

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525596	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2025
NAME OF PROVIDER OR SUPPLIER Complete Care at Hales Corners		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 1 (R20) of 2 residents reviewed for investigations regarding allegations of abuse, that lawn enforcement was notified of potential allegations of abuse.</p> <p>On 4/20/25, R20 told RN (registered nurse) Supervisor-D that CNA (certified nursing assistant)-C pushed R20. The facility immediately placed CNA-C on suspension pending the investigation. The investigation was conducted immediately. The facility failed to notify the police of this allegation of abuse.</p> <p>Findings include:</p> <p>The facility's Abuse, Neglect and Exploitation policy dated 5/28/25 documents: .</p> <p>VII.Reporting/Response</p> <p>A. The facility will have written procedures that include:</p> <p>1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes:</p> <p>a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury or</p> <p>b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.</p> <p>1.) R20 was admitted to the facility on [DATE] with diagnoses of dementia, chronic kidney disease stage 3 and spinal stenosis.</p> <p>R20's Quarterly MDS (minimum data set) dated 4/2/25 indicates R20 has severe cognitive impairment. The MDS also documents that R20 needs maximum assistance with personal hygiene.</p> <p>On 6/16/25 at 9:31 a.m., Surveyor interviewed R20. R20 stated she is happy at the facility and has no concerns with any staff.</p> <p>(continued on next page)</p>		

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Surveyor reviewed the facility self report investigation dated 4/20/25. The self report investigation indicates that on 4/20/25, R20 reported to RN Supervisor-D that CNA-C pushed her. The investigation indicates CNA-C was sent home pending the results of the investigation.</p> <p>NHA (nursing home administrator)-A was notified immediately and the investigation into the potential abuse was initiated immediately.</p> <p>A body check was conducted on R20 and no injuries or discoloration noted.</p> <p>The investigation interviewed staff working with R20 on 4/20/25. Interviewable residents were interviewed regarding CNA-C.</p> <p>R20 was reinterviewed on 4/21/25 and R20 did not remember any incident involving CNA-C.</p> <p>The facility's investigation does not indicate that law enforcement were notified of R20's allegation of abuse.</p> <p>The conclusion of the investigation documents that during cares, CNA-C repositioned R20 onto her side and the action of positioning R20 on her side could have felt like R20 was being pushed.</p> <p>On 6/18/25 at 9:42 a.m. Surveyor interviewed NHA-A. Surveyor asked NHA-A if the facility called the law enforcement regarding R20's allegation of abuse. NHA-A stated NHA-A would have to look to see if law enforcement was called.</p> <p>On 6/18/25 at 10:20 a.m. NHA-A informed Surveyor that the facility did not call law enforcement regarding R20 allegation of abuse. NHA-A stated they did not observe any injuries on R20 so the police were not notified.</p> <p>No additional information was provided as to why the facility did not ensure that R20's allegations of abuse involving a staff member pushing R20 were reported to law enforcement.</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2.) R19 was hospitalized on [DATE] with a change in condition and returned to the facility on 3/11/25. After R19 was readmitted to the facility, on 3/11/25, R19 was sent back to the hospital for increased pain in her knee. R19 was readmitted to the facility on [DATE].</p> <p>On 6/17/25 Surveyor requested the transfer and bed hold notice for R19 hospitalization from 3/5/25 to 3/11/25 and from 3/11/25 to 3/12/25.</p> <p>On 6/17/25 at 1:52 p.m. NHA (Nursing Home Administrator)-A explained to Surveyor that the facility has not been doing the transfer and bed hold notices since they switch over to a new EMR (electronic medical record) in January 2025. NHA-A stated the nurses had been doing the notices when the facility had the old EMR system.</p> <p>No additional information was provided. Based on interview and record review, the facility did not ensure 3 (R49, R19, and R43) of 3 resident's reviewed for hospitalization received the proper notice of transfer, reason for transfer, location of transfer, appeal rights, and name and address (including mail and email) with the telephone number of the Office of the State Long-Term Care Ombudsman.</p> <p>* R49 was transferred to the hospital on 5/20/25 and a transfer notice was not given to R49 and/or R49's representative.</p> <p>* R19 was transferred to the hospital on 3/5/25 and 3/11/25 and a transfer notice was not given to R19 and/or R19's representative.</p> <p>* R43 was transferred to the hospital on 5/12/25 and 6/2/25 and a transfer notice was not given to R43 and/or R43's representative.</p> <p>Findings include:</p> <p>On 6/17/25 at 1:52 PM, Nursing Home Administrator (NHA)- A was interviewed and indicated the facility has not been completing transfer notices for any residents since 1/1/25, when the facility changed medical records systems. NHA-A indicated no transfer notices were issued for transfers to the hospital for the following residents: R19, R43, and R49.</p> <p>The facility's policy titled Transfer and Discharge dated 5/28/25 documents: The facility's transfer/discharge notice will be provided to the resident and resident's representative in a language and manor in which they can understand.</p> <p>1.) On 6/17/25, the Surveyor reviewed R49's medical record and it indicated R49 was transferred to the hospital on 5/20/25. R49's medical record did not include documentation that a transfer notice had been given to the resident and/or their representative for the hospitalization.</p> <p>(continued on next page)</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/17/25 at 3:00 PM, the above findings were shared with NHA-A and Director of Nursing (DON)-B. Additional information was requested if available. None was provided as to why a transfer and bed hold notice were not given to R49 and/or their representative for R49's transfer to the hospital on 5/20/25.</p> <p>3.) R43 was admitted to the facility on [DATE] with diagnosis that include Right leg fracture and Chronic Kidney disease.</p> <p>R43's late entry progress note dated 5/12/25 documents, in part: [R43] was admitted to . hospital . on 5/12/25. Writer contacted resident's daughter to explain bed hold options. Family does not wish to pay for bed hold but does want resident to return to the facility .</p> <p>R43 was hospitalized on [DATE] and returned to the facility on 5/16/25.</p> <p>Surveyor reviewed R43's electronic medical record for documentation that a transfer notice was given to R43. No transfer notice was found.</p> <p>R43's late entry progress note dated 6/2/25 documents, in part: . [R43] was admitted to . hospital . Writer spoke to resident's daughter . regarding bed hold status. Family wants [R250] to return to the facility if needed following this hospitalization but does not wish to pay for the bed hold .</p> <p>R43 was hospitalized on [DATE] and returned to the facility on 6/10/25.</p> <p>Surveyor reviewed R43's electronic medical record for documentation that a transfer notice was given to R43. No transfer notice was found.</p> <p>On 6/17/25 at 12:48 PM, Surveyor interviewed Director of Social Services (SSD)-M. Surveyor asked who is responsible for providing the transfer notice to the resident or resident's family. SSD-M stated that SSD-M takes care of the bed hold notice. SSD-M stated that the Assistant Director of Nursing (ADON)- and nursing staff are typically in charge of presenting the transfer notice to residents and/or families. SSD-M stated that the facility recently changed Electronic Medical Record Systems and before the change, the transfer notice would automatically print with a transfer to the hospital. The new system no longer does that.</p> <p>On 6/17/25 at 12:55 PM, Surveyor interviewed Director of Nursing (DON)-B and ADON-N. Surveyor asked who is responsible for assuring that transfer notices are given to residents or resident representatives when a resident is transferred to the hospital. ADON-N stated that the facility started to do transfer forms again last week. ADON-N stated prior to the new medical record system, which started at the beginning of the year, the old system would automatically print out a packet that would go along with the resident and it included the transfer notice.</p> <p>On 6/17/25 at 3:05 PM, Surveyor informed Nursing Home Administrator (NHA)-A and DON-B of the concern that R43 and/or their representative was not provided a transfer notice when R43 was transferred to the hospital on 5/12/25 and 6/2/25. No additional information was provided.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure residents received treatment and care in accordance with professional standards of practice for 1 (R1) of 12 sampled residents reviewed for a change of condition.</p> <p>*R1 was diagnosed with a wound on 03/09/2025. The facility did not ensure that at the time of R1's initial assessment and diagnosis of a skin wound, a clinician assessed the wound to determine the wound type. The facility did not document the evaluation, assessment, treatment and treatment outcomes for R1's wound.</p> <p>The facility did not have a skin care plan or risk for pressure injuries care plan for R1 until the discovery of R1's wound. R1's Orthopedic specialist was not consulted in the change of condition regarding the orthopedic hardware protruding from R1's skin. The facility did not specify the location of R1's wound on the facility's wound evaluation assessments until 03/26/2025.</p> <p>Findings include:</p> <p>1.) R1 was admitted to the facility on [DATE] following a hospital stay from an ankle fracture resulting in an Open Reduction and Internal Fixation (ORIF) (a surgical procedure used to treat ankle fractures) of the right ankle, with diagnoses which include Dementia (the loss of cognitive function, including memory, thinking, and reasoning, that interferes with daily life).</p> <p>R1's Annual Minimum Data Set (MDS), dated [DATE], documents R1 has a Brief Interview for Mental Status (BIMS) score of 14, indicating R1 is cognitively intact and is at risk for pressure ulcers.</p> <p>R1's Quarterly MDS, dated [DATE], documents R1 has a BIMS score of 3, indicating R1 is severely cognitively impaired, is at risk for pressure ulcers, and has 1 stage 4, unhealed pressure ulcer.</p> <p>Surveyor reviewed R1's care plan, with revision history, and noted the Facility did not have a care plan for R1's risk for pressure injuries prior to R1 developing R1's wound.</p> <p>Surveyor reviewed the Facility provided document titled, WEEKLY PRESSURE ULCER QA&A LOG, dated 06/15/2025 and noted R1 on the list. Surveyor noted R1 is documented on the Facility's list as having a stable, right lateral shin wound.</p> <p>Surveyor reviewed the Facility's documents titled, CAOB- WOUND TEAM: PRESSURE INJURY EVALUATION. Surveyor noted that on 03/09/2025 R1 had a new pressure wound of an unspecified site that was listed as an unstageable pressure injury. The summary on 03/09/2025 documents R1 had a previous scab that has now opened but does not provide the exact location of the open area. The treatment is documented as, cleanse with normal saline followed by skin prep, apply Santyl (Wound debridement: It is used to remove dead tissue (necrotic tissue) from wounds, which helps them heal.) to wound bed and pack with packing gauze followed by foam dressing daily. On 03/12/2025, documents R1's wound has 100 percent slough (a layer of dead tissue, usually yellow or white, that accumulates in the wound bed) on wound bed and edges, with possible bone exposure at base of slough.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/26/2025, documents R1 that R1 has an unstageable, pressure wound of the right outer calf. On 04/02/2025, documents R1 has a stage 4 pressure wound from medical device and documents Area now stage 4 pressure injury r/t (related to) medical device. Now able to see screw from ankle ORIF in 11/2020. Silver screw seen and in center bone noted. On 04/07/2025, documents R1's wound is a stage 4 pressure wound to right, lateral (the side of something, particularly in relation to the body) shin related to a medical device, and documents screw intact. Surveyor noted R1's wound is documented as a stage 4 pressure wound to R1's right, lateral shin through current assessments.</p> <p>Surveyor reviewed R1's Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated March 2025. Surveyor noted that on the day R1's wound was identified, R1 experienced a pain 6 of 10.</p> <p>Surveyor reviewed the Medical Director (MD)-J 's assessments of R1 from 01/31/2025 through current. Surveyor noted that all assessments document R1's skin is intact and warm to touch. Surveyor noted that the assessments did not include a comprehensive evaluation of R1's wound to determine if the wound was caused by pressure or surgical equipment. The assessments also did not document the treatment for R1's wound or the progress of R1's wound treatment.</p> <p>On, 06/17/2025, at 03:14 PM, Surveyor requested documentation from the facility regarding a doctor's evaluation and/or assessment of R1's wound and notification to the doctor when the foreign body was observed coming from R1's wound on 04/02/2025.</p> <p>On, 06/18/2025, at 08:00 AM, Nursing Home Administrator (NHA)-A provided Surveyor with a progress note on 04/02/2025, documenting R1's Power of Attorney (POA) was updated on R1's right lower extremity (RLE), educated that a screw was showing. Discussion with POA regarding consulting an Orthopedic Surgeon to remove the screw or keeping wound clean and treating pain in the Facility. After risk and benefits explained to POA of both options, POA's main goal was to keep R1 comfortable and pain free and to continue wound care and pain management within the facility. Plan of care discussed with R1's Power of Attorney (POA) and MD-J in agreement. Surveyor was also provided a SBAR (Situation, Background, Appearance Review and notify) communication form, dated 03/09/2025 regarding the physician notification of R1's new wound. Surveyor reviewed the document titled PODIATRY GROUP, dated 04/28/2025, which documents that R1 has a painful wound with a dressing in place to R1's lateral right instep/ankle.</p> <p>On, 06/18/2025, at 08:06 AM, Surveyor requested any physician's documentation regarding the evaluation and determination of R1's wound and the evaluation and assessment of the foreign body for R1's wound.</p> <p>On, 06/18/2025, at 08:30 AM, NHA-A provided Surveyor with documents from R1's hospital stay in 11/2020 showing the operation and hardware installed into R1's ankle during that time. Surveyor noted R1 had an Open Reduction and Internal Fixation (ORIF) (a surgical procedure used to treat ankle fractures) of the right ankle on 11/03/2020 by Aurora Orthopedics.</p> <p>On, 06/18/2025, at 08:38 AM, Surveyor requested MD-J evaluation of R1's wound and asked NHA-A to reach out to MD-J to see if MD-J could speak with Surveyor regarding R1's wound. Surveyor informed NHA-A of concerns regarding no Doctor evaluation or assessment for R1's wound. NHA-A indicated that NHA-A has provided all documentation that NHA-A that Surveyor has requested. Surveyor asked NHA-A if Surveyor could speak with MD-J.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On, 06/18/2025, at 09:00 AM, Surveyor received a call from MD-J. MD-J indicated that MD-J is aware of the screw coming from R1's ankle and no further interventions were taken based on R1 and family wishes. MD-J indicated that MD-J is not the wound doctor, but over sees the wound nurse. MD-J indicated that MD-J has assessed R1's wound and there should be notes in the old system. Surveyor noted the Facility's old system changed to the new system prior to the development of R1's wound. MD-J indicated that MD-J would have to go into the system to look at the last time MD-J assessed R1's wound. MD-J indicated that MD-J will only assess wounds if the Wound Nurse needs a second opinion or if there is a concern. Surveyor asked if MD-J assessed R1's wound once the screw became visible. MD-J indicated that MD-J would have to look into that information. Surveyor asked MD-J if MD-J reviews the Wound Nurse's documentation of wounds, MD-J indicated yes, the wound notes are reviewed every 1 to 2 weeks. MD-J indicated MD-J agrees with the Wound Nurse's assessment of R1's wound. Surveyor encouraged MD-J to provide any assessment MD-J documented regarding R1's, MD-J indicated that if MD-J finds MD-J's assessment documentation of R1's wound, MD-J would send the information to NHA-A to provide to Surveyor.</p> <p>Surveyor noted the Wound Nurse was currently out of the country and could not be interviewed.</p> <p>On, 06/18/2025, at 09:32 AM, Surveyor interviewed Registered Nurse (RN)-K in the presence of Director of Nursing (DON)-B. RN-K indicated that RN-K is currently covering for the Wound Nurse and was training with the Wound Nurse for about 2 weeks. RN-K indicated that RN-K is not currently wound certified and just needs to take the test. RN-K informed Surveyor that all wound rounds are done weekly on Mondays. RN-K indicated that she would go around with the Wound RN, the supervisor and DON-B. Surveyor asked RN-K how often MD-J comes to wound rounds, RN-K paused to think, and before RN-K could answer, DON-B interjected saying that MD-J will come a couple times a week to do rounds.</p> <p>On 06/18/2025, at 09:38 AM, Surveyor observed R1's wound with DON-B and RN-L. Surveyor noted R1 to have a small, silver, circular foreign body resembling the head of a small screw, protruding from R1's right, posterior ankle region located laterally from R1's Achilles tendon. Surveyor was only able to observe R1's wound by staff assisting R1 in raising R1's right leg and using a mirror to observe the underside of R1's ankle region. Surveyor observed R1's lower leg circumferentially and no open wounds noted to R1's calf or shin.</p> <p>On, 06/18/2025, at 10:20 AM, Surveyor interviewed NHA-A. Surveyor asked NHA-A who over sees the Wound Care Program to ensure wounds are being assessed, treated and documented properly. NHA-A indicated that the Certified Wound Nurse is the one to see the residents with wounds and update the physician and families. NHA-A indicated that the Facility has recently hired a Nurse Practitioner (NP) that was supposed to start this week or next from Oak Medical. Surveyor asked if NHA-A would expect the physician to be updated regarding R1's screw coming through R1's skin, NHA-A indicated she would have to clarify with the wound team on what they would do. NHA-A indicated that DON-B is in charge of overseeing the wound care program as a whole. Surveyor asked if there was any further information NHA-A has for Surveyor, NHA-A indicated that NHA-A has provided Surveyor with everything. NHA-A informed Surveyor that usually residents will go out to the wound clinic, which is why the Facility is having the NP coming in and the NP would be the dedicated wound care provider.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/20/2025, at 03:07 PM, NHA-A sent an email to Surveyor with the recently hired Wound NP's assessment of R1's wound, dated 06/20/2025. Surveyor noted the NP's diagnosis of R1's wound is documented as, unspecified open wound, right lower leg, initial encounter and other specified complication of internal orthopedic prosthetic devices, implants and grafts, initial encounter. Surveyor noted the NP's wound care assessment included evaluation of R1's wound and the treatment plan.</p> <p>Based on the additional information that was provided, Surveyor conclude that R1's wound was due to R1's internal prosthetic devices protruding from R1's skin and not pressure related as previously documented in R1's medical record.</p> <p>No additional information was provided as to why the facility did not ensure that R1 received treatment and care in accordance with professional standards of practice for R1's wound.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility did not ensure 2 (R19 and R35) of 2 residents received the necessary services for acceptable nutrition.</p> <p>* R19 had a 7.65% weight loss in one month. The weight loss was not communicated to the physician and dietician. A comprehensive assessment was not completed regarding the weight loss. The care plan was not reviewed and updated regarding the weight loss. Interventions were not implemented for R19's weight loss.</p> <p>* R35 required supervision during meals and was observed on two occasions not to receive assistance with meals as per care plan.</p> <p>Findings include:</p> <p>The facility's Weight Monitoring policy dated 5/28/25 documents:</p> <p>4. Weight Analysis: The newly recorded resident weight should be compared to the previous recorded weight. A significant change in weight is defined as:</p> <ul style="list-style-type: none"> a. 5% change in weight in 1 month (30 days) b. 7.5% change in weight in 3 months (90 days) c. 10% change in weight in 6 months (180 days) <p>The following formula may be used to calculate the percentage of weight change:</p> <p>% of body weight loss= (previous weight-current weight/previous weight) x 100</p> <p>Though a significant weight change may not occur, the resident may be identified as below ideal body weight by the Registered Dietician or designee.</p> <p>5. Documentation:</p> <ul style="list-style-type: none"> a. The physician should be informed of a significant change in weight and may order nutritional interventions. b. The physician should be encouraged to document the diagnosis or clinical conditions that may contributing to the weight loss. c. Meal consumption information should be recorded and may be referenced by the interdisciplinary care team as needed. d. If the interdisciplinary care team desires to explore specific meal consumption information for a resident, the Registered Dietician, Dietary Manager, or the nursing department may initiate this process. <p>(continued on next page)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>e. The Registered Dietician or Dietary Manager should be consulted to assist with interventions; actions are recorded in nutrition progress notes.</p> <p>f. Observations pertinent to the resident's weight status should be recorded in the medical record as appropriate.</p> <p>g. The interdisciplinary plan of care communicates care instructions to staff.</p> <p>1) R19 was admitted to the facility on [DATE] with diagnoses of multiple sclerosis, atrial fibrillation and dementia.</p> <p>The significant MDS (minimum data set) dated 3/18/25 indicates R19 has severe cognitive impairments and needs moderate assistance with eating.</p> <p>R19's Nutrition CAA (Care Area Assessment) dated 3/18/25 documents: R19 is underweight. R19's weight at the time of the assessment was 88 lbs and R19 averages 26%-50% meal intake. (R19) also triggered for a mechanical soft diet. (R19) dementia is causing the low intakes and ability to eat without help.</p> <p>R19's most recent comprehensive nutritional assessment dated [DATE] documents: R19 weight at this assessment was 87 lbs. The assessment documents underweight related to dementia as evidence by BMI (body mass index) <18.5. Weight loss gradual; resident has not experienced significant weight change in the past 6 months. The nutritional intervention includes continue current diet/supplements; monitor weight, po (oral) intake, nutrition related lab values, and skin integrity.</p> <p>R19's physician orders dated 2/15/25 indicate R19 is given Boost nutritional supplement twice a day.</p> <p>R19's nutritional problem care plan dated 2/16/25 documents: Monitor/record/report to MD PRN (as needed) s/sx (signs/symptoms) of malnutrition: Emaciation (cachexia), muscle wasting, significant weight loss: 3 lbs in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months. RD to evaluate and make changes PRN.</p> <p>Surveyor reviewed the last 30 days of meal intakes. From 5/29/25 though 6/11/25, R19 ate between 25% to 50% for each meal. From 6/13/25 through 6/17/25 R19 was eating between 25% to 100% of her meals.</p> <p>Surveyor reviewed R19 weights and it documents:</p> <p>6/12/2025</p> <p>80.9 Lbs</p> <p>6/5/2025</p> <p>83.0 Lbs</p> <p>5/29/2025</p> <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>86.0 Lbs</p> <p>5/22/2025</p> <p>86.1 Lbs</p> <p>5/15/2025</p> <p>87.9 Lbs</p> <p>5/8/2025</p> <p>87.6 Lbs</p> <p>5/1/2025</p> <p>90.4 Lbs</p> <p>From 5/29/25 to 6/5/25, R19 lost 3 lbs and from 6/5/25 to 6/12/25, R19 lost 3 lbs. From 5/8/25 to 6/12/25, R19 has weight loss of 7.65%.</p> <p>There is no documentation R19's physician was made aware of the recent weight loss.</p> <p>On 6/17/25 at 12:33 p.m., Surveyor observed R19 being assisted with her lunch meal. LPN (licensed practical nurse)-Q assisted R19 with eating. R19 had mechanical soft ham sandwich, a tomato salad, coffee and a package of [NAME] cookies (hard shortbread cookies). R19 ate all of her sandwich and refused the salad because she didn't like it.</p> <p>On 6/17/25 at 12:40 p.m., Surveyor observed R19 meal tray ticket and the dessert listed was pudding not [NAME] cookies. LPN-Q stated to Surveyor she noticed that R19 was served [NAME] cookies and knew the cookies were not for a mechanical soft diet. LPN-Q stated R19 wanted jello and not pudding. LPN-Q stated she was going to get jello for R19.</p> <p>On 6/17/25 at 3:00 p.m., during the daily exit meeting with NHA (Nursing Home Administrator)-A and DON (Director of Nursing)-B, Surveyor asked to speak with the dietician. NHA-A stated their dietician just started last week and the previous dietician no longer works for the facility. NHA-A stated the dietary manager is responsible for monitoring of weights and dietary manager would report any concerns to the dietician. Surveyor asked to speak with the dietary manager.</p> <p>On 6/18/25 at 9:26 a.m. Surveyor interviewed Dietary Manager (DM)-I, with NHA-A present. Surveyor asked DM-I, what is DM-I's role regarding residents weights. DM-I stated she manages a monthly meeting on weights. DM-I states she gets a print out of all residents weights once a month and the program will trigger residents who have had weight loss. DM-I stated the staff involved in the monthly weight meetings are dietician, nursing, therapy and social service. DM-I states the team comes up with strategies to prevent further weight loss. Surveyor asked DM-I when does she notify the RD (registered dietician). DM-I stated the RD is notified if something pops up out of the blue and is notified of the weight loss data prior to the monthly meeting.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Surveyor asked DM-I, if she was aware R19 in last month had more than 7% weight loss. DM-I stated R19 has been sick with Covid recently and wasn't eating as well. DM-I stated they were scheduled to have the monthly meeting on 6/20/25 and it would have been addressed at that time. Surveyor explained R19 has slowly been losing weight and there is no documentation this was addressed with the physician and interventions put into place based on a comprehensive nutritional assessment.</p> <p>NHA-A stated R19 weight loss should have been addressed and not waited until the 6/20/25 meeting. Surveyor also asked DM-I regarding the observation of [NAME] cookies on R19 meal tray and if it was appropriate for a mechanical soft diet. DM-I stated she spoke with her cook. DM-I stated the cook indicated the facility was out of vanilla wafers, which are appropriate for mechanical soft diets, and thought [NAME] cookies were appropriate. Surveyor explained R19 meal ticket did not indicate any cookies but pudding and that was not on her tray. DM-I stated she understood the concern and will address it with her staff.</p> <p>No additional information was provided as to why the facility did not ensure that R19 received the necessary services for acceptable nutrition.</p> <p>2.) R35 was admitted to the facility on [DATE], with diagnoses including dementia (the loss of cognitive function, including memory, thinking, and reasoning, that interferes with daily life).</p> <p>R35's Significant Minimum Data Set (MDS), dated [DATE], documents Brief Interview for Mental Status (BIMS) score of 2, indicating R35 has severe cognitive impairment and requires supervision or touching assistance with eating.</p> <p>Surveyor reviewed the facility provided list of residents who need assistance at meals, and noted R35 was on the list indicating that R35 required supervision while eating.</p> <p>R35's Activities of Daily Living (ADL) Functional Potential/Rehabilitation and/or Limited mobility care plans documents under the intervention section: EATING: The resident needs supervision / touching assistance by staff to eat. Date Initiated: 01/20/2025.</p> <p>On 06/17/2025, at 09:45 AM, Surveyor observed R35 sitting in a chair in R35's room alone. Surveyor observed R35's meal tray brought to R35's room, and Surveyor noted the Dietary aide delivered R35's tray and placed it on R35's bedside table in front of R35, with the Dietary aide then leaving R35's room.</p> <p>On 06/17/2025, at 09:48 AM, Surveyor observed R35 eating in R35's room unsupervised. At 09:51 AM, Surveyor noted Certified Nursing Assistant (CNA)-P came into R35's room and helped R35 remove lids from R35's cups. At 10:03 AM, CNA-P left R35's room, leaving R35 to eat unsupervised.</p> <p>On 06/17/2025, at 03:14 PM, Surveyor informed the facility of the concern regarding R35 being observed eating with out supervision. Nursing Home Administrator (NHA)-A indicated that under normal circumstances, all residents requiring supervision at meals would sit at the same table in the dining room and someone is supervising the whole time during the meal and if eating in the room they will have an assigned CNA or feeding assistant in the room.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/18/2025, at 10:37 AM, Surveyor observed R35 in R35's room having breakfast. Surveyor noted, no staff in R35's room providing supervision while R35 is eating. R35 began crying and expressed being upset that there was no one there to assist R35 to go to the bathroom. At 10:42 AM, CNA-O came into R35's room to assist R35 to the bathroom.</p> <p>No additional information was provided as to why R35 did not receive supervision to ensure that R35 received the necessary services for acceptable nutrition.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on observation, interview, and record review the facility did not ensure that food was prepared to conserve nutritive value and flavor. This has the potential to effect 3 (R5, R9 and R250) of 3 residents residing at the facility whom receive a puree diet.</p> <p>*Cook-C was observed not following a recipe for preparing texture and modified consistency food for puree diets.</p> <p>Findings include:</p> <p>The facility's policy titled, Pureed Food Preparation dated 5/28/25 documents: Each resident must receive and the facility must provide food that is prepared by methods that conserve nutritive value, flavor and appearance. The policy does not document that the facility must follow a recipe to prepare pureed food.</p> <p>On 06/16/25 at 9:43 AM, Cook-C was observed preparing grilled cheese for residents receiving pureed food. Cook-C was observed putting 8 pieces of untoasted white bread, and 3.5 cups of liquid cheese prepared from a powder mix into the blender. The blended mix was put in a metal cooking container and placed in the oven to keep warm. [NAME] -C was asked for the recipe used for the pureed grilled cheese and Cook-C informed Surveyor that Cook-C does not use a recipe for preparing puree foods.</p> <p>On 6/16/25 at 9:50 AM, Surveyor interviewed Food Service Manager (FSM)-D regarding puree recipes. FSM-D informed Surveyor that recipes for pureed food are available on the computer, but they are not used and the cook just eyeballs puree preparation to make sure it's the right consistency.</p> <p>FSM-D indicated that the cook just purees the food that residents with a regular diet receive. The Surveyor asked if the residents on a regular diet get untoasted white bread with liquid cheese in it. FSM-D said no.</p> <p>On 6/16/25, the facility provided the recipe for pureed grilled cheese that was supposed to be used to prepare puree grilled cheese sandwiches. The recipe documented: Remove portions of grilled cheese sandwich from the regular recipe. Process until fine in consistency. Gradually add hot milk to sandwich mixture while processing.</p> <p>Surveyor noted that the recipe did not indicate how many grilled cheese are used in the recipe but indicated to add 3 and $\frac{12}{12}$ cups of milk.</p> <p>On 6/17/25, at 3:00 PM, at the daily exit meeting, Surveyor informed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B of the above findings. Additional information was requested if available. None was provided as to why Cook-C did not follow recipes to prepare pureed food for residents.</p>		

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide special eating equipment and utensils for residents who need them and appropriate assistance.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility did not provide special assistive eating equipment for 1 (R250) of 1 sampled resident reviewed for assistive eating devices.</p> <p>R250's emergency contact and family member (FM)-E, informed Surveyor that R250 does not always get the adaptive equipment placed on R250's meal tray so that R250 can eat independently. Surveyor observed R250's meal tray ticket and noted that the adaptive equipment listed on the meal tray ticket did not match what was provided on R250's meal tray.</p> <p>Findings include:</p> <p>The facility policy dated 5/28/25 titled, Meal Supervision and Assistance, documents, in part: Check the tray before serving it to the resident to be sure that it is the correct diet ordered and that the food consistency is appropriate to the resident's ability to chew and swallow. Ensure that the necessary non-food items (i.e., silverware, napkin, special devices, straw, etc.) are on the tray; especially assistive and adaptive devices. Report or replace missing items.</p> <p>1.) R250 was admitted to the facility on [DATE] with diagnosis that include Parkinson's disease, Osteoarthritis, Osteoporosis and Unspecified lack of coordination.</p> <p>R250's admission MDS (Minimum Data Set) dated 6/12/25 documents a BIMS (Brief Interview for Mental Status) score that indicates that R250 has a moderate cognitive impairment.</p> <p>R250's Activities of Daily Living Care plan dated 6/7/25 documents, in part: [R250] needs set up or clean up assistance to eat.</p> <p>On 6/16/25 at 9:50 AM, Surveyor interviewed FM-E. FM-E informed Surveyor that R250 needs built up silverware, a split plate and a nosey cup to eat and drink independently. FM-E indicated that the facility does not always supply these utensils on R250's tray.</p> <p>R250 Occupational Therapy Treatment Encounter note dated 6/10/25 documents, in part: [R250] assessed . during meal. Trained built up handled fork and divided plate for increase ease of loading fork. [R250] reports increase ease and shows success with each forkful. [R250] had increase difficulty drinking out of regular cup/lifting up cup. [R250] provided with small nosey cup. [R250] reports it is better as it is lighter. [R250] is able to drink 4 sips then needs assist due to fatigue.</p> <p>On 6/16/25 at 9:50 AM, Surveyor observed R250's breakfast meal tray on R250's bedside table. R250 was finishing eating breakfast. Surveyor observed a meal tray ticket on R250's tray that documented, in part: Adaptive Equip-Built up utensils, small nosey cup, divided plate. Surveyor observed a nosey cup filled with juice and built-up silverware. Surveyor observed a regular glass plate and noted R250 was not supplied with a divided plate.</p> <p>(continued on next page)</p>		

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/16/25 at 1:23 PM, Surveyor observed R250's lunch meal tray on R250's bedside table. R250 was eating lunch. Surveyor observed a meal tray ticket on R250's tray that documented, in part: Adaptive Equip-Built up utensils, small nose cup, divided plate. Surveyor observed built up silverware. Surveyor observed a regular cup of water and a regular cup of coffee and noted R250 was not supplied with a nose cup for R250's liquids. Surveyor observed a regular glass plate and noted R250 was not supplied with a divided plate.</p> <p>On 6/17/25 at 10:39 AM, Surveyor observed R250's breakfast meal tray on R250's bedside table. R250 was eating breakfast while being evaluated by Speech therapist (ST)-F. Surveyor observed a meal tray ticket on R250's tray that documented, in part: Adaptive Equip-Built up utensils, small nose cup, divided plate. Surveyor observed juice in a regular cup and noted R250 was not supplied with a nose cup for R250's liquid. Surveyor observed a regular glass plate and noted R250 was not supplied with a divided plate. Surveyor observed regular silverware and noted R250 was not supplied with built-up silverware.</p> <p>On 6/17/25 at 10:42 AM, Surveyor interviewed ST-F. Surveyor asked who evaluates a resident for adaptive equipment and makes sure the meal tray ticket is correct. ST-F stated that Occupational therapy communicates the need for adaptive equipment, but it is collaborative. ST-F stated that ST-F spoke to the Occupational therapist about the nose cup. ST-F stated that R250 does not need a nose cup because [R250] was refusing. ST-F then asked R250 if R250 wanted the nose cup and R250 indicated that [R250] was fine with a regular cup. ST-F did not address the need for built up silverware or a divided plate with R250 while Surveyor was observing.</p> <p>On 6/17/25 at 1:19 PM, Surveyor observed R250's lunch meal tray on R250's bedside table. Surveyor observed a meal tray ticket on R250's tray that documented, in part: Adaptive Equip-Built up utensils, small nose cup, divided plate. Surveyor observed built up silverware. Surveyor observed water, juice and coffee in a regular cup. Surveyor noted R250 was not supplied with a nose cup for R250's liquids. Surveyor observed a regular glass plate and noted R250 was not supplied with a divided plate.</p> <p>Surveyor noted that over 4 observations, R250's meal tray ticket did not match what R250 received on R250's tray.</p> <p>On 6/17/25 at 10:58 AM, Surveyor interviewed Dietary Aid (DA)-G. Surveyor asked who is responsible for making sure adaptive equipment is listed on the resident's meal tray tickets. DA-G stated that the therapy department communicates the need for any adaptive equipment and that is how it makes it to the meal tray ticket. The cook puts the tray together and makes sure the equipment is correct. DA-G indicated the cook would make sure the plate and silverware are correct and other staff would take care of the liquids on the tray.</p> <p>On 6/17/25 at 1:55 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-H. Surveyor asked if CNA-H delivers meal trays to resident's room. CNA-H indicated that CNA-H does help to deliver trays. Surveyor asked who is responsible for making sure that the meal tray ticket matches what the resident receives. CNA-H stated that when CNA-H delivers a tray, CNA-H will always check to make sure that the ticket and the tray match. Surveyor asked if that includes any adaptive equipment needed. CNA-H stated that CNA-H will make sure that the resident has the adaptive equipment they need.</p> <p>(continued on next page)</p>		

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/18/25 at 9:34 AM, Surveyor interviewed Food Service Director (FSD)-I and Nursing Home Administrator (NHA)-A. Surveyor asked who is responsible for determining what adaptive equipment is needed for each resident. FSD-I indicated that the Occupational Therapist would let FSD-I know what the resident needs and FSD-I will make sure it is placed on the meal tray ticket. Surveyor asked who is responsible for assuring the meal ticket and the resident's tray match and are correct. FSD-I stated that the Dietary aid or whoever delivers the tray should review the tray for accuracy, and that would include any adaptive equipment needed. FSD-I stated that adaptive silverware is typically on the table when a resident eats in the dining room. FSD-I stated that the Dietary aid is responsible for making sure the liquid is served in the correct cup. FSD-I stated that the cook would be responsible for making sure a resident's plate is correct. Surveyor informed FSD-I and NHA-A that Surveyor observed 4 of R250's meal trays and noted that R250 did not always receive the adaptive equipment that is listed on R250's meal tray ticket. FSD-I stated that the facility only has one 4-ounce nose cup, which is the cup that [R250] needs. FSD-I indicated that the 8-ounce nose cup is too heavy for [R250]. FSD-I indicated that FSD-I has ordered more 4-ounce nose cups to accommodate [R250].</p> <p>On 6/18/25 at 9:41 AM, Surveyor informed NHA-A of the concern that R250's meal tray ticket that listed R250 needed adaptive equipment was not always observed being followed. No additional information was provided.</p>		