STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525604	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2026
NAME OF PROVIDER OR SUPPLIER Complete Care at Southpointe		STREET ADDRESS, CITY, STATE, ZIP CODE 4500 W. Loomis Rd. Greenfield, WI 53220	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure 1 out of 2 residents (R20) admitted to the facility with a history of pressure injuries received the necessary care and treatment services to avoid developing a pressure injury.R20 has a significant past medical history of pressure injuries, including needing surgical intervention with skin flaps to heal previous pressure injuries. R20 was at risk for the development of pressure injuries based upon this history. The facility failed to recognize R20's risk factors and implement resident specific measures to prevent the development of pressure injuries. R20 developed a facility acquired, full thickness, unstageable pressure injury.Findings include:Policy review: Pressure Injury Prevention Guidelines date implemented 1/26.Policy: to prevent the formation of avoidable pressure injuries and to promote healing of existing pressure injuries, it is the policy of this facility to implement evidenced-based interventions for all residents who are assessed at risk or who have a pressure injury present.Policy Explanations and Compliance Guidelines: (includes)1. Individualized interventions will address specific factors identified in the resident's risk assessment, skin assessment, and any pressure injury assessment (e.g. moisture management, impaired mobility, nutritional deficit, staging, wound characteristics).4. In the absence of prevention orders, the licensed nurse will utilize nursing judgement in accordance with pressure injury prevention guidelines to provide care and will notify physician to obtain orders.Pressure Relieving Devices:4. The standard mattress for all facility beds are pressure redistribution mattresses.5. The standard seat cushion for wheelchairs are pressure redistribution seat cushions.6. Provide alternative support surfaces as needed. Considerations for utilizing specialized support surfaces:a. medical condition and weight7. Do not use ring or donut shaped devices, synthetic sheepskin pads or mattresses, or egg-crate type mattresses for residents with or at risk for pressure injuries. R20 was admitted to the facility on [DATE] with diagnoses that included: morbid (severe) obesity due to excess calories, end stage renal disease, dependence on renal dialysis, type 2 diabetes mellitus, chronic obstructive pulmonary disease, disorder of muscle and other abnormalities of gait and mobility. A review of the admission MDS (Minimum Data Set), dated 12/16/25, documents for an assessment R20 has a BIMS (brief interview for mental status) score of 15- cognitively intact. R20 has impairment in his range of motion on 1 side of his upper extremity. R20 was receiving therapy services upon admission. R20 was determined to be at risk for developing a pressure injury but did not have any unhealed areas at the time of the assessment reference period. R20 has pressure reducing device for his bed and chair.The Admit/Readmit Assessment, dated 12/11/25, documents under section: C. Skin Integrity/Braden that (R20) has slightly limited sensory perception. (R20) has occasionally moist skin, requiring extra linen change approximately once a day. (R20) walks occasionally and has slightly limited mobility/ ability to change and control body position. (R20) has adequate nutrition. Under friction/shear the assessment documents that (R20) has a problem with this and requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring repositioning with maximum assistance. Skin Observation: skin color is normal. Temperature is warm. Circulation is equal. Moisture is dry. Skin turgor is normal. Skin Integrity: bruising to abdomen, lumbar back, left hip (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: 525604	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2026

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F 0686 Level of Harm - Actual harm Residents Affected - Few	surgical scar, posterior thigh surgical scar, abrasion right wrist and right knee, left knee and left elbow. The assessment also documents that R20 is continent of bowel and bladder.The facility conducted a Braden Assessment on 12/26/25 for R20. The score was 17 points, indicating low risk for developing a pressure ulcer.Surveyor conducted a review R20's individual plan of care and noted that R20 has potential/actual impairment to skin integrity r/t (related to) abnormalities in gait and mobility, DM (diabetes mellitus). This care plan was initiated on 12/11/25 with the following interventions: The resident will have no complications r/t wounds through the review date. Date Initiated: 12/11/2025Revision on: 12/29/2025 The resident will maintain or develop clean and intact skin by the review date. Date Initiated: 12/11/2025 Revision on: 12/29/2025 Encourage good nutrition and hydration in order to promote healthier skin. Date Initiated: 12/11/2025 Encourage me to off my load heels. Date Initiated: 12/11/2025 Encourage/assist me with reposition as needed Date Initiated: 12/11/2025 Follow facility protocols for treatment of injury. Date Initiated: 12/13/2025 Identify/document potential causative factors and eliminate/resolve where possible. Date Initiated: 12/13/2025 Keep skin clean and dry. Use lotion on dry skin. Do not apply on sites of injury. Date Initiated: 12/11/2025. My skin will be assessed on a weekly basis on my scheduled bath day and document findings on a weekly skin assessment. Date Initiated: 12/11/2025 Report any skin redness/impaired integrity areas to my nurse. Date Initiated: 12/11/2025 Risk and benefits of (Specify reposition, positioning devices, good skin care, etc.) were explained. Date Initiated: 12/11/2025 The resident needs monitoring/reminding/assistance to turn/reposition at least every 1-2 hours, more often as needed or requested. Date Initiated: 12/11/2025 Revision on: 03/06/2026 The resident needs pressure relieving/reducing cushions, pillows, sheepskin padding etc. to protect the skin while up IN CHAIR. The resident needs pressure relieving/reducing mattress, pillows, sheepskin padding etc. to protect the skin while IN BED. Date Initiated: 12/11/2025 Revision on: 12/11/2025 Use a draw sheet or lifting device to move resident. Date Initiated: 12/11/2025 Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. Date Initiated: 12/11/2025 Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. Date Initiated 12/11/2025.R20's plan of care also documents that R20 has alteration in kidney function due to end stage renal disease (ESRD). Date initiated: 12/13/2025. Interventions included:* Pressure -redistribution cushion to go with resident to dialysis. Initiated 12/13/2025* Resident specific dialysis schedule. Tuesdays, Thursdays, Saturdays. Time: 5:30 AM to 9:30 AM. Transportation pick-up time 1 hour prior to dialysis at 4:30 AM. Initiated 12/13/2025.Surveyor reviewed the product information for the pressure redistribution cushion that R20 was using in his wheelchair, both at the facility and then also taken to dialysis. The cushion is a emerald Selectis Foam Cushion. This cushion is said to be designed for comfort, pressure redistribution and durability. The weight capacity is 300 pounds. In R20's electronic medical record, located in the miscellaneous section, the facility had scanned in admission/referral information, dated 12/4/25 from the discharging hospital. This hospital paperwork contained past medical history and past surgical history information. 3/2/21 - sacral ulcer repair3/16/21 - gluteal flap debridement and readvancement3/23/21 - sacral ulcer repair3/31/21 - STSG (split thickness skin graft) to left buttocksR20's history of sacral injury repair, gluteal flap debridement and skin graft to the left buttocks was not documented, by the facility, in any other part of the medical record. R20's plan of care for potential/ actual skin impairment did not take this significant history of pressure injury care and treatment into account when assessing R20's risk factors and developing a plan of care and interventions. The facility assessed R20 to be at low risk for developing a pressure injury, even though there was a documented history of pressure injury treatment.On 2/8/2026 at 9:15 PM, eINTERACT SBAR (Situation, Baseline, Assessment, Recommendation) Summary for Providers: Situation: The Change In in Condition (CIC)/s reported on this CIC Evaluation are/were: Skin wound or ulcer. Resident/Patient is in the facility for: Long Term Care Primary Diagnosis is: M62.82 (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	RHABDOMYOLYSIS. Relevant medical history is: COPD (chronic obstructive pulmonary disease), Diabetes, Chronic Renal Failure/ESRD (end stage renal disease). Outcomes of Physical Assessment: Positive findings reported on the resident/patient evaluation for this change in condition were: (blank). Skin Status Evaluation: Wound - Pain Status Evaluation: Does the resident/patient have pain? (blank). observations, evaluation, and recommendations are: Open area noted to sacrum/buttocks. Describe with measurements. Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: A. Recommendations: APN (Advanced Practice Nurse), Wound care to evaluate and treat. B. New Testing Orders: C. New Intervention Orders (none noted) This was written by LPN (Licensed Practical Nurse) - U. Surveyor noted there were no measurements or description of the wound/wound bed included in this information including the specific side/location of the pressure injury except sacrum/buttocks.A nursing note dated 2/8/2026 at 9:43 PM; Wound noted to right buttock during cares. Site was cleaned and dressing was applied. MD notified. On 2/8/26 at 9:58 PM, LPN U documented on an admission head to toe skin form. New pressure injury to right buttock measures 1.8 cm x 0.2 cm x 0.2. No drainage. No signs/ symptoms of infection. No complaints of pain. Surveyor noted there was no admission on 2/8/26. There is no indication an RN assessed R20's pressure injury to determine stage and document the characteristics of R20's facility acquired pressure injury.On 2/8/26, the facility conducted a Braden Skin Assessment. The score was 16 and indicated R20 is at low risk for pressure injury development. Surveyor was also provided a copy of the skin injury report dated 2/8/26 7:00 PM prepared by LPN- U. Small bleeding open area noted to right gluteal cleft/sacrum area during cares. Resident stated, I don't notice anything there. MD updated, wound care to follow. (R20) denies pain. Immediate intervention: area cleansed, and dry dressing applied. DON (Director of Nursing) notified 2/8/26 9:43 PM. MD notified on 2/8/26 at 9:43 PM. Family notified on 2/8/26 at 9:26 PM.A nursing note dated 2/9/2026 at 03:08AM documents; R20 is being monitored for an open area on the right buttock. TX (treatment) applied, and no pain or discomfort noted. On 03/12/2026 7:51 AM Surveyor conducted a review of the information that DON- B provided regarding R20's sacrum wound, and original assessment completed by Wound Care RN- I. The following was reviewed:Wound assessment 2/9/26sacrum/ buttock (left) Surveyor noted the documented information from 2/8/26 (date pressure injury was originally noted) indicated the area was located on the right side.11.0 cm x 7.0 cm by depth is undetermined. Unstageable.70 % slough, 20 % epithelial, 10% sloughpoorly defined (wound edges), hyperpigmentedChamoysyn q (each) shift (treatment ordered) This assessment was signed by Wound RN- I on 2/9/26. 2/9/26 IDT (interdisciplinary team) review: Alert and orientated x4, able to make needs known. Synopsis: Open area to sacrum/ buttocks. DX (diagnoses): ESRD with dialysis, HTN (hypertension), COPD (chronic obstructive pulmonary disease), GERD (gastroesophageal reflux disease), HLD (hyperlipidemia), Hyperparathyroidism, OSA (obstructive sleep apnea), DM11 (diabetes mellitus type 2), OA (open area). Interventions in place: offer to off load heels, pressure reducing mattress, foam w/c (wheelchair) cushion, Nephro (kidney), check for incontinence every 2 hours. Root Cause: Pressure possibly due to prolonged sitting, Interventions: ROHO cushion and dialysis updated to use ROHO cushion during treatments, heel boots, a/p (alternating pressure) air mattress, Prostat (nutritional supplement), reposition every 2 hours, [NAME]-Vite, offer to lay down after lunch. The following physician orders were obtained on 2/9/26:*A/P (alternating pressure) Air mattress to bed. Ensure function and placement every shift. Settings between 260lbs -300lbs. Every shift for prevention/healing. Active 2/9/2026 2:00 PM *Reposition every two hours. every 2 hours for prevention/wound healing. Active 2/9/2026 11:00 AM*Pressure relieving boots while in bed as much as tolerated or allowed. every shift for protection. Active 2/9/2026 2:00 PM.*Roho Cushion in w/c. Check for proper inflation q-shift (each shift). every shift for wound care. Active 2/9/2026 2:00 PM. *Cleanse sacrum/ buttocks wounds with soap and water followed by apply Chamoysn ointment each shift and as needed. Every shift for wound care. Active 2/9/26 at 9:09 AM.R20's individual plan of care was updated on 2/9/26 for the potential/ actual impairment to skin integrity due to abnormalities in gait and mobility. The (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	plan documents that R20 on 2/8/26 has a pressure ulcer to the sacrum/ buttocks. Interventions were updated:*A/P air mattress to bed. Ensure function and placement every shift. Settings between 260-300 pounds. Initiated 2/9/26.*Offer to lay down after lunch. Initiated 2/10/26.*Reposition every 2 hours. Initiated 2/9/26. * Pressure relieving boots while in bed as much as tolerated or allowed. Initiated 2/9/26.* Roho cushion in wheelchair. Check for proper inflation each shift. Initiated 2/9/26. Nursing note dated 2/9/2026 at 9:55 PM; (R20) on report for OA (open area) to R (right) buttock, treatment in place. Encouraged to ambulate and reposition every 2 hours.Nursing note dated 2/10/2026 05:16 AM; (R20) is being monitored for open area on the right buttock. Nursing note dated 2/10/2026 at 1:43 PM; Remains on report for open area to buttocks. (R20) has no complaints of pain or discomfort. Treatment applied per order. Tylenol administered for 6/10 pain. No other complaints or concerns at this time.Nursing note dated 2/10/2026 at 9:32 PM; (R20) on report for open wound to R (right) buttock. Chamosyn cream applied as ordered. Repositioned 2 hrs. at this time.Nursing note dated 2/11/2026 at 3:43AM; (R20) on report for open wound at the right buttocks. Denies any pain. Treatment applied.Nursing note dated 2/11/2026 at 1:20 PM; (R20) monitored for o/a (open area) R buttock. Seen per wound team. (R20) out of facility with friends at this time. Prior to leaving, no c/o (complaints of) pain or discomfort. Ate breakfast and took all medications.Nursing note dated 2/11/2026 at 9:36PM; (R20) monitored for OA to Right buttock. Tx (Treatment) applied. No c/o pain. Repositioned in bed q2hrs (Every 2 hours). Toileting cares provided by staffOn 2/11/26, APNP (Advanced Practice Nurse Practitioner)-S conducted an initial assessment of R20's new acquired pressure injury. The following is from the progress note:Reason: Wound Initial Visit Type: Wound Care Initial Evaluation Date: 02/11/2026. Chief Complaint: wound of Left side sacrum. (R20) is a pleasant [AGE] year old who is a resident at (name of facility). He/ she has a medical history of HTN, incontinence, ESRD, DM, and morbid obesity. I am consulted to assess a new pressure injury to the left side of his/her sacrum. (R20) is seen today sitting up in his wheelchair and can stand with assistance and his/her walker. (R20) has a good appetite and sleeps well. There is significant scarring noted during assessment which appears surgical, (R20) stated that he had wounds in this area in the past and has had a previous flap during the covid pandemic, per patient. No fevers or chills or additional skin concerns. Interventions in Place: Pressure reduction devices, mattress per facility protocol, cushion per facility protocol; nursing and wound care, nutritional support, PT/OT (physical therapy/occupational therapy) if needed. Diagnosis that could affect wound healing: Previous wound with flap closure, morbid obesity, diabetes mellitus, ESRD (end stage renal disease) on HD (hemodialysis), Rhabdo (rhabdomyolysis), history of incontinence of stool and some urine. Physical Examination: L sacrum- unstageable Wound measuring approximately 8 x 7 cm by UTD (unable to determine) consisting of 60% stable eschar, 10% dry granular tissue and 30% epithelial scar tissue. There is evidence of a surgical incision which (R20) says he did have a previous flap closure in the past on the same area. Scant serous drainage noted. Wound edges are well-defined. No obvious sign of infection or any odor Status: New. Assessment and Plan: Pressure ulcer of unspecified buttock, unstageable * Located in the left side of his/her sacrum. Ordered Santyl and dry dressing to affected (sic) area. Continue offloading efforts, alternating pressure mattress and diligent peri care with toileting. (R20) states he had a wound here in the past, unsure if it was a pressure injury or other type of wound as R20 doesn't remember the origin, but he did have a surgical flap many years ago. Unable to find any surgical history amongst (sic) his DC (discharge) summary with more information regarding his previous wound in this area. Discussed with wound (RN- I) general wound care instructions: Keep the wound clean and dry - Monitor for signs of infection (increased redness, warmth, swelling, drainage, odor, or pain) - Maintain adequate nutrition and hydration to support healing- Report any changes in wound appearance or symptoms to healthcare team. Wound care re-evaluation in 1 week.Surveyor noted the initial wound documentation and ongoing reference to R20's pressure injury by facility nursing staff document the facility acquired area to be located on R20's right side. Wound RN-I and APNP-S assessed the area to be located on R20's left side.On (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	2/18/2026 at 08:30AM, Wound APNP-S completed an assessment/wound care follow-up for R20. Chief complaint: Wound of Left side sacrum. (R20) is seen today lying in bed. He has no pain complaints in the wound. He eats and sleeps well, eating all his/her breakfast. No fever or chills or additional skin concerns. Diagnosis that could affect wound healing: Previous wound with flap closure, morbid obesity, HTN, DM, ESRD on HD, Rhabdo history of incontinence of stool and some urine. Physical Examination: L (left) sacrum- unstageable. Full thickness wound measuring approximately 4 x 11 cm by UTD consisting of 60% stable eschar, 10% granular tissue and 30% epithelial scar tissue bridge. There is evidence of a surgical incision which (R20) says he did have a previous flap closure in the past on the same area. Scant serous drainage noted. Wound edges are well-defined with new epithelial growth noted. No obvious sign of infection or any odor. Status: stable. Plan: Cleanse wound, apply Santyl to necrotic tissue and cover with xeroform and dry dressing daily and prn (as needed). On 2/25/2026 at 08:45AM, Wound APNP-S completed an assessment/follow-up wound care. Chief Complaint: wound of Left side sacrum. (R20) is seen today lying in bed. He has no pain complaints in the wound and appears comfortable during assessment. He eats and sleeps well, eating most of his meals. Physical Examination: L sacrum- unstageable. Full thickness wound measuring approximately 4 x 10 cm by UTD consisting of 60% softening eschar, 10% granular tissue and 30% epithelial scar tissue bridge. Moderate malodorous serous drainage noted. Wound edges are well-defined with new epithelial growth noted. No obvious sign of infection or any odor after cleansing wound. Status: improving. Plan: Cleanse wound, apply Santyl to necrotic tissue, fb (followed by) Dakin's moist gauze (1 - 4x4) and cover with dry dressing daily and prn.On 3/4/2026 at 08:15AM, Wound APNP- S completed an assessment/ follow-up wound care. Chief Complaint: Wound of Left side sacrum. (R20) is seen today lying in bed. He has no pain complaints in the wound and appears comfortable during assessment. He eats and sleeps well, eating most of his/her meals. No fever or chills or additional skin concerns. (R20) is agreeable to a sharp debridement today after reviewing risks and benefits. He gave verbal consent. Physical Examination: L sacrum- unstageable. Full thickness wound measuring approximately 3.5 x 6 cm by UTD with an undermine from 12-2 o'clock with the deepest at 1' o'clock measuring 4 cm. Consisting of 80% loosened soft eschar, 20% granular tissue. Moderate malodorous serous drainage noted. Wound edges are well-defined with new epithelial growth noted. No obvious sign of infection or any odor after cleansing wound, sharp debrided 100% of the necrotic eschar revealing well adherent slough. Status: improving. Plan: Cleanse wound, apply Santyl to necrotic tissue, fb Dakin's moist gauze (1 - 4 x 4) and cover with dry dressing daily and prn. Procedure: bedside surgical excisional debridement of the L side of his sacrum. Reason for procedure: presence of necrotic tissue. Description of wound: Full thickness wound measuring approximately 3.5 x 6 cm by UTD with an undermine from 12-2 o'clock with the deepest at 1 o'clock measuring 4 cm. Consisting of 80% loosened soft eschar, 20% granular tissue. Moderate malodorous serous drainage noted. Wound edges are well-defined with new epithelial growth noted. Size of wound after procedure: no change in measurement. Depth of procedure: approximately 2 cm. Tissue type removed: soft loose eschar. Instruments used: forcep and iris scissor Patient (R20) tolerance: tolerated well, denied pain. No bleeding. Dressing applied: yes, Santyl and Dakin's moist gauze. Treatment plan: Cleanse wound, apply Santyl to necrotic tissue, fb Dakin's moist gauze (1 - 4x4) and cover with dry dressing daily and prn.On 3/12/26 at 8:45 AM, Surveyor interviewed Wound RN-I regarding R20's facility acquired pressure injury to the sacrum/buttocks. Surveyor asked why the assessment on 2/8/26, performed by LPN-U was very different from the assessment that RN- I completed on 2/9/26. Surveyor was referring to LPN- U documenting a small bleeding open area to R20's right gluteal cleft/sacrum and Wound RN-I (12 hours later) documenting R20 had an unstageable pressure ulcer to the sacrum/buttocks measuring 11 cm x 7 cm by unable to determine depth. Wound RN- I stated that he believes LPN- U only measured the open area that had the small amount of bleeding, and his assessment referenced the entire area on the skin that appeared soft, spongy and with dark colored slough. Wound RN- I stated R20 has dark skin color so it may have been difficult for (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	LPN- U to observe the entire area. Wound RN-I stated that the treatment was obtained in the morning of 2/9/26 and then Wound Nurse Practitioner (APNP-S) came on 2/11/26 and assessed the area and changed the treatment to something a bit more aggressive. Surveyor asked Wound RN-I why staff were documenting on the pressure injury being located on the right buttocks in the progress notes and weekly skin checks. Wound RN- I stated that he is not sure why, the area was on the sacrum and left side. They may have been following LPN- U's initial assessment. Surveyor asked Wound RN-I why R20 developed the unstageable pressure injury. Wound RN-I stated that there were interventions in place prior to the area developing. R20 had a cushion in his wheelchair but we don't know what (R20) is sitting on when he is at dialysis. Wound RN- I stated that he obtained orders for a ROHO cushion and alternating air mattress after the area developed and also encouraged (R20) to rest in bed after lunch. Wound RN-I stated the wound is evolving, they needed to break down the slough and it is now forming granulation pockets. The Santyl treatment is doing its job. On 03/12/2026 at 11:11 AM, Surveyor conducted an interview with DON- B. DON- B stated that the initial assessment, completed by LPN-U measured the open area, the area that actually was seen with blood. DON- B stated that if it isn't open, sometimes they (Nursing) don't measure the whole thing. LPN- U measured the area he found concerning, where it was bleeding. Surveyor asked DON-B about Wound RN-I's assessment. DON- B stated Wound RN- I's measurements, the next morning, were documented on paper, which is what he prefers. He saw the area about 12 hours after LPN-U assessed it. DON-B stated it did not grow that much in size; it is just different measurements. DON-B stated that the treatment ordered is for sacrum/buttock area, not just the right buttock. Surveyor shared concerns that staff continued to document that they were treating and monitoring the right buttocks. DON- B stated that the team discusses wounds in morning meeting, saw there was an open area, and Wound RN- I saw wound around 9:30AM or so.On 3/12/26 at 1:13 PM, Surveyor interviewed Wound APNP-S regarding R20's pressure injury to the sacrum. Wound APNP- S stated that she recalls first seeing the wound and it was a large area, and it was all eschar. Wound APNP-S stated that it does not seem like the area would just happen overnight. Wound APNP-S shared R20 had significant scar from his hip across the back. R20 told Wound APNP- S that he had surgery where they did a flap repair. Wound APNP-S stated that she was not aware of that medical history and did look in the medical record. Surveyor shared that hospital paperwork, prior to admission, contained medical history documenting on 3/2/21 - sacral ulcer repair, 3/16/21 - gluteal flap debridement and readvancement, 3/23/21 - sacral ulcer repair, 3/31/21 - STSG (split thickness skin graft) to left buttocks. Wound APNP-S stated there is concern for how long he is sitting in his wheelchair and sitting at dialysis without changing positions. Wound APNP-S stated that an unstageable area, on dark colored skin, is easily missed. Wound APNP-S stated an LPN may not be able to identify soft eschar with dark pigmented skin. Wound APNP- S stated that wound is improving due to the area being debrided, the necrotic tissue is going away. On 3/12/26 at 12:45 PM, Surveyor observed R20 receive wound care provided by Wound RN- I and Unit Manger- L. The following was observed by the Surveyor. EBP (enhanced barrier precautions) and hand hygiene performed appropriately. R20 lying on their right side with a towel over left thigh. A large scar noted traveling from left hip to top of buttocks with indentation of skin (CDI-clean dry & intact) in fold. Left buttocks wound: (12 noon to 3 o'clock) ABD (abdominal) pad dated 3/11. ABD pad removed, gauze packing removed with no drainage noted. Wound measures 3.5cm x 6 cm. No eschar noted, 30% granulation, 70% slough. Tunneling noted going up towards head/neck. Measured at 4.5 tunneling. Edges noted with fine line of slough. Santyl applied to gauze, wound packed and FBD (foam border dressing) applied dated 3/12. Right buttocks CDI, dime size healed previous wound noted at 10 o'clock on left buttocks.On 3/12/26 at 1:00 PM, Surveyor interviewed DON-B regarding the above treatment observations and concerns that R20 was not provided with the appropriate services to avoid the development of the unstageable pressure ulcer to his sacrum. DON-B stated that the facility had a pressure-reducing cushion in his wheelchair and a pressure-reducing mattress on the bed. R20 was more mobile when he was first admitted . Therapy never said there was a need for more pressure (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Complete Care at Southpointe		STREET ADDRESS, CITY, STATE, ZIP CODE: 4500 W. Loomis Rd. Greenfield, WI 53220	

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F 0686 Level of Harm - Actual harm Residents Affected - Few	relief. DON-B stated that she can't control what happens at Dialysis and that they did call dialysis to make sure that R20 was using the ROHO cushion during treatments. Surveyor asked if this was after the pressure injury developed. DON-B indicated yes and stated that the facility did everything they needed to. Surveyor asked if DON-B was aware of R20's history of pressure injuries to the sacral area and surgical repair. DON-B stated that everyone saw that R20 had big scars but R20 never told us what they were from. On 3/16/26 the facility submitted additional information to review regarding R20 developing a facility acquired unstageable pressure injury. The information included discharge documents, the SBAR, nurse practitioner documents, Braden assessments, communication with dialysis dated 2/12/26, etc. The facility shared R20 had been with the facility for nearly two months before the pressure injury developed. The facility contended R20 was admitted with the wheelchair & cushion from hospitalization at the VA (Veterans Affairs) stating the VA would have been aware of R20's history and risk when providing this equipment. Surveyor noted the facility did not assess the equipment and risk factors for R20's routine after moving into the facility to determine appropriateness of equipment or set clear parameters for repositioning and offloading to address possible risk factors for R20. The facility also shared the initial nurse (LPN) deferred obtaining a measurement due to the complexity of the skin presentation at the time. Surveyor noted LPN-U did document a measurement (1.8 x .2 x 0.2) which was very different than the measurement obtained on 2/9/26 (11 x 7 x UTD) by Wound RN-I. Surveyor noted concern facility staff did not notice a change in R20's skin until the skin opened and was determined to be unstageable and individualized risk factors for R20 were not assessed by the facility and addressed in a preventative plan of care.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based upon interview and record review, the facility did not ensure the mandatory staffing data submitted for the fourth quarter of 2025 (July 1- September 31) was accurate based on payroll and other verifiable and auditable data in a uniform format according to specifications established by Centers for Medicare and Medicaid Services (CMS). During review of the payroll-based-journal (PBJ) staffing data for the facility, the facility was triggered for excessively low weekend staffing. This had the potential to affect all 92 residents. Findings include: The facility's Assessment was reviewed, including staffing hours and acuity levels of care being provided. The facility's assessment documented the ratio for staffing needs per resident in the facility and triggered for low weekend staffing for the fourth quarter of 2025. Surveyor reviewed nursing schedules, along with the nurse staff posting hours for that time period and noted that there were no documented trends or gaps in weekend staff coverage. On 3/11/2026, at 12:41 PM, Surveyor interviewed Scheduler-M about the nurse and Certified Nursing Assistant (CNA) schedules. Scheduler-M stated they had been in this role since 2023. Scheduler-M stated the weekend staffing is the same as the staffing during the week. Scheduler-M stated there is a weekend supervisor in the facility during the weekend that is not accounted for during the week, but all other staffing is the same. Surveyor shared with Scheduler-M the concern the facility triggered for low weekend staffing from July 1 through September 30, 2025. Scheduler-M stated the facility switched systems that they were using to report PBJ staffing data in January 2026. Scheduler-M was not sure who did the actual submission of data but knew that prior to using the new system for reporting, Scheduler-M had to give Human Resources the additional information if a salaried employee covered a shift. Scheduler-M stated the new system picks up those staff members because they now clock in if they are working an additional shift or duty so PBJ staffing data is correct. Scheduler-M stated the facility always has enough staff; if there are any call-ins, Scheduler-M can find someone to cover the shift. Scheduler-M stated they do not use any agency staff and employees are willing to cover the shifts because they offer bonuses and overtime. Scheduler-M stated Scheduler-M is also a CNA so Scheduler-M will occasionally cover a shift as well as the nursing managers. On 3/11/2026 at 12:51 PM, Surveyor shared with Nursing Home Administrator (NHA)-A the facility triggered for low weekend staffing for the fourth quarter (July 1-September 30, 2025). NHA-A stated the facility switched payroll systems which is what is used to report PBJ data starting in September 2025 and was rolled out fully January 2026. No additional information was provided as to why the facility did not ensure that mandatory staffing data submitted for the fourth quarter of 2025 (July 1- September 30) was accurate based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, the facility did not ensure their abuse policy and procedure was implemented for 1 of 8 employees reviewed for 4-year background checks potentially affecting a portion of the 97 residents residing in the facility. Certified Nursing Assistant (CNA)-R did not have an up-to-date background check completed within the four-year time frame. Findings include: The facility policy and procedure titled Abuse, Neglect and Exploitation dated 3/2/2026 documents: 1. Screening A. Potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. 1. Background, reference, and credentials' checks shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers, and consultants. 2. Screenings may be conducted by the facility itself, third-party agency or academic institution. 3. The facility will maintain documentation of proof that the screening occurred. On 3/10/2026, Surveyor requested from Nursing Home Administrator (NHA)-A the personnel files for eight employees to review for the required background checks. CNA-R was hired on 11/2/2020. CNA-R's Background Information Disclosure (BID) form, the Department of Justice (DOJ) letter, and the Interagency Border Inspection System (IBIS) form were completed on 9/25/2020, prior to CNA-R beginning employment, and on 3/10/2026, after Surveyor had requested the information. Surveyor noted six years between background checks; a background check should have been completed in September 2024. In an interview on 3/11/2026 at 9:44 AM, Surveyor asked Director of Human Resources (DHR)-G if there was a background check completed for CNA-R between 2020 and yesterday, 3/10/2026. DHR-G stated when Surveyor had asked for CNA-R's background check information, DHR-G noticed it had not been completed in the last four years. DHR-G stated DHR-G did an audit of all employee records and DHR-G was the only employee DHR-G could not find current paperwork for. NHA-A stated the facility was purchased by another company in 2022 and all employees had background checks completed at that time. Surveyor asked NHA-A when had the background checks been completed. NHA-A stated the background checks were completed in June and July of 2022. NHA-A stated NHA-A understood documentation was needed to show the background checks were completed and they were unable to find any forms at that time. On 3/12/2026 at 3:54 PM, NHA-A provided the DOJ letter dated 2/10/2022. NHA-A stated NHA-A and DHR-G were still looking for the BID and IBIS and will provide them when they are located. On 3/13/2026 at 4:34 PM, NHA-A sent an email with CNA-R's BID form signed on 2/10/2022. No IBIS form was provided. Surveyor noted CNA-R's BID form and DOJ letter were both dated 2/10/2022; a new background check for CNA-R should have been completed by 2/10/2026, a month prior to the recertification survey. The facility completed a background check on 3/10/2026, one month beyond the four-year timeline, after it was requested by Surveyor.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility did not store food in accordance with professional standards for food service safety on the unit refrigerators for three of the four units in the facility, potentially affecting the residents residing on 3 units in the facility. *Unit 1 refrigerator was 52 degrees, above the facility determined temperature range. *Unit 2 refrigerator was 34 degrees, below the facility determined temperature range. *Unit 3 did not have a thermometer in the freezer as indicated in the facility policy. An undated bag of opened, unsealed mixed fruit was observed in the freezer. Findings include: The facility policy and procedure titled Monitoring of Refrigerator Temperature dated 5/2025 documents: Policy: It is the policy of this facility to maintain temperatures of coolers and freezers at the appropriate temperature to promote food safety. This policy also addresses refrigerated storage. Policy Explanation and Compliance Guidelines: 1. Logs will be kept at the nurses station for the freezer or refrigerator unit. a. Temperatures will be checked and logged once per day by designated personnel. b. Logs will be changed out and filed each month. 2. Thermometers shall be placed inside each cooler/freezer. 3. All refrigerators must be kept between 36 and 46 degrees F. The United States Food and Drug Administration (FDA) website https://www.fda.gov/food/buy-store-serve-safe-food/refrigerator-thermometers-cold-facts-about-food-safety documents: To ensure that your refrigerator is doing its job, it's important to keep its temperature at 40 degrees F or below; the freezer should be at 0 degrees F. The facility policy and procedure titled Use and Storage of Food Brought in by Family or Visitors dated 3/2026 documents: 2. All food items that are already prepared by the family or visitor brought in must be labeled with content and dated. 1.) On 3/12/2026 at 10:31 AM, Surveyor observed the refrigerator and freezer on Unit 1. The thermometer in the refrigerator read 52 degrees F. Surveyor noted Registered Nurse Unit Manager (RNUM)-L went into the refrigerator after Surveyor stepped away. Surveyor asked RNUM-L if there was a temperature log for the refrigerator. RNUM-L stated Director of Nursing (DON)-B wanted all the logs the day before so RNUM-L would have to go get it from DON-B. RNUM-L returned to the unit at 10:41 AM with the temperature log in hand. The log documented the refrigerator temperature was consistently 40 degrees F. RNUM-L stated temperatures are taken on the night shift. Surveyor shared with RNUM-L the observation of the temperature of the refrigerator was 52 degrees F. RNUM-L stated RNUM-L saw that was the temperature and turned the thermostat down. RNUM-L stated the refrigerator was being cleaned before and maybe, when they were wiping it out, they bumped the thermostat setting. Surveyor and RNUM-L looked at the thermometer and the temperature was 48 degrees F. 2.) On 3/12/2026 at 10:44 AM, Surveyor observed the refrigerator and freezer on Unit 2. The thermometer in the refrigerator read 34 degrees F. Licensed Practical Nurse Unit Manager (LPNUM)-K made the same observation. LPNUM-K stated LPNUM-K had just gone through the refrigerator to make sure all was right prior to Surveyor coming to look at it. LPNUM-K stated the refrigerator was a little too cold and adjusted the thermostat to bring it into the desired range. 3.) On 3/12/2026 at 10:51 AM, Surveyor observed the refrigerator and freezer on Unit 3. No thermometer was found in the freezer. Surveyor observed a bag of mixed fruit in the freezer. The bag was open to the air and did not have any label or date on it. LPN-C was present when Surveyor observed the freezer and bag of fruit. Surveyor asked LPN-C if there was a thermometer for the freezer. LPN-C did not see a thermometer and stated LPN-C has never logged a temperature for the freezer; the log only asks for a refrigerator temperature. Surveyor shared with LPNUM-K the observation of no thermometer in the freezer on Unit 3 and the opened, unlabeled bag of mixed fruit. Surveyor brought LPNUM-K to the Unit 3 refrigerator. The bag of mixed fruit had been discarded into the garbage can. LPNUM-K stated LPNUM-K did not observe the mixed fruit in the freezer; Surveyor shared that other staff members on Unit 3 observed the fruit and most likely threw it away because it was unlabeled and open to the air. LPNUM-K provided a thermometer for the Unit 3 freezer. On 3/12/2026 at 3:41 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PM, Surveyor shared with Nursing Home Administrator (NHA)-A the observations made on Unit 1, Unit 2, and Unit 3. Surveyor shared the concerns that two of the refrigerators were not in the range the facility determined was acceptable, the freezer on Unit 3 did not have a thermometer in it, and an opened, unlabeled bag of mixed fruit was in the freezer of Unit 3. Surveyor shared with NHA-A that staff members were present when these were observed and the staff members addressed the concerns after it was brought to their attention by Surveyor. On 3/13/2026 at 4:25 PM, NHA-A emailed a response to surveyor indicating the observations made by Surveyor during the survey process were investigated by the facility and confirmed that each of the concerns brought forward by Surveyor were addressed by staff after they were brought to their attention by Surveyor.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure 1 (R62) of 2 residents reviewed abuse, neglect, misappropriation and exploitation was free from misappropriation of funds and possible exploitation.On 10/31/25 the facility was notified by Adult Protective Services of an allegation Certified Nursing Assistant (CNA)-Q had misappropriated R62's funds. Investigation revealed CNA-Q misappropriated funds from R62 using their debit card but also convinced R62 to provide R62 with cash, R62's PayPal account information to link R62's PayPal account to CNA-Q's account, and use of R62's cell phone. Findings include:The facility policy titled Code of Conduct revised 11/2025 documents: Policy: The purpose of this policy is to guide employees with respect to standards of conduct expected by this company as part of its compliance and ethics program. Improper activities could damage the company's reputation and otherwise result in serious adverse consequences. All employees are expected to adhere to acceptable business practices and exhibit a high degree of personal integrity and professionalism at all times. Procedure: 1. Conduct that interferes with the safe operation of our company brings discredit to the company or its residents or staff, or is offensive to a resident, family member, visitor, or employee will not be condoned and can be grounds for disciplinary action. 2. Examples of conduct and behavior that are considered inappropriate and are therefore prohibited by this policy may include: .a. Misuse or abuse of nursing home funds, dishonesty, theft, misrepresentation, conflict of interest, or false statement in connection with any aspects of employment.t. Misappropriation of facility/ patient funds, securities, supplies or other assets.6. Am employee may be subject to disciplinary action, up to and including termination when: .b. The employee violates any of our company's policies, rules, regulations, or procedures.The facility policy titled Abuse, Neglect, Exploitation revised 3/2/2026 documents: Policy: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. II. Employee Training:A. New employees will be educated on abuse, neglect, exploitation, and misappropriation of resident property and exploitation.B. Existing staff will receive annual education through planned in-services and as needed.C. Training topics will include:1. Prohibiting and preventing all forms of abuse, neglect, misappropriation of resident property .4. Reporting process for abuse, neglect, exploitation, and misappropriation of resident property .III. Preventing Abuse, Neglect, and Exploitation: The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property . F. Provide residents, representatives, and staff information on how and to whom they may report concerns, incidents and grievances without the fear of retribution; and providing feedback regarding the concerns that have been expressed .H. Assigning responsibility for the supervision of staff on all shifts for identifying inappropriate staff behaviors.VII. Reporting/ Response:A. The facility will have written procedures that include:1. Reporting of all alleged violations to the Administrator, state agency, adult protective services (APS) and to all other required agencies . within specified timeframes .2. Assuring that reporters are free from retaliation or reprisal.R62 was admitted to the facility on [DATE]. R62's quarterly minimum data set (MDS) dated [DATE] indicated R62 had intact cognition with a Brief Interview for Mental Status (BIMS) score of 13 and the facility assessed R62 being dependent on 2 staff for activities of daily living (ADLs). R62 is their own person and in charge of their own finances.Surveyor reviewed a facility self-report regarding misappropriation of funds for R62 by a staff member, certified nursing assistant (CNA)-Q. The facility self-reported documents:- On 10/31/2025, at 11:30AM, two APS workers entered the facility and notified nursing home administrator (NHA)-A about an anonymous notification indicating CNA-Q was using R62's uber and paypal accounts.- Police were notified. R62 and CNA-Q were interviewed; CNA-Q admitted getting $400.00 from R62, ordering extra food for herself when R62 made food orders, and having R62's (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PayPal account linked to CNA-Q's PayPal account. R62 admitted to giving CNA-Q $100.00, use of a cell phone, and card information. The facility self report documents the relationship of R62 and CNA-Q was that of a close relationship. The facility self report documents R62 acknowledges that she would purchase additional meals for them to enjoy together.On 3/9/2026, at 10:44 AM, Surveyor interviewed R62 who remembered giving CNA-Q R62's bank card so when R62 wanted to order food, CNA-Q would already have the information to go ahead and order the food. Surveyor asked R62 if R62 asked for the bank card back from CNA-Q. R62 denied asking for R62's card back and let CNA-Q hold onto it but was not aware CNA-Q was making more purchases. R62 stated the facility provided R62 with a locked drawer in the nightstand, but R62 gave CNA-Q the bank card and it was not taken without R62 knowing. R62's 10/31/2025 trauma assessment documents: Financial struggle trauma- not having control of my finances/not being aware of my financial situationOn 3/9/2026, at 3:09 PM, Surveyor interviewed APS-P who stated they received an anonymous call regarding possibility CNA-Q was using R62's money. APS-P entered the facility and alerted administration of the concerns. Surveyor asked APS-P if the anonymous tip came from another employee or someone else. APS-P was not sure who the anonymous person was and could not say if it was another facility employee or someone else. APS-P stated once the police were notified and entered the facility there was not much more for APS-P to do and APS-P did not look further into the concern other than reporting to the State Agency.On 3/12/2026, at 1:09 PM, Surveyor interviewed NHA-A who stated NHA-A was not aware of CNA-Q having R62's bank card until APS-P came into the facility. NHA-A stated the facility called the police and initiated an investigation right away, during staff interviews, no one noted knowing that CNA-Q was using R62's bank card or had taken money from R62. Surveyor asked if all facility staff were educated on the abuse policy specifically misappropriation of resident funds. NHA-A stated about 85 - 90% of the facility was educated and had to complete a quiz. Surveyor asked what facility staff did not complete the education. NHA-A replied NHA-A would have to look at the listing and see who has not completed the education yet. Surveyor shared concern with NHA-A CNA-Q took R62's money and card even though it was given by R62 and used for personal gain. NHA-A understood the concern.Surveyor noted upon review of the facility self report, investigation and training post incident the facility initiated training on abuse, neglect, misappropriation and mistreatment but did not train all staff. Surveyor noted Post incident, the facility has not assessed or established a plan of care for R62's desire to order takeout food and the need for staff to assist with ordering leaving R62 vulnerable to possible further exploitation. Additionally, R62 expressed she believed R62 was a friend and R62 ordered extra food to have CNA-Q's company. There is no indication the facility assessed R62's need for friendship and/or whether R62 was lonely leading her to foster a friendship with staff that make her vulnerable to possible additional misappropriation and exploitation post incident. On 3/24/26 the facility submitted additional information to review regarding possible concerns related to abuse and neglect. Surveyor noted the explanation of details did not specifically address concerns identified with R62.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure that 1 (R5) of 7 Residents reviewed with limited range of motion received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.R5 has an active MD order for a left palm guard to be worn. Surveyor observed R5 without a left palm guard in place multiple times during survey. R5's left palm guard was not part of R5's Comprehensive Care plan or Certified Nursing Assistant (CNA) Kardex.Findings include: The facility policy with an implemented date of 1/26 and titled, Range of Motion, document, in part: Residents who enter the facility without limited range of motion will not experience a reduction in range of motion unless the resident's clinical condition demonstrated that a reduction in range of motion is unavoidable. Based on the comprehensive assessment, the facility will provide interventions, exercises and/or therapy to maintain or improve range of motion. The facility will provide treatment and care in accordance with professional standards of practice. This includes but is not limited to: Appropriate services (specialized rehabilitation, restorative, maintenance), Appropriate equipment (braces or splints. Care plan interventions will be developed and delivered through the facility's restorative program or through specialized rehabilitative services as ordered by the attending practitioner. Interventions will be documented on the resident's person-centered care plan. A nurse with responsibility for the resident will monitor for consistent implementation of the care plan interventions.R5 was admitted to the facility on [DATE] with diagnosis that include Cerebrovascular disease (condition affecting blood vessels in the brain often leading to stroke, Stroke, Gastrostomy tube (medical device that delivers food, liquids and medication directly in the stomach, and contractures (permanent, rigid tightening of muscles, tendons, skin, or tissues that restrict joint movement and cause deformity).R5's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documents R5 is severely cognitively impaired. R5 has impairments on both the right and left sides of R5's upper and lower extremities. R5 is dependent on staff for R5's care, mobility and transfers.R5's active MD order with a start date of 3/14/24 documents: Left hand palm guard on x 24 hours, may remove for hand hygiene. Every shift.R5's active MD order with a start date of 1/30/26 documents: Resident is [to] wear right palm on am and off at [night] as tolerated. One time a day for right palm guard and remove per schedule.Surveyor noted R5 had an active order to wear a right- and left-hand palm guard; there is no order discontinuing R5's active use of a left palm guard.R5's Contracture to bilateral hands care plan initiated on 3/13/24 documents the following pertinent interventions: Resident is [to] wear right palm on am and off at [night] as tolerated (initiated on 1/30/26).R5's resolved care plan interventions include the following: Receiving splint/brace assistance (Initiated 3/13/24 and resolved on 1/20/26). Assist the resident with the use of supportive devices left palm guard. (initiated 3/13/24 and resolved on 1/20/26). Surveyor noted R5's Contracture care plan has an active intervention to wear a right palm guard but does not have an active intervention to wear a left palm guard. On 3/09/2026 at 12:18 PM, Surveyor observed R5 lying in bed. R5 is wearing a right-hand palm guard. R5's left hand is contracted and partly hanging off R5's bed. R5 is not wearing a palm guard on R5's left hand.On 3/10/2026 at 8:15 AM, Surveyor observed R5 lying in bed. R5 is wearing a right-hand palm guard. R5's left hand is contracted. R5 is not wearing a palm guard on R5's left hand. On 3/10/2026 at 1:43 PM, Surveyor observed R5 lying in bed. R5 is wearing a right-hand palm guard. R5's left hand is contracted. R5 is not wearing a palm guard on R5's left hand. On 3/11/2026 at 7:58 AM, Surveyor observed R5 lying in bed. R5 is wearing a right-hand palm guard. R5's left hand is contracted. R5 is not wearing a palm guard on R5's left hand.On 3/11/2026 at 12:50 PM, Surveyor observed R5 lying in bed. R5 is wearing a right-hand palm guard. R5's left hand is contracted. R5 is not wearing a palm guard on R5's left hand. On 3/11/2026 at 1:03 PM, Surveyor interviewed Certified Nursing Assistant (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525604	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Southpointe	4500 W. Loomis Rd. Greenfield, WI 53220

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(CNA)-H. Surveyor asked if R5 wears any braces, splints or palm guards. CNA-H stated that R5 is supposed to wear a palm guard on R5's right hand. CNA-H stated that R5 will sometimes take it off and throw it. Surveyor asked where staff find what type of brace/splint/palm guard needs to be worn by residents. On 3/12/26 at 10:19 AM, CNA-H returned to Surveyor and informed Surveyor that braces, splints and palm guard use is listed in the CNA Kardex/Care plan. R5's CNA Kardex as of 3/11/26 documents, in part: Under dressing/Splint care is listed, Resident is [to] wear right palm on am and off at [night] as tolerated.Surveyor noted CNA-H stated that R5 wears a right palm guard and the right palm guard is listed on the CNA Kardex. Surveyor noted that CNA-H did not mention R5 wearing a left palm guard despite a continuing order for R5 to ear one. On 3/12/2026 at 10:08 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-E. Surveyor asked if R5 wears any braces, splints or palm guards. LPN-E stated that LPN-E has been using palm guards or carrots (a soft cone-shaped orthotic device designed to be inserted into a severely contracted hand to prevent fingers from digging into the palm) on both hands. LPN-E stated that LPN-E would look in the medical record and check to make sure. LPN-E looked in R5's medical record and stated that R5 should be wearing a palm guard on R5's left hand. LPN-E stated that R5 did recently receive Occupational Therapy (OT) for the right hand. LPN-E stated that R5 has had a palm guard for the left hand for a long time but thinks the right hand was recently added. Surveyor asked what R5 was wearing on R5's hands today. Surveyor and LPN-E walked to R5's room. R5 was observed lying in bed. R5 had a palm guard on R5's right hand. R5 was not wearing a palm guard on R5's left hand. LPN-E stated that LPN-E had put a carrot in R5's left hand earlier in the morning. LPN-E stated that R5 will sometimes take the palm guard or carrot off and will throw it. LPN-E found the carrot under R5's bed.On 3/12/2026 at 10:19 AM, Surveyor interviewed LPN Unit Manager (LPN UM)-K. Surveyor asked what was being done for R5's right- and left-hand contractures. LPN UM-K stated that R5 has palm guards in place. LPN UM-K stated that LPN UM-K wanted to check the medical record to make sure. LPN UM-K stated that R5 has a left-hand palm guard order in place. LPN UM-K stated that R5 should have a right palm guard as well. LPN UM-K stated that R5 saw OT earlier in the year and a right palm guard was ordered. LPN UM-K entered the order, and care planned the right palm guard. Surveyor asked if the left palm guard was discontinued at that time. LPN UM-K indicated that R5 has had the left palm guard for ages and does not think it was discontinued.On 3/12/26 at 10:37 AM, LPN-E returned to Surveyor. LPN-E stated that R5 has always had a palm guard on R5's left hand. Staff noticed that R5's right hand had some contracture and that is why OT was ordered. OT completed sessions with R5 and ordered a right-side palm guard. The order and care plan intervention was put in place for the right side. OT never discontinued the palm guard to the left hand. LPN-E stated that the left palm guard was accidentally removed from the care plan. LPN-E provided a therapy communication form to Surveyor.R5's Therapy Communication Form dated 1/29/26 and signed by OT-O documents, in part: [Patient] to wear right palm guard during the day, off at night as she tolerates.On 3/12/26 at 11:10 AM, Surveyor interviewed OT-O. Surveyor asked what is in place for R5's hand contractures. OT-O stated that R5 has had a left palm guard in place since 2024. The right palm guard was ordered in January of this year. Surveyor asked if the left palm guard was discontinued after the right palm guard was put in place. OT-O stated No. OT-O R5 should have both in place. On 3/12/26 at 12:38 PM, Surveyor interviewed Director of Nursing (DON)-B. Surveyor informed DON-B of the concern that R5 has an active order for a right- and left-hand palm guard to be worn. Surveyor observed R5 without R5's left palm guard multiple times, on different days during the survey. DON-B stated that LPN UM-K had put R5's left palm guard on in the morning on the first day of survey. Surveyor informed DON-B that Surveyor observed R5 in the afternoon and the palm guard was off. Surveyor informed DON-B that R5's left palm guard was not part of R5's active care plan or Kardex. Surveyor asked if it should be care planned. DON-B stated it should be care planned.On 3/12/2026 at 2:10 PM, Surveyor informed Nursing Home Administrator (NHA)-A of the concern that R5 had an active order for a left palm guard. Surveyor had multiple observations of the left palm guard not in place. R5's left palm guard is not part of R5's active comprehensive care plan or CNA Kardex.

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NAME OF PROVIDER OR SUPPLIER Complete Care at Southpointe		STREET ADDRESS, CITY, STATE, ZIP CODE 4500 W. Loomis Rd. Greenfield, WI 53220	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that proper notification was sent to the State Long-Term Care Ombudsman for 6 (R1, R2, R3, R8, R10 and R103) of 6 residents reviewed for transfers or discharges. *R1 was transferred to the hospital on 8/5/25 and 10/23/25. The facility did not notify the State Ombudsman of R1's hospitalizations. *R2 was transferred to the hospital on [DATE]. The facility did not notify the State Ombudsman of R2's hospitalization. *R3 was transferred to the hospital on [DATE]. The facility did not notify the State Ombudsman of R3's hospitalization. *R8 was transferred to the hospital on [DATE]. The facility did not notify the State Ombudsman of R8's hospitalization. *R10 was transferred to the hospital on [DATE] and 2/3/26. The facility did not notify the State Ombudsman of R10's hospitalizations. *R103 was transferred to the hospital on 1/8/26. The facility did not notify the State Ombudsman of R103's hospitalization. Findings include: On 3/11/26, Nursing Home Administrator (NHA)-A provided a report titled, Admission/Discharge to/from report. Discharges 5/1/25 to 3/10/2026 to Surveyor. NHA-A indicated that this report lists the discharged residents that the State Ombudsman was made aware of from May 2025 through 3/10/26. On 3/11/2026 at 1:14 PM, Surveyor interviewed Social Work Director (SWD)-J. Surveyor asked about the process of notifying the State Ombudsman of transfers and discharges. SWD-J stated that SWD-J sends the transfer/discharge report by email at the beginning of each month. Included in the report is any resident who is discharged home, transferred/discharged to the hospital and any resident death. Surveyor informed SWD-J that not all residents reviewed for transfers/discharges are found on the report provided to Surveyor. SWD-J stated that SWD-J would look at the report. SWD-J pulled up the report on the facility electronic health record (EHR) system. SWD-J confirmed that not all residents were listed on the report. SWD-J stated that if a resident's status is not listed as discharged in the EHR, then the resident will not appear in this report. SWD-J indicated that SWD-J will work on finding a report that will include all residents that are transferred/discharged to the hospital. On 3/12/2026 at 2:10 PM Surveyor informed NHA-A of the concern that the State Ombudsman was not notified when R1, R2, R3, R8, R10 and R103 were transferred to the hospital. NHA-A stated that NHA-A was trying to figure out a report that would include all the necessary residents that could be sent to the Ombudsman each month. (continued on next page)

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Complete Care at Southpointe	4500 W. Loomis Rd. Greenfield, WI 53220

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Many	1.) R3 was admitted to the facility on [DATE] with diagnoses that include Colon cancer, Colostomy, Stroke and Type 2 Diabetes. On 12/8/25, R3 experienced a change of condition and was transferred to the hospital. Surveyor reviewed the Admission/Discharge to/from report. Discharges 5/1/25 to 3/10/2026 document provided by NHA-A for evidence that the State Ombudsman was notified of R3's hospitalization. Surveyor noted R3's 12/8/25 hospitalization was not listed in the report that was sent to the State Ombudsman. 2.) R8 was admitted to the facility on [DATE] with diagnosis that include Alzheimer's, Dementia, Stage 3 chronic kidney disease, and Anemia. On 10/13/25, R8 experienced a change of condition and was transferred to the hospital. Surveyor reviewed the Admission/Discharge to/from report. Discharges 5/1/25 to 3/10/2026 document provided by NHA-A for evidence that the State Ombudsman was notified of R8's hospitalization. Surveyor noted R8's 10/13/25 hospitalization was not listed in the report that was sent to the State Ombudsman. 3.) R10 was admitted to the facility on [DATE] with diagnosis that include heart disease and type 2 diabetes. On 11/21/25, R10 was transferred to the hospital after a clinic visit in which R10 experienced a change of condition. On 2/13/26, R10 was transferred to the hospital for a planned surgical procedure. Surveyor reviewed the Admission/Discharge to/from report. Discharges 5/1/25 to 3/10/2026 document provided by NHA-A for evidence that the State Ombudsman was notified of R10's hospitalizations. Surveyor noted R10's 11/21/25 and 2/13/26 hospitalizations were not listed in the report that was sent to the State Ombudsman. 4.) On 8/4/2025, R1 experienced a change of condition and was transferred to the hospital for further evaluation per physician recommendation and was admitted to the hospital. On 10/23/2025, R1 experienced a change in condition and was transferred to the hospital for further evaluation per physician recommendation and admitted was admitted to the hospital. Surveyor reviewed the Admission/Discharge to/from report. Discharges 5/1/2025 - 3/10/2026 document provided by Nursing Home Administrator (NHA)-A for evidence that the State Ombudsman was notified of R1's hospitalizations. Surveyor noted R1's 8/5/2025, and 10/23/2025 hospitalizations were not listed on the report that was sent to the State Ombudsman. 5.) On 11/5/2025, R2 experienced a change of condition and was transferred to the hospital for further evaluation per physician recommendation and was admitted to the hospital. Surveyor reviewed the Admission/Discharge to/from report. Discharges 5/1/2025 - 3/10/2026 document provided by NHA-A for evidence that the State Ombudsman was notified of R2's hospitalization. Surveyor noted R2's 11/5/2025 hospitalization was not listed on the report that was sent to the State Ombudsman. (continued on next page)

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Many	On 3/11/2026 at 1:14 PM, A Surveyor interviewed Social Work Director (SWD)-J who stated SWD-J sends the transfer/discharge report to the State Ombudsman via email at the beginning of each month. SWD-J stated the report includes any resident who is discharged home, transferred/discharged to the hospital, and any resident death. A Surveyor informed SWD-J that not all residents reviewed for transfers/discharges are found on the report provided to Surveyors. SWD-J pulled up the report on the facility electronic health record (EHR) system and confirmed not all residents were listed on the report. SWD-J stated if a resident's status is not listed as discharged in the EHR, the resident will not appear in the report. SWD-J shared concerns and will work on finding a report that will include all residents that are transferred/discharged to the hospital. On 3/12/2026 at 2:10 PM A Surveyor informed NHA-A of the concern the State Ombudsman was not always notified when R1, R2, R3, R8, R10 and R103 were transferred and admitted to the hospital. NHA-A stated NHA was aware of the concern and was trying to figure out a report that would include all the necessary residents that should be sent to the Ombudsman each month. 6.) On 1/8/26, R103 was transferred to the hospital for a change in condition. R103 was admitted for acute renal failure and did not return to the facility. On 3/11/26, Nursing Home Administrator (NHA)-A provided a report titled, Admission/Discharge to/from report. Discharges 5/1/25 to 3/10/2026 to Surveyor. NHA-A indicated that this report lists the discharged residents that the State Ombudsman was made aware of from May 2025 through 3/10/26. Surveyor conducted a review and noted that R103 was not on the provided discharge/transfer list. On 3/12/2026 at 2:10 PM Surveyor informed NHA-A of the concern that the State Ombudsman was not notified R103 were transferred to the hospital. NHA-A stated that NHA-A was trying to figure out a report that would include all the necessary residents that could be sent to the Ombudsman each month.