. On 5/21/25, at 12:35 PM, Surveyor interviewed R174, who is wearing a gown, and R174 stated R174 prefers to be dressed. That's why I am always cold and why I like my room really warm. On 5/22/25, at 10:17 AM, Surveyor observed R174 in bed with a gown. R174 informed Surveyor that R174 prefers to wear a gown only at night. On 5/21/25, at 12:32 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-H who stated that several Residents come in with no clothes, if they have clothes, we will put them on, otherwise we put gowns on. On 5/21/25, at 12:41 PM, Surveyor interviewed Social Worker (SW)-F regarding clothes for Residents. SW-F confirmed there are donated clothes down in laundry. SW-F informed Surveyor that sometimes staff will go down to laundry themselves and obtain clothes for Residents. If staff were to inform SW-F a Resident needs clothes, SW-F would call the family and have them bring in clothing items. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/21/25, at 3:03 PM, Surveyor shared the dignity concern that R65, R68, R173, and R175 have been in gowns during the survey process and at times Surveyor has observed R68, R173, and R174 in common areas of the facility with gowns on with Nursing Home Administrator (NHA)-A, Director of Nursing (DON-B), and Director of Quality Compliance (DQC)-C. The facility provided no further information at this time. On 5/22/25, at 9:58 AM, Surveyor interviewed Physical Therapist (PT)-J. PT-J stated that occupational therapy is limited in working on dressing with a Resident if a Resident has no clothes as well as therapy would be limited in working with a Resident on walking if a Resident has no shoes. PT-J stated they would need to double gown a Resident if the Resident has no clothes. On 5/22/25, at 10:18 AM, Surveyor interviewed Maintenance Director (MD)-N who confirmed MD-N is the supervisor of laundry. MD-N explained MD-N prefers staff approach a laundry staff member for donated clothing items which MD-N stated the facility has. MD-N stated there are different sized clothing items and a variety for both men and woman. MD-N stated if laundry staff notice a closet is empty, they will bring up donated clothing items. MD-N stated usually the social worker or admissions will let the laundry department know if a Resident needs donated clothing items. Surveyor notes that R65, R68, and R173 were dressed on 5/22/25, the last day of the survey process.

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents a notice of rights, rules, services and charges. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 4 Residents (R172, R23, R13 and R65) of 18 sampled residents were fully informed of, but not limited to; resident rights, required financial information and options, and consent to treat prior to or upon admission. *R172 was admitted to the facility on [DATE] and did not sign the admission agreement within a reasonable timeframe which includes facility information regarding: consent for treatment, financial agreement, and resident rights and responsibilities. R172 was discharged from the facility on 3/28/25, and did not acknowledge receipt of the admission agreement before discharge from the facility. On 3/22/25 R172 alleged $1800 was missing from the resident. Review of whether R172 was aware of the facility options/restrictions available to safeguard R172's belongings was reviewed. R172 was never provided or disclosed this information, to be included in the facility admission policy, as the admission agreement was not presented or signed By R172 during their admission time in the facility. *R13 was admitted to the facility on [DATE] and and did not sign the admission agreement within a reasonable timeframe which includes facility information regarding: consent for treatment, financial agreement, and resident rights and responsibilities. R13 was discharged from the facility on 4/1/25, and did not acknowledge receipt of the admission agreement before discharge from the facility. R13 was admitted to the facility a second time on 4/30/25. R13 did not acknowledge receipt of the admission agreement until 5/16/25. *R23 was admitted to the facility on [DATE] and did not sign the admission agreement within a reasonable timeframe which includes facility information regarding: consent for treatment, financial agreement, and resident rights and responsibilities. R23 did not acknowledge receipt of the admission agreement until 3/26/25. *R65 was admitted to the facility on [DATE] and did not sign the admission agreement within a reasonable timeframe which includes facility information regarding: consent for treatment, financial agreement, and resident rights and responsibilities. R65 was discharged from the facility on 3/14/25, and did not acknowledge receipt of the admission agreement before discharge from the facility. R65 was admitted to the facility a second time on 4/9/25. R65 did not acknowledge receipt of the admission agreement until 4/29/25. Findings Include: The facility's admission policy implemented 1/25 documents: .The facility will maintain an admissions policy governing admissions to the facility to ensure fair and impartial admission practices. 5.A nursing facility must disclose and provide a Resident or potential Resident, prior to time of admission, notice of special characteristics or service limitations of the facility that guides its practices and routines which must be communicated to any potential Resident. The facility's admission of a Resident implemented 1/25 documents: (continued on next page)

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	.The admission process is intended to obtain all possible information regarding the Resident for the development of the comprehensive plan of care, and to assist the Resident in becoming comfortable in the facility. Policy Explanation and Compliance Guidelines: The admission process has several phases: a. The facility designated staff member(S) may meet with prospective Residents/families while they are first touring the facility. Information about facility services should be provided. B. Once the Resident/family has selected the facility, pre-admission information should be gathered. ac. A Resident Handbook and/or Facility orientation material should be provided to the Resident/family prior to or upon admission, so they understand what to bring to the facility. On 5/21/25, at 12:26 PM, Surveyor interviewed Admissions staff (Admit)-G regarding the process of reviewing the admission agreement with Residents. Admit-G stated that Admit-G attempts to review the admissions agreement with Residents as soon as Admit-G can. Admit-G stated reviewing the admission agreement is usually completed the next day, the 2nd day after a Resident admits to the facility. Admit-G is not aware of a specific time-line to review the admissions agreement. Admit-G stated the admission process with a Resident includes, but not limited to: financial information, resident rights and rules, services provided, permission for photograph. Admit-G is aware that Admit-G has not always reviewed the information included in the admission process in a timely manner with Residents. 1.) R172 was admitted to the facility on [DATE]. R172 was her own person while at the facility. R172 discharged from the facility on 3/28/25. R172's admission Minimum Data Set (MD'S) completed 3/19/25 documents 172's Brief Interview for Mental Status (BIMS) score to be 15 indicating R 172 was cognitively intact for daily decision making. R172 admitted to the facility on [DATE]. R172 discharged to the hospital on 3/28/25 and did not return to the facility. On 3/31/25, the facility documents that the facility's admission agreement was not completed due to R172 being discharged to the hospital. The facility initiated an investigation on 3/22/25, due to R172's allegation that R172 was missing $1,800.00. Surveyor notes there is no documentation that the facility reviewed how the facility could facilitate safeguarding R172's personal possessions including the possible loss or theft of the $1,800.00 as the admission agreement was not signed. 2.) R13 was admitted to the facility on [DATE]. R13 is currently her own person. R13's admission Minimum Data Set (MDS) completed 5/6/25 documents R13's Brief Interview for Mental Status(BIMS) score to be 8, indicating R13 demonstrates moderately impaired skills for daily decision making. (continued on next page)

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R13's first admission to the facility was on 3/10/25. R13 discharged from the facility on 4/1/25. The facility did not review the admission agreement including but not limited to: consent for treatment, financial agreement, and resident rights and responsibilities. R13's second admission to the facility was on 4/30/25. Documentation provided by the facility states that R13 did not acknowledge review and receipt of the admission agreement until 5/16/25. 3.) R23 was admitted to the facility on [DATE]. R23 is her own person. R23's admission Minimum Data Set (MDS) completed 3/17/25 documents R23's Brief Interview for Mental Status(BIMS) score to be 15, indicating R23 is cognitively intact for daily decision making. R23 was admitted to the facility on [DATE] and did not acknowledge review and receipt of the admission agreement until 3/26/25. 4.) R65 was admitted to the facility on [DATE]. R65 is currently is his own person. R65's admission Minimum Data Set (MDS) completed 4/16/25 documents R65's Brief Interview for Mental Status(BIMS) score to be 12, indicating R65 demonstrates moderately impaired skills for daily decision making. R65 was admitted to the facility on [DATE] and the facility documents R65 did not review the admission agreement due to being discharged on 3/14/25. R65 was admitted to the facility a second time on 4/9/25. R65 did not acknowledge the review and receipt of the admission agreement until 4/29/25. On 5/21/25, at 3:03 PM, Surveyor shared the admission concern with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, and Director of Quality Compliance (DQC)-C that R172, R13, R23, and R65 did not review or receive the admission agreement explaining areas to include: resident rights and responsibilities, financial agreement, services provided, while a Resident in the facility or up to 7-20 days after admission to the facility. Surveyor shared that neither R172, R13, R23, and R65 received the required financial information and options, the abuse policy and procedure and resident rights. The Residents either never gave consent to treat until after a considerable amount of time after admission to the facility. The Residents would not have been provided the disclosure of facility characteristics within a timely manner. On 5/28/25, at 1:09 PM, Surveyor reviewed additional information provided by the facility. The concern remains that the either the Residents never gave consent for treatment, resident rights including being free from abuse or neglect, how to contact the ombudsman and/or state agency, financial information and options or was not obtained until at a minimum of 7 days later.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not ensure a resident receiving an antidepressant medication was comprehensively assessed for use. This was observed with 1 (R40) of 5 resident medication reviews. * R40 was admitted to the facility on an antidepressant medication. There is not a comprehensive assessment for use of the medication, including indicators for use and non-pharmacological interventions. Findings include: The facility's policy and procedure titled Use of Psychotropic Medication dated 2/25. The definition for adequate indications for use states: refers to the identified, documented clinical rationale for administering medication that is based upon an assessment of the resident's condition and therapeutic goals and after any other treatments have been deemed clinically contraindicated. For psychotropic medications, without documentation in the record explaining that the practitioner has determined that other treatments have been deemed clinically contraindicated, the indication for use is inadequate. R40 was admitted to the facility on [DATE] with a diagnoses including Depression and Stroke. The Hospital Discharge summary, dated [DATE], includes orders for Prozac 20 milligram (mg), 3 capsules daily. The facility physician admission orders documents Prozac 20 mg, 3 capsules every day for Depression. The 3/4/25 admission Minimum Data Set (MDS) assessment documents daily use of an antidepressant medication. The Care Area Assessment (CAA) for Psychotropic Drug Use, completed by MDS Registered Nurse (RN) -C on 3/10/25, documents Prozac (antidepressant) for depression. This CAA does not include symptoms of depression R40 experiences, along with non-pharmacological interventions. A Significant Change in Status MDS assessment completed on 4/22/25 documents daily use of an antidepressant medication. The Care Area Assessment (CAA) for Psychotropic Drug Use, completed by MDS RN -C on 4/30/25, documents Prozac (antidepressant) for depression. This CAA does not include symptoms of depression R40 experiences, along with non-pharmacological interventions. R40's plans of care were reviewed. R40 has a care plan, initiated on 2/26/25, titled The resident uses antidepressant medication Prozac. There is NOT documentation of indicators for use of the antidepressant. The interventions listed indicates the side effects of the medication to be monitored. R40's medical record contained Behavior Management/ Medication Review forms dated 2/27/25, 3/28/25 and 4/25/25. These forms document R40 is on Prozac 60 milligrams (mg) every day for Depression. There are no indicators for use. There is no documentation to support the use of the antidepressant. There is no documentation of non-pharmacological interventions or depression symptoms specific to R40's use of the antidepressant. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/21/25, at 1:30 PM, Surveyor interviewed Unit Manager (UM) -D. UM-D stated They will look for indicators for use of the antidepressant medication. UM-D did not have any additional information. UM-D did not complete a comprehensive assessment on R40's antidepressant use. On 5/21/25, at 2:02 PM, Surveyor interviewed Social Worker (SW) -F. SW-F stated They just look at the medication itself and do not ask about symptoms for use. SW-F does not complete a comprehensive assessment for psychotropic medication for R40. On 5/21/25, at 3:03 PM, at the facility exit meeting with Nursing Home Administrator (NHA)-A and Director of Nurses (DON) -B, Surveyor shared the concerns with R40's antidepressant medication. There is no a comprehensive assessment for use, including care plan, non-pharmacological interventions and specific symptoms for treatment. Following exit from the survey, the facility provided additional documentation to review for R40 indicating R40 refused to meet with the facility behavioral/psychological services provider and two medication reviewed had been completed. Review of the medication reviews dated 2/27/25 and 3/27/25 do not include documentation of behaviors and their frequency to support monitoring of R40 for indicators for use of the medication. They also do not include any non pharmacological interventions for the resident when depressed other than to self direct activities at their own leisure. On 4/30/25 R40 declined formal psychological services, there is no indication the facility established a plan of care to address and monitor indications for use and interventions related to R40's receipt of antidepressants.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not conduct a comprehensive assessment of depression/mood with the admission Minimum Data Set (MDS), and Significant Change in Status (SCS) MDS, for 1 (R40's) of 18 sampled residents. * R40 was admitted to the facility with orders to receive Prozac (an antidepressant) daily. R40's admission MDS dated [DATE] and SCS MDS dated [DATE] do not fully assess R40's depression/mood symptoms to lead to a Care Area Assessment (CAA) and development of a comprehensive plan of care for R40 that addresses indicators for use, individual symptoms for R40 and intervention to include nonpharmacological interventions (Cross-reference F605). Findings include: R40 was admitted to the facility on [DATE] with diagnoses including Depression and Stroke. The Hospital Discharge summary, dated [DATE], includes orders for Prozac 20 milligram (mg), 3 capsules daily. The facility physician admission orders document Prozac 20 mg, 3 capsules every day for Depression. R40's admission Minimum Data Set (MDS) assessment was completed on 3/4/25. This assessment documents daily use of an antidepressant medication. The assessment for mood indicates 0 for the presence of and frequency of experiencing little interest or pleasure ion things or feeling down, depressed and hopeless. Additional assessment of depression/mood including questions C-I are not assessed giving an inaccurate severity score/an incomplete assessment. The Care Area Assessment (CAA) for Psychotropic Drug Use, completed by MDS Registered Nurse (RN)- C on 3/10/25, documents Prozac (antidepressant) for depression. This CAA does not include symptoms of depression R40 experiences, along with non-pharmacological interventions. R40's Significant Change in Status MDS assessment was completed on 4/22/25. This assessment documents daily use of an antidepressant medication. The assessment for presence of and frequency of experiencing little pleasure are assessed as 0. The assessment for feeling down, depressed, or hopeless to include the presence of and frequency are assessed as 1's. This indicates presence of these symptoms 2-6 days of the assessment period. Additional questions C-I to assess the presence and frequency of additional symptoms of depression/mood are not assessed on the MDS. This gives an inaccurate severity score of 01. The Care Area Assessment (CAA) for Psychotropic Drug Use, completed by MDS RN-C on 4/30/25, documents Prozac (antidepressant) for depression. This CAA does not include symptoms of depression R40 experiences, along with non-pharmacological interventions. On 5/21/25, at 1:40 PM, Surveyor interviewed MDS RN-C. MDS RN-C stated they just code the medication and the medication goes to the behavior management team. They just monitor symptoms on the Medication Administration Record (MAR) and does not know where that information comes from. MDS RN-C did not conduct a comprehensive assessment related to R40 antidepressant use. (continued on next page)

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	525547	A. Building B. Wing	05/22/2025

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/21/25, at 2:02 PM, Surveyor interviewed Social Worker (SW)-F. SW-F stated they just look at the medication itself and does not ask about symptoms for use. SW-F does not complete a comprehensive assessment for psych medication for R40. On 5/21/25, at 3:03 PM, at the facility exit meeting with Nursing Home Administrator (NHA)-A and Director of Nurses (DON)-B, Surveyor shared the concerns with R40's antidepressant medication. There is not a comprehensive assessment for use, including a care plan, non-pharmacological interventions and specific symptoms for treatment. Following exit from the facility additional information was submitted from the facility to include medication reviews for R40, and a care conference progress note. Surveyor noted the medication reviews do not include clear Review of the medication reviews dated 2/27/25 and 3/27/25 do not include documentation of behaviors and their frequency to support monitoring of R40 for indicators for use of the medication. They also do not include any non pharmacological interventions for the resident when depressed other than to self direct activities at their own leisure. The care conference note dated 4/30/25 indicates R40 declined formal psychological services, there is no indication the facility established a plan of care to address and monitor indications for use and interventions related to R40's receipt of antidepressants. This progress note references presence of depression for R40. Also included is a late entry PHQ 9 (Personal Health Questionnaire) with an effective date of 4/8/25. There is no indication this assessment contributed to the completion of accurate MDS assessments or creating plans of care to address R40's use of an antidepressant.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525547	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Glendale West	6263 N Green Bay Ave Glendale, WI 53209

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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 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 ensure residents are accurately screened for a mental disorder prior to admission or prior to the expiration of a 30-day exemption for 2 (R41 and R13) of 4 residents reviewed for the PASARR (Preadmission Screening and Resident Review). *R41 did not have a PASARR level 1 screen resubmitted prior to the expiration of the 30-day exemption documented on the original PASARR level 1. *R13 did not have a serious mental illness documented on the PASARR level 1 which would have triggered the PASARR level 2 to be initiated. Findings include: The facility policy and procedure titled Resident Assessment - Coordination with PASARR Program dated 8/2024 documents: Policy Explanation and Compliance Guidelines: 1. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening. a. PASARR Level I - initial pre-screening that is completed prior to admission i. Negative Level I Screen - permits admission to proceed and ends that PASARR process unless a possible serious mental disorder or intellectual disability arises later. ii. Positive Level I Screen - necessitates a PASARR Level II evaluation prior to admission. 3. Exceptions to the preadmission screening program, dependent upon the State requirements, include those individuals who: a. Are readmitted directly from a hospital. b. Are admitted directly from a hospital, requires nursing facility services for the condition for which the individual received care in the hospital, and has been certified by the attending physician before admission that the individual is likely to require less than 30 days of nursing facility services. 4. If a resident who was not screened due to an exception above and the resident remains in the facility longer than 30 days: a. The facility must screen the individual using the State's Level I screening process and refer any resident who has or may have MD, ID, or a related condition to the appropriate state-designated authority for Level II PASARR evaluation and determination. (continued on next page)

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	525547	A. Building B. Wing	05/22/2025

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1.) R41 was admitted to the facility on [DATE] with diagnoses of dementia and unspecified psychosis. R41 had physician orders on admission for Seroquel, an antipsychotic, 50 mg twice daily for psychosis and Ativan, an antianxiety medication, 0.5 mg every two hours as needed for anxiety for fourteen days. A PASARR level 1 was submitted on 2/26/2025 documenting R41 had a hospital discharge exemption of a 30 day maximum. A level 2 screen was not required at that time due to the exemption documented on the level 1 screen. On 5/19/2025 during the survey process, Surveyor was not able to locate a PASARR level 1 for R41 prior to 3/28/2025, 30 days after R41 was admitted since R41 was still a resident of the facility. Surveyor requested from Nursing Home Administrator (NHA)-A for a copy of R41's PASARR level 1 and level 2 screens. On 5/21/2025 at 9:17 AM, NHA-A provided a copy of R41's PASARR level 1 submitted 2/26/2025 with the 30 day exemption. Surveyor asked NHA-A what facility member completes the PASARRs prior to a resident being admitted to the facility. NHA-A stated NHA-A completes all the PASARRs for the facility. Surveyor asked NHA-A if R41 had a revised PASARR level 1 submitted prior to the expiration of the 30 day exemption. NHA-A stated NHA-A completed the PASARR level 1 screen prior to R41's admission on [DATE] and saw that the agency did not require a level 2. Surveyor shared with NHA-A that NHA-A had entered yes for the question of R41 having a 30 day hospital exemption and therefore a level 2 would not be required. Surveyor shared with NHA-A that a resident who stays at the facility beyond the 30 days, a follow up PASARR level 1 needs to be submitted. NHA-A stated since R41 was taking psychotropic medications with diagnoses and was on hospice, NHA-A thought the agency would not complete a level 2. Surveyor shared with NHA-A that R41 has been a resident of the facility for over two months without an accurate PASARR level 1 and one should have been submitted prior to the expiration of the 30 days. NHA-A agreed a follow up PASARR was not completed and would resubmit a new PASARR level 1. 2.) R13 was admitted to the facility on [DATE] with diagnoses including anxiety disorder (mental health disorder characterized by feelings of worry, fear that interfere with daily activities), and unspecified psychosis (disorder with symptoms including incoherent or nonsense speech or behavior inappropriate for the situation). R13 is currently her own person. R13's admission Minimum Data Set (MDS) completed 5/6/25 documents R13's Brief Interview for Mental Status(BIMS) score to be 8, indicating R13 demonstrates moderately impaired skills for daily decision making. R13's MDS documents that R13 is not currently considered by the state level 2 Preadmission Screen and Resident Review(PASARR) process to have serious mental illness and/or intellectual disability or a related condition. R13's MDS documents R13 has no mood or behavior symptoms. On 5/19/25, Surveyor reviewed R13's level 1 PASARR summary. Surveyor noted the facility answered NO to the question: .Does the person have a major mental disorder? . The National Institute of Mental Health-https://www.nimh.nih.gov documents: (continued on next page)

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	525547	A. Building B. Wing	05/22/2025

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	. psychosis, including unspecified psychosis, is considered a serious mental illness. It involves a disruption in thinking and perception, leading individuals to lose touch with reality. This can manifest as delusions, hallucinations, disorganized thinking, or disorganized behavior, causing significant distress and impairment in daily functioning. While unspecified psychosis is a diagnosis of exclusion, meaning it's used when a person experiences psychotic symptoms but doesn't fit into a specific psychotic disorder category, it is still a serious condition that requires prompt attention and appropriate treatment. What is psychosis? Psychosis refers to a collection of symptoms that affect the mind, where there has been some loss of contact with reality. During an episode of psychosis, a person's thoughts and perceptions are disrupted and they may have difficulty recognizing what is real and what is not. People with psychosis typically experience delusions (false beliefs, for example, that people on television are sending them special messages or that others are trying to hurt them) and hallucinations (seeing or hearing things that others do not, such as hearing voices telling them to do something or criticizing them). Other symptoms can include incoherent or nonsense speech and behavior that is inappropriate for the situation. Psychiatrists use The Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5) to help them decide if a patient has psychosis. Psychosis is when a person has abnormalities in thoughts and perceptions. https://hcpc.[NAME].edu documents: .anxiety disorders are considered serious mental illnesses. They are characterized by excessive worry, fear, and nervousness that can significantly interfere with daily life, work, and relationships. Sometimes anxiety disorders can cause fear so intense it totally disables its victims. Anxiety disorders are the most common of all mental illnesses, and they are also the most treatable. Anxiety Disorder, Unspecified in the DSM-5 is a diagnosis used when an individual experiences significant anxiety and/or panic, but their symptoms don't fully meet the criteria for a specific anxiety disorder, such as Generalized Anxiety Disorder (GAD), Panic Disorder, or a specific phobia. It's essentially a catch-all category for individuals who experience anxiety-related distress or impairment that doesn't fit neatly into other, more defined anxiety disorder diagnosis. According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), both Unspecified Psychosis and Unspecified Anxiety Disorder meet the definition of a major mental disorder. Surveyor noted R13 is currently not receiving psychotropic medications to treat symptoms of a major mental illness. R13's diagnosis of Unspecified Psychosis is most likely suggesting that R13 has symptoms that may indicate the presence of a major mental illness. On 5/20/25, at 3:17 PM, Nursing Home Administrator (NHA)-A confirmed that NHA-A completes the PASARR on each Resident admitted to the facility. NHA-A informed Surveyor that NHA-A documented NO to R13 having a major mental disorder because R13 does not have a diagnosis to substantiate a YES. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/21/25, at 3:03 PM, Surveyor shared the concern with NHA-A, Director of Nursing (DON)-B, and Director of Quality Compliance (DQC)-C that R13 has 2 major mental disorders under the DSM-5 and R13's PASARR was completed incorrectly stating R13 has no major mental disorder. No further information was provided by the facility at this time.

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	525547	A. Building B. Wing	05/22/2025

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2.) R13 was originally admitted to the facility on [DATE] and was readmitted again on 4/30/25. R13's original admission to the facility was on 3/10/25. Review of R13's baseline care plan indicates Registered Nurse (RN)-D signed R13's first baseline care plan on 3/26/25. Surveyor noted R13's baseline care plan has no documentation that R13 reviewed R13's plan of care. There is no documentation that R13 was provided a copy of the baseline care plan. R13 had a care plan meeting on 3/18/25 and there is no documentation that R13's plan of care was reviewed with R13. R13's 2nd admission was on 4/30/25. Licensed Practical Nurse (LPN)-O signed R13's baseline care plan on 5/7/25. There is no documentation that R13 was provided a copy of this baseline care plan. R13 had a care plan meeting on 5/8/25 and there is no documentation that R13's plan of care was reviewed with R13. 2.) R23 was admitted to the facility on [DATE]. R23 is her own person. On 5/19/25, at 9:07 AM, R23 informed Surveyor that R23 has not received anything like a plan of care, they never have, and they have been admitted to the facility several times. Review of R23's admissions indicates Registered Nurse (RN)-D signed R23's baseline care plan on 3/12/25. Surveyor notes that R23's baseline care plan has no documentation that R23 reviewed R23's plan of care. There is no documentation that R23 was provided a copy of the baseline care plan. R23 had a care plan meeting on 3/17/25 and there is no documentation that R23's plan of care was reviewed with R23. 3.) R65 was admitted to the facility on [DATE]. R65 is currently is his own person. On 5/19/25, at 10:04 AM, R65 informed Surveyor that R65 does not recall receiving a plan of care, I don't have any papers in my room. R65 was admitted to the facility on [DATE] and a baseline care plan was not completed. R65 went out to the hospital on 4/16/25 and was re-admitted to the facility on [DATE]. Registered Nurse (RN)-D signed R65's baseline care plan on 2/19/25, which was R65's first admission. Surveyor notes that R65's baseline care plan has no documentation that R65 reviewed R65's plan of care. There is no documentation that R65 was provided a copy of the baseline care plan. R65 has had no care plan meeting to review the plan of care. 4.) R172 was admitted to the facility on [DATE]. R172 discharged from the facility on 3/28/25. Review of R172's baseline care plans indicates Registered Nurse (RN)-D signed R172's baseline care plan on 3/26/25. Surveyor notes that R172's baseline care plan has no documentation that R172 reviewed R172's plan of care. There is no documentation that R172 was provided a copy of the baseline care plan. R172 had a care plan meeting on 3/27/25, however, there is no documentation that R172's plan of care was reviewed. (continued on next page)

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	525547	A. Building B. Wing	05/22/2025

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/21/25, at 3:03 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, and Director of Quality Compliance (DQC)-C that R13, R23, R65, and R172 did not have baseline care plans completed and there is no documentation the plan of care was reviewed with R13, R23, R65, and R172 with 48 hours No further information has been provided by the facility at this time. Based on interview and record review, the facility did not ensure a baseline care plan was developed and implemented within 48 hours of a resident's admission for 5 (R13, R23, R65, R173, R322) of 18 Residents. *R13, R23, R65, and R173's baseline care plans were not completed within the required 48-hour timeframe. The facility did not provide evidence that the baseline care plan was reviewed with the resident or the resident's representative. *R322 was admitted to the facility on [DATE]. R322's baseline care plan was signed by facility staff as being complete on 12/24/24, which is not within the required 48-hour timeframe. R322's baseline care plan was not signed by R322. Findings include: The facility policy dated 8/24, titled Baseline Care Plan, documents, in part: The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care . The baseline care plan will: Be developed within 48 hours of a resident's admission. Include the minimum healthcare information necessary to properly care for a resident . A written summary of the baseline care plan shall be provided to the resident and representative in a language that the resident/representative can understand. The summary shall include, at a minimum, the following: a. The initial goals of the resident. B. A summary of the resident's medications and dietary instructions. C. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. A supervising nurse or [Minimum Data Set (MDS)] nurse/designee is responsible for providing the written summary of the baseline care plan to the resident and representative. This will be provided by completion of the comprehensive care plan . 1.) R322 was admitted to the facility on [DATE] with diagnosis that include Congestive heart failure, Type 2 Diabetes, and End stage renal disease. R322's admission Minimum Data Set (MDS) assessment dated [DATE] documents R322's cognition is moderately impaired. R322 is responsible for self. R322's Baseline care plan dated 12/19/24 was completed by Unit Manager Registered Nurse (RN)-D. Surveyor noted that the base line care plan was signed as complete on 12/24/24 by RN-D, which is not within the 48-hour timeframe. Surveyor noted that the baseline care plan was not signed by R322. On 5/20/25 at 9:10 AM, Surveyor interviewed R322's Spouse-E. Spouse-E informed Surveyor that R322 is unavailable for interview. Spouse-E stated that R322 was not provided with a copy of R322's baseline care plan. (continued on next page)

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	525547	A. Building B. Wing	05/22/2025

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor noted in R322's Electronic Medical Record (EMR) at the facility, Spouse-E is listed as R322's spouse and is listed as Emergency contact #1. Surveyor reviewed R322's electronic medical record and did not find evidence that the baseline care plan summary was signed by R322 or provided to R322. On 5/21/25 at 10:19, Surveyor interviewed Unit Manager, RN-D. Surveyor asked who is tasked with completing the baseline care plan. RN-D stated that RN-D or another nurse manager is responsible for completing the baseline care plan. RN-D stated that RN-D will open the baseline care plan assessment within 24 hours of admission and get it started. RN-D stated that RN-D leaves it open for therapy to do their evaluation. Surveyor asked if the baseline care plan is signed and reviewed by the resident. RN-D stated that the base line care plan is reviewed and signed with the resident or resident representative at the first care conference which is usually in the first week. RN-D stated that R322's baseline care plan was started on the day R322 was admitted to the facility. On 5/21/25 at 10:39 AM, Surveyor interviewed Director of Nursing (DON)-B about baseline care plans. Surveyor asked who is responsible for completing the baseline care plan. DON-B stated that a nursing manager will complete the baseline care plan. RN-D does the bulk of the baselines care plans, but it is a team effort. Surveyor asked what the expectation is for completing the baseline care plan. DON-B stated that it should be started on admission. DON-B stated that DON-B is not sure of the policy but knows it is started on admission. DON-B stated that DON-B would get back to surveyor. DON-B did not provide further information about baseline care plans. On 5/21/25 at 1:00 PM, Surveyor interviewed Social Worker (SW)-F about baseline care plans. SW-F stated that nursing is responsible for starting the baseline care plan. SW-F is given the baseline care plan by nursing staff. SW-F stated that the baseline care plan is then reviewed with the resident at the first care conference, which is typically within the first week. Surveyor asked if the baseline care plan is reviewed with the resident prior to that. SW-F stated that it is not reviewed prior to that. On 5/22/25 at 12:09 PM Surveyor asked SW-F what is given to the resident at the first care conference. SW-F stated that baseline care plan and medication list is given to the resident or resident representative at that time. Surveyor asked where that is documented. SW-F stated that it should be in the care conference note, but SW-F sometimes forgets. Surveyor asked if the resident or resident representative signs anything at the care conference. SW-F stated that in the past, they don't typically sign anything but that will be changing. SW-F stated that SW-F just found out that the resident or representative needs to sign the baseline care plan. After signing the baseline care plan, it will be scanned into the EMR. SW-F stated that the new process will begin now. On 5/21/25 at 3:16 PM, Surveyor informed Nursing Home Administrator (NHA)-A, and DON-B of the concern that R322 was admitted on [DATE]. R322's baseline care plan was not signed by facility staff as completed until 12/24/24. There is no evidence that R322 was provided a written summary of R322's baseline care plan and no evidence that R322 signed R322's baseline care plan.

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	525547	A. Building B. Wing	05/22/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not develop a comprehensive plan of care for residents on antidepressant medication. This was observed with 3 (R40, R6, & R71) of 18 residents reviewed for plans of care. * R40 and R6 were admitted to the facility on antidepressant medication and did not have a plan of care for their depression. * R71 did not have bowel or bladder care that included goals and interventions. Findings include: 1.) R40 was admitted to the facility on [DATE] with diagnoses including Depression and Stroke. The Hospital Discharge summary, dated [DATE], includes Prozac 20 milligram (mg), 3 capsules daily. The facility admission physician orders document Prozac 20 mg, 3 capsules every day for Depression. R40's admission Minimum Data Set (MDS) assessment was completed on 3/4/25. This assessment documents daily use of an antidepressant medication. The Care Area Assessment (CAA) for Psychotropic Drug Use, completed by MDS Registered Nurse (RN) -C on 3/10/25, documents Prozac (antidepressant) for depression. This CAA does not include the symptoms of depression R40 experiences, along with non-pharmacological interventions. R40's Significant Change in Status MDS assessment was completed on 4/22/25. This assessment documents daily use of an antidepressant medication. The Care Area Assessment (CAA) for Psychotropic Drug Use, completed by MDS RN -C on 4/30/25, documents Prozac (antidepressant) for depression. This CAA does not include symptoms of depression R40 experiences, along with non-pharmacological interventions. R40's plans of care were reviewed. R40 has a care plan, initiated on 2/26/25, titled The resident uses antidepressant medication Prozac. There is no documentation of indicators for use of the antidepressant. The interventions listed indicate the side effects of the medication to be monitored. R40 does not have a plan of care for depression symptoms and treatment to include specific symptoms along with non-pharmacological interventions. On 5/21/25, at 1:30 PM, Surveyor interviewed Unit Manager (UM) -D. UM-D stated They will look for indicators for use of the antidepressant medication. UM-D did not have any additional information. UM-D did not develop a comprehensive plan of care for R40's depression. On 5/21/25, at 2:02 PM, Surveyor interviewed Social Worker (SW)-F. SW-F stated They just look at the medication itself and do not ask about symptoms for use. SW-F did not develop a comprehensive plan of care for R40's depression. (continued on next page)

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	525547	A. Building B. Wing	05/22/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/21/25, at 3:03 PM at the facility exit meeting, with Nursing Home Administrator (NHA)-A and Director of Nurses (DON) -B, Surveyor shared the concerns with R40's antidepressant medication. There is not a comprehensive assessment or use, including care plan, non-pharmacological interventions and specific symptoms for treatment2.) R6 was admitted to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, dementia, psychotic disturbance, mood disturbance, anxiety and depression. R6's Annual Minimum Data Set (MDS) assessment, dated 5/6/2025, documented a Brief Interview Mental Status (BIMS) score of 11, indicating that R6's cognation is intact. Section B, documents that R6 is understood and understands. Surveyor reviewed R6's care plan and could not locate a care plan for R6's depression. Surveyor reviewed the care plan for depression medication but that had only interventions related to the medication itself and nothing with interventions for the depression diagnosis. On 5/22/2025, at 8:16 AM, Surveyor interviewed Assistant Director of Nursing (ADON)-K who indicated to be one of the people responsible for going over care plans and making sure they are correct and current. ADON-K indicated that the depression care plan should show up in Point Click Care (PCC). PCC is a program used for R6's health information while at the facility. Surveyor informed ADON-K that it was not observed in PCC. ADON-K stated to Surveyor that a depression care plan will be put in for R6 right away. Surveyor also explained that there was a care plan for R6's depression medication, which had the following two interventions: Monitoring/document/report PRN (as indicated) adverse reactions to antidepressant therapy; Administer antidepressant medications as ordered. Surveyor reviewed the treatment record for R6. It is documented that on April 18th, 19th and 20th of 2025 that side effects were observed for depression medication. There was no documentation that the adverse effects of R6's medication were reported to a physician on April 18th, 19th or 20th. On 5/22/2025, at 11:19 AM, Surveyor informed Nursing Home Administrator (NHA)-A, of the above findings. Surveyor explained that there is no care plan for depression and the care plan found for depression medication intervention was not followed. No additional information received for R6 not having a depression care plan with interventions and goals. No information received as to why the interventions for depression medication were not followed on the above dates of April 2025. 3.) R71 was admitted to the facility on [DATE] with diagnoses that include heart failure, generalized anxiety disorder, depression, osteoarthritis. R71's admission Minimum Data Set (MDS), dated [DATE], documents a Brief Interview of Mental Status (BIMS) of 11, indicating R71 is cognitively intact. The MDS documents mobility as needs some help, as helper does some of the effort, and R71 does some of the activity. Under the bowel and bladder section, it is documented that R71 is occasionally incontinent of bladder and never incontinent of bowel. (continued on next page)

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	525547	A. Building B. Wing	05/22/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed the care plan for R71 and there was not a bladder care plan initiated for R71, despite the MDS documenting that R71 is occasionally incontinent of bladder. On 5/22/2025, at 8:06 AM, Surveyor interviewed Assistant Director of Nursing (ADON)-K who indicated that she was one of the individuals responsible for going over care plans and making sure they are correct and current. Surveyor informed ADON-K of the above findings and R71's lack of a bladder care plan. ADON-K indicated not remembering much relating to R71 and would review R71's care plan and let Surveyor know. On 5/22/2025, at 11:19 AM, Surveyor informed Nursing Home Administrator (NHA)-A, of concerns with R71's care plan, and no start for a bladder care plan for R71. No additional information was provided as to why R71 had no care plan for bladder incontinence despite it being documented in R71's admission MDS dated [DATE].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525547	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Glendale West	6263 N Green Bay Ave Glendale, WI 53209

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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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility did not ensure residents with vision impairment received proper treatment and assistive devices including arrangements for an optometrist (eye doctor) visit for 1 (R21) of 1 resident's reviewed for vision. R21 has not been seen by an optometrist since 8/20/21 and R21's last missed vision appointment on 11/18/22 was never rescheduled to evaluate R21's advancing vision issues with an active request and signed consent to receive vision care. Findings include: R21 was admitted on [DATE] which includes a diagnosis of legal blindness and other optic atrophy. R21's comprehensive Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 13, indicating R21 has intact cognition. R21 has highly impaired vision with no corrective lenses, glasses or contacts. R21's active Physician Order, dated 10/5/23, documents, May be seen by Optometrist No directions specified for order. R21's Care Plan, date Initiated, 10/06/2023, documents, Focus: The resident has impaired visual function r/t (related to) can see and ID (Identify) objects. Goal: The resident will maintain optimal quality of life within limitation imposed by visual function (SPECIFY how) through the review date. Date Initiated: 05/25/2022 Revision on: 04/17/2025. The resident will maintain optimal quality of life within limitation imposed by visual function (SPECIFY how) through the review date. Date Initiated: 05/25/2022 Revision on: 04/15/2025 Interventions: The resident will have no indications of acute eye problems through the review date. Date Initiated: 05/25/2022 Revision on: 04/17/2025. Arrange consultation with eye care practitioner as required. Date Initiated: 05/25/2022. Keep my personal items in the same place so I can find them. Date Initiated: 05/25/2022. Monitor/document/report PRN (as needed) any s/sx (signs and symptoms) of acute eye problems: Change in ability to perform ADLs, (Assistance with Daily Living) Decline in mobility, Sudden visual loss, Pupils dilated, gray or milky c/o halos around lights, double vision, tunnel vision, blurred or hazy vision. Date Initiated: 05/25/2022. Offer me a consult with optometrist/ophthalmologist, as needed. Date Initiated: 05/25/2022. Tell the resident where you are placing their items. Be consistent. Date Initiated: 05/25/2022 R21's HealthDrive Request for services form completed on 12/30/19, documents R21 requests to be seen for eye care and consents to services requested. R21's HealthDrive's Eye Care Group form on 8/20/21 documents, R21's visit assessment concludes optic atrophy; both eyes, macular degeneration, dry, both eyes; intermediate dry stage, cataract mixed; worse; both eyes; mild to moderate, exotropia, constant; no change; L (left) eye, legal blindness, as defined in USA. R21's plan documents, monitor; follow up comprehensive 8/20/22, patient education and advise staff of any changes, monitor, cataract surgery not recommended due to poor prognosis, monitor, staff education-patient will require assistance with ADL's (assistance with daily living). R21's action required by nursing home staff, glasses required, no. Eyelid care required, no. Recommend new orders, no. (continued on next page)

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	525547	A. Building B. Wing	05/22/2025

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R21's HealthDrive's Eye Care Group form on 11/18/22, documents, Patient was scheduled to be treated today but was not treated. Reason: Patient was unavailable-in bed. On 05/19/25 at 10:01 AM, R21 stated her vision is very bad. She had glasses but they did not work well. She believes she has talked to someone about this. On 05/20/25 at 11:03 AM, Surveyor interviewed Social Worker (SW)-F who stated the process for residents to receive vision appointments starts with the resident's requesting services and signing a consent. Once this is established, residents are on the list for HealthDrive to come to the facility quarterly for vision appointments. Surveyor asked SW-F why R21 stopped receiving vision care with her last scheduled visit on 11/18/22 which was missed and SW-F stated, she does not know but will find out. On 05/21/25 at 08:33 AM, Surveyor interviewed SW-F, who received information from HealthDrive. SW-F stated R21's last visit was scheduled for 11/18/22 but R21 was in bed. HealthDrive does not know why R21 was no longer on their list following last attempted visit, but HealthDrive has re-added R21 to list and she will be seen 6/2/25. On 05/22/25 at 10:41 AM, Surveyor interviewed SW-F, who stated, HealthDrive sends a summary for each visit but if resident is no longer going to be seen, she does not know because it has not happened since she has been here in a year. Surveyor asked, SW-F if HealthDrive stops seeing a resident, whose responsibility is it to find out why and SW-F stated, That is a good question and did not provide answer. Surveyor asked SW-F if there is a tracking mechanism in place to know if a resident was missed for any reason and SW-F stated she doesn't keep one, but HealthDrive should have one. She will reach out to HealthDrive and see if they have any system. On 05/22/25 at 10:54 AM, Surveyor spoke with R21 who stated she has told someone a few weeks ago that she wanted a visit for vision because her right eye becomes blurry as the day goes on, but she has not heard anything. Surveyor told R21 that a visit has been set up for 6/2/25. R21 stated she had not been informed of upcoming visit and stated she did not know why she had not been seen since 8/20/21 or why her last scheduled visit on 11/18/22 was not rescheduled. Surveyor notes, the facility does not have a system in place for monitoring HealthDrive visits, to include if visits occurred, when visits are missed or canceled or if residents decide to longer have services provided. On 05/22/25 at 3:15 PM, Surveyor notified Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B of the concerns regarding R21 not being seen by optometry to continue to evaluate the care plan and decline of R21's vision. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Following exit from the survey, the facility submitted additional information regarding R21 to include the statement Resident (R21) has macular degeneration, cataracts in both eyes and is legally blind. The residents (sic) care plan since 2022 (attached for Surveyor review) states to arrange consultation with eye care practitioner as needed. Resident s followed by (name of replacement plan group), during each visit with the NP (nurse practitioner) resident has not expressed any concerns. The order from (name of replacement plan group) for resident (attached for Surveyor to review) states opthalmology consult as needed and they have not recommended a consult. (Name of replacement plan group) also documented that resident refuses to get out of bed and an eye examination cannot be done with resident in bed. Surveyor noted the additional information does not address R21's discussion with staff expressing concern with changes in her right eye and a request for a vision appointment. The documents submitted from the replacement plan provider are noted to be date 9/11/24 and 12/12/24. The 12/12/24 form documents a generic statement of: Continue with Routine labs and in house services per facility policy: Podiatry; Opthalmology; Dental; Audiology; and Psychiatric Consults PRN (as needed). The 9/11/24 does not reference a review of vision or services related to vision as provided to surveyor for review.

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	525547	A. Building B. Wing	05/22/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure adequate supervision and safety to prevent an accident from occurring for 1 of 1 Resident (R65) reviewed for accidents. *R65's physician orders instructed 1:1 (one on one) supervision with all meals. Surveyor had observations during the survey process of R65 not receiving supervision with meals. Findings Include: The facility's Accidents and Supervision policy implemented 11/24 documents: .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(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: 1. Identification of Hazards and Risks 2. Evaluation and Analysis 3. Implementation and Interventions 4. Monitoring and Modification 5 Supervision-is an intervention and a means of mitigating accident risk. The facility will provide adequate supervision to prevent accidents. Adequacy of supervision: a. Defined by type and frequency b. Based on the individual Resident's assessed needs and identified hazards in the Resident environment (continued on next page)

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	525547	A. Building B. Wing	05/22/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R65 was admitted to the facility on [DATE] with diagnoses of Hemiplegia and Hemiparesis Following Cerebral Infarction (complete paralysis on one side of body and partial/incomplete weakness on one side following stroke), Dysphagia (difficulty swallowing foods), Metabolic Encephalopathy(brain dysfunction resulting from underlying condition that disrupts the metabolic processes), Chronic Kidney Disease (progressive damage and loss of function in the kidneys), Anemia (low red blood cells and hemoglobin), and Essential Hypertension (chronic condition of persistently high blood pressure). R65 is currently is his own person. R65's admission Minimum Data Set (MDS) completed 4/16/25 documents R65's Brief Interview for Mental Status(BIMS) score to be 12, indicating R65 demonstrates moderately impaired skills for daily decision making. R65's MDS documents R65 has no mood or behavior symptoms. R65 has range of motion (ROM) impairment on 1 side of both upper and lower extremity, set-up for eating, requires substantial/maximum assistance for showers, upper and lower dressing and transfers. R65 requires partial to moderate assistance for mobility. R65's MDS also documents that R65 is holding food in mouth/cheeks or residual food in mouth after meals and has complaints of difficulty or pain when swallowing. R65's nutrition care area assessment completed 4/16/25 (CAA) documents: Mechanical soft NAS diet R65 will maintain adequate nutritional status as evidenced by maintaining weight within 5% of 160 lbs, no signs/symptoms of malnutrition, and consuming at least 50% of at least 3 meals daily through review date. R65's initial nutrition assessment completed 4/11/25 by Dietitian (RD)-Q documents R65 is setup help only and on a mechanical soft texture thin liquid diet at time of admission. R65's current physician orders documents: -No added salt (NAS) diet mechanical soft texture, regular (thin) consistency, 1:1 supervision for meals-start date 4/9/25 -1:1 supervision for all meals, hold meals if increased coughing, three times a day-start date of 4/18/25 Surveyor reviewed R65's Treatment Administration Record (TARS) for April and May and notes that nursing staff was monitoring for 1:1 supervision for all meals, three times a day. R65's initial nutrition assessment is inconsistent with R65's physician orders of 1:1 supervision with all 3 meals. R65's care card instructing certified nursing assistants (CNAs) as of 5/19/25 documents R65 is on a mechanical soft diet, thin liquids, and feeds self with set up. R65's comprehensive care plan documents: R65 has a swallowing problem due to (Surveyor notes this has not been completed) (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Initiated 4/22/25 Interventions: -All staff to be informed of R65's special dietary and safety needs -Diet to be followed as prescribed -Instruct R65 to eat in an upright position, to eat slowly, and to chew each bite thoroughly -Monitor for shortness of breath, choking, labored respirations, lung congestion · The resident will have clear lungs, no signs and symptoms of aspiration through the review date. · The resident will have no choking episodes when eating through the review date. · The resident will maintain weight and nutritional balance through the review date. · The resident will not have injury related to aspiration through the review date. All initiated 4/29/25 Surveyor notes R65's care card and comprehensive care plan were not updated with R65's physician order of 1:1 supervision with all 3 meals. On 4/10/25, Speech/Language Pathologist (SLP)-P's SLP screen documents R65 is on a mechanically altered diet, holds food in mouth/cheeks or residual food in mouth after meals, and complaints of difficulty or pain when swallowing. Recommendations are for SLP Evaluation for swallow. SLP-P in the summary, documents that a problem has been identified and SLP evaluation indicated. SLP-P's documentation completed 4/10/25 located in SLP-P's evaluation and plan of treatment includes the following applicable goals: -R65 will increase ability to safely swallow mechanical soft/ground consistencies to within functional limits in order to meet primary nutrition/hydration needs. -R65 will safely and efficiently swallow mechanical soft/ground textures 90% of the time without compensatory strategies and/or maneuvers as evidenced by minimal to absent signs/symptoms of oral/pharyngeal dysphagia. (continued on next page)

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	525547	A. Building B. Wing	05/22/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/16/25, R65 is discharged to the hospital from the facility. R65's hospital discharge summary completed 4/22/25 includes SLP notes from the hospital. SLP's progress notes completed 4/18/25 documents: Swallow Recommendations: 3. Constant supervision/tray setup-ensure slow rate, small bites, liquid wash as appropriate 4. Discontinue feeding if increased coughing, throat clears, increased breathing 5. Monitor mentation, hold by mouth intake as appropriate, may need total assist as needed due to cognition/mentation Recommendations documented by the SLP from the hospital: -Liquid-thin and IDDSI (International Dysphagia Diet Standardization Initiative) 7 Easy-to-Chew -Feeding Guidelines: *Tray set-up, constant supervision by staff, slow rate of intake, small bites, alternate liquids and solids, stay upright after meals, small single sips, and check mouth for leftover food The overall short term goal is that R65 will tolerate a least restrictive diet without overt signs/symptoms of dysphagia/aspiration R65's nutrition assessment completed by RD-Q after R65's return from the hospital dated 4/25/25 documents R65 now requires one person physical assistance. SLP-R, a different speech/language therapist completed a SLP screen on 4/27/25 indicating R65 has a swallow disorder as evidenced by holding food in mouth or cheeks or residual food in mouth after meals and complaints of difficulty or pain when swallowing. On 4/27/25, SLP-R documented: .Due to the documented physical impairments and associated functional deficits, without skilled therapeutic intervention, R65 is at risk for: decreased ability to return to prior level of supervision/assistance. R65 presents with mild oral dysphagia which necessitates skilled SLP services for dysphagia to analyze oral function, assess/evaluate for safest level of oral intake and design and implement strategies in order to improve ability to safely consume highest level of oral intake. R65's completed MDS 5 day dated 4/28/25 documents R65 continues to hold food in mouth/cheeks or residual food in mouth after meals and complaints of difficulty or pain when swallowing. On 4/28/25, SLP-R documented providing .R65 with verbal education regarding safe swallow strategies with rationale and explanations for implementation On 5/1/25, SLP-P documented .Mildly discoordinated oral movements and mastication noted. (continued on next page)

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	525547	A. Building B. Wing	05/22/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/19/25, SLP-P documents .R65 with mildly wet vocal quality post swallow of fruit, but cleared with secondary swallow On 5/19/25, at 12:38 PM, Surveyor observed Admissions (Admit)-G deliver R65's lunch tray and bring in a cup of juice, and set the tray on R65's overbed table. R65 is up in wheelchair. On 5/19/25, at 12:44 PM, Surveyor observed R65 drinking juice. On 5/19/25,at 12:59 PM, Surveyor observed Certified Nursing Assistant (CNA)-S lower R65's overbed table, take the cover off the fruit, and moved the plate closer to R65. On 5/19/25, at 1:04 PM, Surveyor observed R65 eating lunch with no supervision. On 5/19/25, at 1:12 PM, Surveyor observed R65 continuing to eat lunch with no supervision. On 5/20/25, at 8:05 AM, Surveyor observed CNA-I bring R65's breakfast tray, opened up everything, raised R65's head of bed, and left the room. On 5/20/25, at 8:11 AM, Surveyor observed R65 eating breakfast in bed, unsupervised, head of bed is slightly elevated. On 5/20/25, at 8:40 AM, Surveyor observed that R65 ate all of breakfast, and no staff was in the room to supervise. On 5/20/25, at 12:26 PM, Surveyor observed R65 sitting in wheelchair, eating lunch with staff supervising R65. On 5/20/25, at 12:52 PM, Surveyor observed that R65 ate all of R65's lunch, finishing up cup of juice. Surveyor observed R65 did not receive any supervision from staff. On 5/21/25, at 8:49 AM, Surveyor interviewed SLP-P in regards to R65. Surveyor asked SLP-P to define what 1:1 supervision is defined as. SLP-P stated it would be assistance of 1 and watching R65 throughout the meal. SLP-P is not aware of the physician's order for 1:1 supervision for R65. SLP-P stated R65 has few teeth, and has a history of swallowing difficulty. On 5/21/25, at 8:49 AM, Surveyor observed R65's breakfast tray in front of R65, cover still on, and R65 is laying in bed. R65's head of bed is slightly elevated but not enough to eat comfortably. R65 has not started to eat yet. On 5/21/25, at 8:57 AM, Surveyor observed CNA-H go into R65's room and set up R65 for breakfast, elevated bed completely in a better position. On 5/21/25, at 8:59 AM, Surveyor observed CNA-I go into R65's room and shut the door. On 5/21/25, at 9:19 AM, Surveyor asked CNA-H what CNA-I was doing in R65's room and CNA-H stated CNA-I was watching R65 eat. CNA-H stated CNA-H cut up the pancakes but R65 needs monitoring. On 5/21/25, at 12:41 PM, Surveyor observed R65 eating lunch, with no staff supervision. (continued on next page)

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	525547	A. Building B. Wing	05/22/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/21/25, at 3:03 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, and Director of Quality Compliance (DQC)-C that R65's physician orders document R65 is to have 1:1 supervision with all meals, and Surveyor has observations of 3 meals that R65 did not receive supervision, R65's hospital record indicates the need for physical supervision, R65's most recent nutritional assessment completed 4/25/25 indicated that R65 now requires 1 person physical assistance, and that SLP-P was not aware that R65 had a physician order for 1:1 supervision. No further information was provided by the facility at this time. On 5/22/25, at 8:36 AM, Surveyor interviewed RD-Q. Surveyor asked RD-Q if RD-Q reviewed re-admission hospital paperwork in regards to R65. RD-Q can not remember if RD-Q did. Surveyor asked RD-Q if RD-Q reviewed R65's physician orders upon return from the hospital. RD-Q can not remember. Surveyor asked RD-Q if RD-Q was aware that R65's physician orders documented 1:1 supervision for all meals. RD-Q stated that RD-Q has R65 needing 1:1 supervision in the 'tray system'. Surveyor asked RD-Q what total assistance is defined as. RD-Q stated the expectation would be that a staff member should sit with R65 and feed R65. RD-Q does not know why R65 was downgraded from regular to mechanical soft. I'm assuming he has a tooth issue due to the diet change. RD-Q does not know anything about R65's teeth. On 5/22/25, at 11:20 AM, DON-B submitted additional information of SLP progress notes, and hospital paperwork. Surveyor explained to DON-B that Surveyor had all identified documentation but would review it again. DON-B stated DON-B was told to bring Surveyor the additional information. Surveyor shared the concern that between the facility, SLP, and Dietitian, that there is confusion to exactly what level of supervision R65 requires for meals. Surveyor explained what SLP-P and RD-Q had communicated to Surveyor in previous interviews. DON-B understands the confusion and the concern regarding R65. On 5/22/25, at 11:33 AM, Surveyor interviewed Unit Manager Registered Nurse (RN)-D who does not remember why a diet change was needed for R65. RN-D would make a recommendation if there was difficulty swallowing and sent to speech therapy for follow-up. On 5/28/25, at 1:35 PM, Surveyor reviewed the additional information the facility provided. The concern remains that R65 had current physician orders for 1:1 supervision for all 3 meals and during the survey process the facility was not following the physician orders. The TARS document nursing staff were acknowledging and signing off they were monitoring that R65 was receiving 1:1 supervision at all 3 meals. SLP-P who Surveyor interviewed was not aware that R65 had physician orders for 1:1 supervision so a complete assessment of R65 was not completed by SLP-P in that SLP-P did not complete a record review of R65's medical record. RD-Q confirmed R65 was in the tray system in the facility as needing 1:1 supervision. Additional review of records provided by the facility indicate the physician order for 1:1 supervision was discontinued on 5/20/25, during the survey.

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	525547	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Glendale West	6263 N Green Bay Ave Glendale, WI 53209

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility did not ensure the medication rate was below 5 percent in 1 (R422) of 3 residents observed receiving medications. The facility medication error rate was 16.67 percent. *R422 had medications that were not administered in the right dose or were omitted from the medications administered. R422 had insulin ordered and the wrong dose was drawn up in the syringe. Findings include: The facility policy and procedure titled Administering Medications dated 12/28/2024 documents: 4. Medications are administered in accordance with prescriber orders, including any required time frame. On 5/20/2025 at 7:56 AM, Surveyor observed Licensed Practical Nurse (LPN)-L obtain R422's blood sugar. The result was 216. At 8:15 AM, Surveyor observed LPN-L prepare R422's morning medications and documented the medications as they were placed into the medication cup: -Allopurinol 100 mg -Aspirin 81 mg -Vitamin D 25 mcg -Docusate 100 mg -Furosemide 40 mg -Midodrine 5 mg -Acetaminophen 1000 mg LPN-L drew up 3 units of 70/30 insulin from the vial and when showing Surveyor the dosage, noticed that the needle was bent. LPN-L discarded the syringe and took out a new syringe. LPN-L drew up the 70/30 insulin and showed Surveyor the dose drawn up. LPN-L had drawn up 5 units. Surveyor asked LPN-L how many units were ordered. LPN-L stated 3 units and then recognized that 5 units were drawn up in the syringe. LPN-L corrected the dose to 3 units before administering to R422. Surveyor reviewed R422's physician orders. R422 had an order for Vitamin D 25 mcg 2 capsules and Docusate 100 mg 2 capsules to be given. Surveyor noted R422 had orders for Pantoprazole Sodium 40 mg and Thiamine 100 mg to be given at 8:00 AM that were not administered during the morning medication pass. (continued on next page)

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	525547	A. Building B. Wing	05/22/2025

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Complete Care at Glendale West	6263 N Green Bay Ave Glendale, WI 53209

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/20/2025 at 9:05 AM, Surveyor asked LPN-L if R422 received one or two capsules of Vitamin D and Docusate. LPN-L stated LPN-L administered one of each of the medications and should have given two of each. Surveyor asked LPN-L if R422 received Pantoprazole or Thiamine. LPN-L stated LPN-L did not give either of those two medications and should have. LPN-L stated LPN-L was flustered because R422 was sitting at the medication cart waiting to go to dialysis and it threw LPN-L off. LPN-L stated LPN-L would have caught that R422 did not get the Pantoprazole when LPN-L looked at the medication card because the pills are punched out by date and would have seen that the #20 punch was not done for that medication. LPN-L stated LPN-L would bring the four medications to dialysis for R422. On 5/21/2025 at 3:03 PM, Surveyor shared with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B the medication pass task had been completed and the medication error rate was 16.67 percent with five errors out of 30 opportunities. Surveyor shared the observation of LPN-L on 5/21/2025 giving one Vitamin D and Docusate instead of the ordered two capsules, not giving Pantoprazole or Thiamine, and LPN-L drawing up 5 units of 70/30 insulin when the order was 3 units and Surveyor intervening to ensure R422 received the correct dose of insulin.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure the residents were free of significant medication errors for 1 (R122) of 1 resident reviewed for medication transcriptions. R122 had a hospital discharge order for Apixaban, an anticoagulant, 5 mg once in the morning and once at bedtime. The order was transcribed by the facility as Apixaban 5 mg once daily. R122 was a resident of the facility for 34 days and received the wrong dose of Apixaban on those days. Findings include: R122 was admitted to the facility on [DATE] with diagnoses of chronic respiratory failure, chronic obstructive pulmonary disease, diabetes, dysphagia requiring a gastrostomy tube for nutrition and medication administration, and atrial fibrillation (a fluttering of the atria in the heart potentially causing blood clots to form and creating an increased risk for a stroke). R122 had an activated Power of Attorney (POA). R122 discharged from the facility on 1/6/2025 and was not a resident at the time of survey. Apixaban, or Eliquis, is an anticoagulant prescribed to reduce the risk of blood clots from forming. R122's hospital discharge orders dated 12/2/2024 included Apixaban 5 mg tablet commonly known as Eliquis: take 1 tablet (5 mg) by mouth or tube in the morning and 1 tablet (5 mg) before bedtime for atrial fibrillation. On 12/3/2024, Assistant Director of Nursing (ADON)-K transcribed the order from the hospital discharge medication list to R122's Medication Administration Record (MAR). The order was entered onto the MAR as: Apixaban Oral Tablet 5 mg - give 1 tablet via PEG-Tube (Percutaneous Endoscopic Gastrostomy tube) one time a day related to paroxysmal atrial fibrillation. Surveyor noted the hospital order for Apixaban was twice daily and the facility entered the order as Apixaban once daily, halving the dose R122 was to be taking. R122's facility physician signed the order as transcribed by ADON-K for 5 mg of Apixaban daily. No documentation was found indicating the physician was aware R122 had been on twice the dosage in the hospital and wanted the medication decreased. No documentation was found indicating R122's POA had been notified of the change in dose of Apixaban. In an interview on 5/21/2025 at 1:48 PM, Unit Manager Registered Nurse (UMRN)-D stated the unit nurse would complete the physical head to toe assessment on a newly admitted resident and either UMRN-D, ADON-K, or DON-B would put in the standing orders and hospital discharge orders into the computer. UMRN-D stated the orders would then be double checked by one of the other administrative nurses. Surveyor shared with UMRN-D Surveyor could see who entered the order into the medical record. Surveyor asked UMRN-D if there was documentation in the medical record to indicate who double checked the order. UMRN-D stated no, there was no place in the electronic medical record to show the order had been double checked. Surveyor asked UMRN-D if UMRN-D could recall any conversations with R122's POA regarding medications. UMRN-D stated R122's POA came in and was concerned R122 did not get any medications, but the medications were given via the PEG tube because the discharge summary stated to administer the medications that way. RNUM-D stated R122 could take the medications orally and Speech Therapy cleared R122 to take medications orally, so the orders were changed at that time. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 5/22/2025 at 10:48 AM, Surveyor asked ADON-K where do the nurses that enter orders for a newly admitted resident get the orders from. ADON-K stated the resident comes with an order summary from the hospital and that is reviewed and compared with other medication lists in the hospital documentation to make sure there were not any changes made to the medications. ADON-K stated sometimes they will get an oral report for orders. ADON-K stated the medications are reviewed the next day to make sure there is not an error. Surveyor showed ADON-K R122's discharge medication list from the hospital dated 12/3/2024 and asked ADON-K how that order would be entered into the residents MAR. ADON-K read the order and stated ADON-K would enter the order as Apixaban 5 mg twice a day. Surveyor showed ADON-K R122's facility admission orders. ADON-K stated the Apixaban was not entered into the MAR as it was ordered; it should have been twice a day instead of once a day. Surveyor noted ADON-K is the nurse that entered R122's Apixaban order on 12/3/2024. On 5/22/2025 at 11:20 AM, DON-B provided Surveyor with a physician progress note dated 12/3/2024, the date of admission. DON-B stated the progress note documented the order for Apixaban one time daily was collaborated by the physician with the pharmacy on the scheduled prescriptions. Surveyor reviewed the physician progress note. Surveyor noted the physician progress note was a late entry for 12/3/2024 and the medication list was pulled from the facility MAR with pharmacy notation from 12/4/2024. Surveyor shared with DON-B the concern the medication list that was reviewed by the physician per the progress note was comprised of the orders that had been entered into R122's MAR by ADON-K on 12/3/2024 which was not entered correctly for the Apixaban from the hospital discharge summary medication list. Surveyor shared the concern there was no documentation of a conversation indicating the physician was aware the hospital order was for Apixaban twice daily and wanted to decrease the dose to once daily. Surveyor shared the concern with DON-B that R122 received half the dose of Apixaban that should have been administered for the 34 days R122 was in the facility potentially increasing the risk of blood clot formation and stroke. In an interview on 5/22/2025 at 1:11 PM, ADON-K stated the physician was in the facility on 12/3/2024 when R122 was admitted . ADON-K stated the physician reviewed R122's medications and approved Apixaban once daily. Surveyor shared with ADON-K the concern no documentation was found of the Apixaban 5 mg twice daily entered into R122's MAR as ordered from the hospital and then the dose being decreased by the physician at the facility or any documentation to show the physician was aware of the Apixaban being decreased. On 5/28/2025 at 6:17 AM, Nursing Home Administrator (NHA)-A sent an email with additional information regarding R122's medication transcription error. Surveyor reviewed the information attached to the email. A physician visit on 12/9/2024 documents: All medications including all prescriptions, over-the-counter, herbals, and nutritional supplements with each medication's name, dosage, frequency, and administered route have been documented, updated, reviewed, and reconciled on the date of the visit within the Nursing Home's EMR (electronic medical record) system. Specialty-pertinent medications are documented and reconciled within the practice EMR system on the date of the visit. Surveyor noted the medication list reviewed by the physician was what was entered into the MAR by facility staff and does not indicate the medications were compared to the hospital discharge medications.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure the medical record for 1 (R33) of 18 residents reviewed was complete accurately documented and readily accessible. *During the survey investigation, it was determined R33 was admitted to the facility on [DATE] with multiple pressure injuries that were not comprehensively assessed until 11/25/2024, three days after admission, and treatments were not documented as being completed from 11/22/2024 to 11/25/2024. On 5/28/25, after completion of the survey, the facility submitted hand written documents that were not part of the medical record that indicated details of wound assessments alleged to be completed on 11/22/24. The hand written forms did not include who completed the documentation and were not included as part of the formal medical record until concerns were raised by the surveyor. Findings include: The facility policy and procedure titled Pressure Injury Prevention and Management dated 10/2024 documents: 3. c. Licensed nurses will conduct a full body skin assessment on all residents upon admission/re-admission, weekly, and after any newly identified pressure injury. Findings will be documented in the medical record. d. Assessment of pressure injuries will be performed by a licensed nurse. The staging of pressure injuries will be clearly identified to ensure correct coding on the MDS (Minimum Data Set). The facility policy and procedure titled Wound Treatment Management dated 12/2024 documents: 7. Treatments will be documented on the Treatment Administration Record or in the electronic health record. R33 was admitted to the facility on [DATE] with diagnoses of encephalopathy (a brain disorder), diabetes, dementia, and rheumatoid arthritis. R33's admission MDS dated [DATE] documented R33 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 13 and had one Stage 4 pressure injury on admission, three Unstageable pressure injuries on admission, and two Deep Tissue Injury pressure injuries on admission. On 11/21/2024 on hospital discharge paperwork, the hospital documented R33 had a Stage 4 pressure injury to the coccyx that measured 6.5 cm x 10.5 cm x 1.5 cm with undermining from 12 o'clock to 4 o'clock with the deepest area at 3 o'clock measuring 2.2 cm, a wound to the right lateral leg from friction/shearing that measured 4 cm x 1.5 cm x 0.3 cm, a wound to the right ischial tuberosity (lower buttock) that measured 6.7 cm x 1.4 cm x 0.1 cm, a wound to the right hip/trochanter that measured 5 cm x 3.5 cm x 0.1 cm, a wound to the right great toe and wounds to the left foot and multiple toes. On 11/22/2024 on the Admit/Readmit Assessment form, a Registered Nurse (RN) documented R33 had skin issues to the coccyx, the right buttock, the right heel, the left heel, the right toe(s), and the left toe(s). Surveyor noted the documentation of the wounds did not include measurements, staging if caused by pressure, an etiology, or a description of the tissue type in the wound beds; the right toes and left toes were not individualized as to what type of wounds, how many wounds, and where the wounds were located. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R33 had the following wound treatment orders on admission [DATE]: -Dakins one quarter strength: apply to wounds topically one time a day for wound care, apply to clean dry gauze. -Wound care to right lower extremity: cleanse area with normal saline, pat dry, apply calcium alginate to wound bed, skin prep to peri wound, cover with ABD pad, wrap with Kerlix to secure, change every other day. Surveyor noted this order was not signed out on the Treatment Administration Record (TAR) as being completed on 11/23/2024. -Wound care to Stage 4 pressure injury to coccyx and Unstageable pressure injury to the right hip: cleanse area with saline, apply quarter strength Dakins to clean gauze, apply to wound bed, skin prep to peri wound, cover with foam border dressing daily. Surveyor noted this order was not signed out on the TAR 11/23/2024 and 11/24/2024. -Wound care to left foot and toes: apply skin prep to foot/heels and toes twice daily. Surveyor noted this order was not signed out as completed on the TAR 11/22/2024, 11/23/2024, and 11/24/2024. R33's Potential/Actual Impairment to Skin Integrity Care Plan was initiated on 11/22/2024 with interventions: -Encourage to elevate heels. -Encourage/assist with repositioning as needed. -Ensure pressure relieving cushion is used in dialysis chair when R33 is in the chair for dialysis sessions; document if R33 refuses to use the cushion. -Weekly skin assessment with scheduled bath day and document findings on a weekly skin assessment. -Report any skin redness/impaired skin integrity areas to the nurse. -Use barrier cream to prevent skin impairment issues as needed. On 11/25/2024 at 12:33 PM in the progress notes, an RN documented R33 had a Deep Tissue Injury (DTI) to the left tip of the great toe and left heel, a Stage 4 pressure injury to the coccyx, and Unstageable pressure injuries to the right hip, right ischium, and right lateral ankle. Dressings were applied to all wounds. R33 had a low air loss mattress with bilateral offloading boots, and R33 would be repositioned every 2-3 hours and per R33's request. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/25/2024 on the Wound Rounds form, an RN documented the Stage 4 pressure injury to the coccyx measured 9 cm x 7 cm x 2.4 cm with 100% beefy red tissue and the Unstageable pressure injury to the right lateral upper ankle measured 5 cm x 0.8 cm x 0.4 cm with 80% pink or red non-granulating tissue and 20% slough. Surveyor was not provided with the Wound Round forms for the other noted pressure areas and was unable to access the record to see initial measurements of the wounds. The Wound Round forms in R33's record documented the left heel DTI healed on 1/8/2025, the left great toe tip DTI healed on 2/19/2025, the right hip Unstageable pressure injury healed on 1/8/2025, and the right ischium Unstageable pressure injury healed on 1/1/2025. Surveyor noted R33's pressure injuries were not comprehensively assessed until 11/25/2024, three days after admission. R33's Potential/Actual Impairment to Skin Integrity Care Plan was revised on 11/25/2024 with interventions: -Low air loss mattress. -Off loading boots bilateral when in bed. -Reposition every 2-3 hours and as needed per R33's request. -Treatment per physician orders. R33's Stage 4 pressure injury to the coccyx was comprehensively assessed weekly. R33's Unstageable right lateral upper ankle pressure injury was determined to be an arterial wound on 2/26/2025 and was comprehensively assessed weekly and healed on 5/7/2025. On 5/19/2025 at 10:00 AM, Surveyor observed R33 sleeping in bed. R33 had an air mattress in place and heel boots on. On 5/22/2025 at 7:49 AM, Surveyor observed Director of Nursing (DON)-B complete R33's wound care. R33 was in bed on the air mattress and bilateral heel boots were in place. DON-B stated the wound Nurse Practitioner comes weekly and would be assessing R33's wounds later that day. In an interview on 5/22/2025 at 10:54 AM, Assistant DON (ADON)-K stated a newly admitted resident should be assessed for skin impairment as soon as possible with measurements and descriptions of the wound or wounds. ADON-K stated if a Licensed Practical Nurse (LPN) does the initial intake, they would document where the wounds were located but then an RN would look at the resident that day, or if they came in after 8:00 PM, an RN would assess the wound in the morning. On 5/22/2025 at 11:19 AM, Surveyor shared with DON-B the concerns R33 did not have a comprehensive assessment of the pressure injuries that were present on admission on [DATE] until 11/25/2024, three days later, and the wound treatment orders were not signed out as being completed on the TAR on those days. DON-B stated DON-B would look to see if there was any more information. On 5/22/2025 at 1:14 PM, ADON-K provided Surveyor with a wound log showing R33's wounds when R33 was admitted on [DATE]. The log was handwritten and documented the following: -Coccyx pressure injury Stage 4, granulation tissue, friable, serosanguineous drainage, measured 8 cm x 6 cm x 1.7 cm. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Left heel pressure injury DTI, intact blood filled blister, measured 3.2 cm x 2.4 cm. -Right hip pressure injury Unstageable, 25% epithelial, slough, measured 4.7 cm x 2.9 cm. -Right ischium pressure injury Unstageable, pink 80%, ne 20%(unknown documentation), measured 1 cm x 0.8 cm. -right ankle pressure injury Unstageable, friable, serosanguineous drainage, measured 5 cm x 0.8 cm. Surveyor noted the wound log did not have any signature of who documented the information, no date was written other than the wounds were discovered on 11/22/2024, and the descriptions and measurements were not complete. The wound log was not part of R33's medical record.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 (R45) of 11 residents observed. *R45 was placed in Enhanced Barrier Precautions (EBP) and facility staff did not don a gown on when assisting R45 with cares. Finding Include: The Facilities Policy titled, Enhanced Barrier Precautions revised 11/2024, documents: Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug, resistant organisms. Policy explanation and compliance guidelines: . 4. High-contact resident care activities include: . G. Device care or use: central line, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, pick lines, midline catheters. R45 was admitted to the facility on [DATE] with diagnosis that include Cerebral Aneurysm, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominate side, dysarthria (slurred speech) and anarthria (loss of speech), dysphasia, neuromuscular dysfunctional bladder. R45's Quarterly Minimum Data Set (MDS) assessment, dated 5/1/2025, documented a Brief Interview Mental Status (BIMS) score of 3, indicating poor cognitive awareness. Section B, documents that R45 is usually understood and understands. R45's infection control care plan (requires enhanced barrier precautions), dated 7/28/2024, with a target date of 8/15/2025, documents: Gown and gloves to be worn by staff during high contact resident care activities that provide opportunities for transfer of Multidrug-Resistant Organism's (MDRO)'s to staff hands and clothing. Includes: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, and wound care. Surveyor observed a plaque on R45's door indicating a need for enhanced barrier precautions with cares. On 5/21/2025, at 9:34 AM, Surveyor observed Licensed Practical Nurse (LPN)-L changing R45's tube feeding from one container over to a new one and LPN-L did not have on a gown. On 5/21/2025, at 9:41 AM, Surveyor observed Certified Nursing Assistant (CNA)-M, who was moving R45's catheter bag off the floor and replaced the privacy cover that was on the catheter without a gown. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/22/2025, at 8:16 AM, Surveyor interviewed Assistant Director of Nursing (ADON)-K, regarding staff not using proper Personal Protective Equipment (PPE) during cares of R45's tube-feeding and catheter cares. ADON indicated being present during observation of no PPE on 5/21/2025. ADON-K stated that she already educated both LPN-L and CNA-M of the fact that gowns should have been in place during those activities. On 5/22/2025, at 11:22 AM, Surveyor informed Nursing Home Administrator (NHA)-A, of the concern that proper PPE was not observed during R45's contact cares on 5/21/2025. Surveyor also informed NHA-A that ADON-K was present during observations and educated staff on PPE use. No additional information was given as to why proper PPE was not utilized for R45 during contact cares.