STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525596	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Hales Corners	9449 W. Forest Home Ave. Hales Corners, WI 53130

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 - Few	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 record review, observation, interviews, and facility document review, the facility failed to maintain a resident's dignity by failing to close the door and curtains while providing care for one resident (Resident (R) 3) out of total sample of six residents. This failure had the potential to compromise the resident's dignity. Findings include: Review of R3's comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/16/25, located in the MDS tab of the EMR, revealed R3 was admitted to the facility on [DATE] with diagnoses that included dementia and age-related osteoporosis. R3 had a Brief Interview for Mental Status (BIMS) score of seven out of 15, which indicated R3 had severe cognitive impairment. On 02/19/26 at 5:30 AM, observation from the hallway revealed Certified Nursing Assistant (CNA) 1 at R3's bedside performing cares. R3 was undressed with curtains open and door open, visible to the hallway. During an interview on 02/19/26 at 5:37 AM, CNA1 admitted she had failed to provide privacy and dignity for R3 by failing to draw the curtains and close the room door during cares. During an interview on 02/19/26 at 5:40 AM, the nursing supervisor, Registered Nurse (RN) 3 stated it was her expectation that CNA1 should have provided privacy and dignity to R1 regardless of the time of the day. During an interview with the Director of Nursing (DON) on 02/19/26 at 6:00 PM, she stated it was her expectation that CNA1 should have covered R1 during care. Review of a copy of the facility's undated admission Agreement revealed, the facility shall ensure that all residents are afforded their right to dignified existence, self-determination, respect, full recognition of their individuality, consideration and privacy in treatment and care for personal needs and communication with and access to persons and services inside and outside the facility. The facility shall protect and promote the rights of each resident and shall encourage and assist each resident in the fullest possible exercise of these rights.

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

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and policy review, the facility failed to document a thorough investigation into the allegation of neglect for one resident (Resident (R) 4) and did not evaluate a Certified Nursing Assistant's (CNA's) history of concerning interactions with residents during an investigation of neglect reported by R2 for two of three facility reported incidents reviewed for abuse or neglect. This failure created the potential for similar incidents to recur.Findings include: 1. Review of R4's admission Record, located in the electronic medical record (EMR) under the Profile tab, revealed R4 was admitted to the facility on [DATE] and had diagnoses including myocardial infarction, congestive heart failure, and cellulitis. Review of the facility's Misconduct Incident Report, provided by the facility and dated 01/21/26, revealed that on 01/19/26, R4's family member (FM) 5 expressed concern about swelling in R4's feet. Nursing staff assessed her condition, noted swelling in both legs and feet, and recommended evaluation in the emergency room. The resident was subsequently admitted to the hospital for treatment of acute exacerbation of chronic heart failure. Social Worker (SW) 1 assisted with filing a grievance on FM5's behalf during a follow-up call on 01/21/26 when FM5 alleged the facility had neglected R4. Review of R4's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/29/26, located in the EMR under the MDS tab, revealed R4 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated R4 was cognitively intact. Review of the facility's investigation, provided by the facility, revealed no documentation that the facility had interviewed any other residents about neglect concerns or educated staff on the abuse and neglect policies as part of a comprehensive investigation of the allegation. During an interview with the Administrator on 02/19/26 at 5:55 PM, she stated she did not deem it necessary to conduct interviews with other residents as part of the facility's investigation because R4's case was unique and there were no other residents with similar concerns. Also, she did not deem it necessary to conduct staff training related to the incident because the matter was reported out of the abundance of caution, and there was no actual neglect or abuse in R4's case. The administrator stated R4's leg swelling was resolved, and the wound had progressed to being scabbed over. 2. Review of R2's admission Record, located in the EMR under the Profile tab, revealed she was admitted to the facility on [DATE] with diagnoses that included vaginal cancer. R2 was discharged on 11/11/25. Review of a Misconduct Incident Report, provided by the facility and dated 08/26/25, revealed that R2 reported an allegation of abuse by CNA3 to her daughter and Registered Nurse Supervisor (RN) 4. R2 stated that CNA3 entered her room, got close to her, and said, Be sure you know who you accuse. ?R2 reported feeling intimidated by the interaction with CNA3. Review of the facility's investigation, provided by the facility, revealed the facility found the allegation to be unsubstantiated. The investigation did not provide education on abuse training for CNA3 or any other staff and did not provide any other education or training for CNA3. Review of CNA3's personnel file, provided by the facility, revealed her employment ended 10/06/25. Multiple areas of concern with CNA's conduct were documented to include: On 05/25/25, former resident, R6, reported that CNA3 told him he should be more independent, including propelling himself to the dining room and completing his own personal care tasks. CNA3 provided supplies but did not ensure that R6 was properly set up or that his needs were met before leaving. R6 noted this had occurred on prior Sundays and stated that CNA3's tone was authoritative. The resident was subsequently reassigned to a different caregiver. On 06/01/25, former resident R5 reported that CNA3 yelled at her for being wet and made comments that caused embarrassment regarding her incontinence. R5 also stated CNA3 insisted R5 sleep in a gown instead of a T?shirt, selected clothing for her without her preference, and repeated care tasks R5 had already (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed. She further reported being left on the toilet long enough to play two games on her phone. CNA3 was removed from her care. Further review of CNA3's personnel file revealed CNA3 was placed on a Growth and Development Plan on 09/16/25 which stated, The purpose of this Performance Improvement Plan [PIP] is to define serious areas of concern, gaps in your work performance, reiterate expectations, and allow you the opportunity to demonstrate improvement and commitment.Areas of concern: Customer service, speaking to residents/staff respectfully and in a professional manner. Observations, previous discussion, or additional training provided:1. Discussions about proper communication with residents;2. Resident Rights - not following resident preferences;3. Performance improvement plan on 06/13/25 [referring to previous PIP];4. Discussion on previous grievances with residents. During an interview with the Administrator on 02/19/26 at 5:55 PM, she explained that a new entity assumed control of the facility on or about September 2025, resulting in a clean slate for personnel files and prior staff-related incidents. When asked why additional corrective actions had not been taken regarding CNA3, despite multiple past documented resident concerns, the Administrator stated the incidents occurred before her tenure and that the facility was following the disciplinary process already in place, including a performance improvement plan for CNA3. She stated she was unaware of all the concerns related to CNA3's work documented in the personnel file. She further noted she was not permitted to disclose or utilize CNA3's prior personnel records after the new ownership assumed control. The Administrator stated that all nursing staff received annual abuse prevention training. Review of Review of facility's policy titled Abuse, Neglect and Exploitation dated 3/2005 and revised 6/2005 revealed, An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. A. Written procedures for investigations include: . Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and Providing complete and thorough documentation of the investigation.