STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525659	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Grande Prairie	10330 Prairie Ridge Blvd. Pleasant Prairie, WI 53158

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and interview, the facility did not ensure that food was prepared, distributed, and served in accordance with professional standards for food service safety (Wisconsin Food Code) in the main kitchen. This deficient practice has the potential to affect all 79 residents who receive food from the main kitchen. *Dietary Manager (DM)-C, Dietary Aide (DA)-D, and DA-E were observed in the main kitchen preparing and handling food without wearing hair restraints that covered facial hair. DA-E was observed wearing a hat that did not fully restrain hair. Findings include:The Wisconsin Food Code documents: Food employees shall wear hair restraints such as hair coverings or nets, beard restraints that are designed and worn to effectively keep their hair from contacting exposed food.On 5/11/26 at 8:27 AM, Surveyor conducted an initial tour of the main kitchen with DM-C. Surveyor observed DM-C handling food in the main kitchen while not wearing a hair restraint for exposed facial hair. On 5/12/26 at 8:18 AM, Surveyor observed DM-C handling food in the main kitchen while not wearing a hair restraint for exposed facial hair. On 5/12/26 at 11:16 AM, Surveyor observed DM-C, DA-D, and DA-E preparing and handling food in the main kitchen without wearing a hair restraint for exposed facial hair. Surveyor observed DA-E wearing a hat that did not fully restrain hair. On 5/12/26 at 11:31 AM, DM-C confirmed the facility follows the Wisconsin Food Code standard of practice for food safety. On 5/12/26 at 11:42 AM, Surveyor observed DA-D and DA-E preparing and handling food in the main kitchen without wearing a hair restraint for exposed facial hair. Surveyor observed DA-E wearing a hat that did not fully restrain hair. On 5/12/26 at 1:50 PM, Surveyor shared concern with DM-C that Surveyor had several observations of DM-C, DA-D, and DA-E not wearing a hair restraint for exposed facial hair and DA-E wearing a hat that did not fully restrain hair. DM-C stated DM-C thought facial hair could be less than a quarter inch in length without wearing a beard restraint. DM-C stated DM-C would get the proper hair and beard restraints for kitchen staff right away. On 5/12/26 at 2:31 PM, Surveyor informed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B of the above findings. No additional information was provided as to why food was not prepared, distributed, and served in accordance with professional standards for food service safety.

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

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

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F 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 on interview and record review, the facility did not ensure it submitted accurate mandatory staffing information based on payroll data in a uniform electronic format to the Centers for Medicare & Medicaid Services (CMS). This had the potential to affect all 79 residents residing in the facility.Staffing information for Quarter 1 (October 1 - December 31, 2025) of the Payroll Based Journal (PBJ) was not accurately submitted to CMS.Findings include:The CMS Electronic Staffing Data Submission Payroll-Based Journal, Long-term Care Facility Policy Manual, dated June 2022, documents: Chapter 1: Overview, 1.1 introduction .(U) mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS .1.2 Submission Timelines and Accuracy. Direct care staffing and census data will be collected quarterly and is required to be timely and accurate .Report Quarter: staffing and census data will be collected for each fiscal quarter. Staffing data includes the number of hours paid to work by each staff member each day within a quarter. Census data includes the facility's census on the last day of each of the three months in a quarter. The fiscal quarters are as follows: Fiscal Quarter, Date range: (quarter) 1 October 1-December 31, (quarter) 2 January 1-March 31, (quarter) 3 April 1-June 30, (quarter) 4 July 1-September 30.Surveyor reviewed the facility's PBJ Staffing Data Report, CASPER Report 1705D, for Fiscal year 2026 (run on 3/9/2026) which documented the facility had excessively low weekend staffing for the 1st Quarter (October 1 - December 31, 2025).Surveyor reviewed the facility's weekend schedules from October 2025 through December 2025. Surveyor noted licensed nurses and certified nursing assistants present on each shift, for each unit. Surveyor noted the facility's schedules indicated call ins, agency staff and which staff who picked up shifts. Surveyor noted there were numerous call-ins, however the shifts were filled by staff or agency. On 5/12/2026, at 10:04 AM, Surveyor interviewed Scheduler-H and asked to verify nursing staff per shift scheduled from October to December of 2025. Per Scheduler-H, the staffing totals are dependent on the resident census. On first shift and second shift, 8 to 9 Certified Nursing Assistants (CNAs) and 5 to 6 Nurses with at least 1 Registered Nurse (RN) are the minimum staffing requirements. On third shift, 5 to 6 CNAs and 2 Nurses with 1 RN is the minimum staffing requirement.Per Scheduler-H, the facility is transitioning over to a new staffing scheduling system where the facility staff can view their hours and shifts to pick up. Scheduler-H inputs the shifts not filled with agency staff and removes agency staff as facility staff pick up the shifts. Scheduler-H denies any low staffing on certain shifts or the weekends and stated more staff are scheduled than the minimum required amount to account for staff call ins.Surveyor noted the schedules documented many staff calling in and the openings being filled by other facility staff or agency staff. However, Surveyor noted that the facility did not have low staffing levels on the weekends as indicated in the facility's PBJ Staffing Data Report for the 1st Quarter (October 1 - December 31, 2025).On 4/29/2026, at 09:36 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A regarding the facility's low ratings for staffing on the Payroll-Based Journal. NHA-A stated someone from the facilities corporate is responsible for submitting the Payroll-based Journal. NHA-A denied any low staffing levels on weekends. On 5/12/2026, at 1:41 PM, Surveyor interviewed CNA-F regarding staffing. CNA-F has worked at the facility for 2 years and works a mix of first and second shifts and will pick up often. CNA- F denies the facility being low staffed and stated there is enough staff scheduled regularly to meet resident needs. On 5/14/2026, at 8:55 AM, Surveyor interviewed Licensed Practical Nurse (LPN)- G who has worked for the facility for about 2 years and picks up multiple shifts. LPN- G stated there is always plenty of nursing staff. LPN- G stated there is enough time to complete tasks and has no concerns with staffing levels.On 5/12/2026, at 2:35 PM, Surveyor informed NHA-A and DON-B of (continued on next page)

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the concern with Payroll Based Journal reporting being inaccurate for the first quarter of the 2026 fiscal year.No additional information was provided as to why the facility did not accurately submit staffing information for Quarter 1 (October 1 through December 31, 2025) for the Payroll Based Journal (PBJ).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, drugs used in the facility were not labeled in accordance with currently accepted professional principles. *Surveyor observed 6 expired stock medications and 63 loose medication pills in 2 of 3 medication carts.This deficient practice has the potential to affect more than 3 residents residing on the units that utilize the medication carts for medication administration. Findings:The facility's policy, titled Medication Storage, with an implement date of 3/2026, does not document any policies regarding expired medications.On 05/12/2026, at 12:47 PM, Surveyor observed medication pass on the MESA unit with Licensed Practical Nurse (LPN)-N. Within the medication cart, Surveyor observed Vitamin B with an expiration date of 4/2026, Thiamin with an expiration date of 4/2026, Cetirizine unable to read expiration date with no open date, Non-aspirin no expiration date and Senna S- no expiration date. LPN-N asked the Unit Manager about the dates and the Unit Manager stated that LPN-N will toss the medications and get new ones. LPN-N indicated if a medication doesn't have an expiration date, LPN-N will put the open date and discard 30 days after.On 05/12/2026, at 1:10 PM, Surveyor observed the [NAME] short hall medication cart with Registered Nurse (RN)-O. While observing the drawers of the medication cart, Surveyor observed 58 loose medication pills. RN-O disposed of the loose medication pills in the drug buster container used to destroy medications. On 05/12/2026, at 2:41 PM, Surveyor observed the Garden unit medication cart with Unit Manager-L. Surveyor observed 5 loose medications and 1 bottle of liquid pain relief with an expiration date of 4/2026. On 05/12/2026, at 1:41 PM, Surveyor informed Director of Nursing (DON)-B of the above concerns. DON-B indicated nurses will usually go through the medications on the carts when residents discharge and will go through the medication cart monthly reviewing for expired medications. DON-B informed Surveyor that DON-B did not know what the expectation is for loose medication pills in the medication cart. On 5/14/2026, at 11:56 AM, Surveyor informed the facility of the above concerns, no additional information was provided.

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility did not ensure residents who are fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding, including risk for dehydration for 1 (R8) of 2 residents reviewed for enteral feeding.*R8 has an order for 12 hours continuous feed from 8PM to 8AM. Surveyor observed that on 5/11/2026, 5/12/2026 and 5/13/2026 that R8's tube feeding was not administered as ordered.Findings include:The facility policy, titled Enteral Tube Feeding via Continuous Pump, updated 12/14/2025, documents: Documentation The person performing this procedure should record the following information in the resident's medical record: . 2. Amount and type of enteral feeding. 7. If the resident refused the procedure, the reason(s) why and the intervention taken. Reporting . 3. Notify the supervisor if the resident refuses the procedure.R8 was admitted to the facility on [DATE] with diagnoses including gastrostomy (a surgical opening made through the skin of the abdomen directly into the stomach) and dysphasia (difficulty swallowing).R8's Annual Minimum Data Set, dated [DATE], documents that R8 was assessed to have a Brief Interview for Mental Status score of 6, indicating that R8 has severe cognitive impairment. The MDS also documents that R8 was assessed as having a feeding tube in place during the assessment period. On 05/11/2026, at 9:42 AM, Surveyor observed R8's tube feeding bottle and flush bag hanging on a pole in R8's room. Surveyor noted R8 was not in the room, the tube feeding bottle was dated 5/10/2026 with a start time of 8:30 PM. The tubing was labeled: Rate 69 milliliters (ml) per hour (hr), was not currently running and appeared to be about completely full.On 05/12/2026, at 9:58 AM, Surveyor observed R8's tube feeding bottle and flush bag hanging on a pole in R8's room. Surveyor noted R8 was not in the room. The tube feeding bottle was dated 5/11/2026 at 8PM at 69 ml/hr. Surveyor noted the tube feeding bottle was almost full.R8's physician order and noted the following, at bedtime, administer Osmolite 1.5CAL as a continuous feed via Pump at 69 ml per hour for 12 hours per day, 2000 - 0800 (nocturnal feed) 150ml flush every 4 hours.Surveyor noted R8 should receive 828ml of Osmolite total over 12 hours. Surveyor was unable to locate any documentation R8's electronic health record that R8 did not receive R8's total tube or why R8 was observed to have tube feeding solution almost full on 5/11/26 and 5/12/26. Surveyor noted R8 is on a puree diet with thickened liquids, with an overall intake of 25-50% at times with tube feeding to meet the lower end of energy needs, per Registered Dietician notes.On 05/13/2026, at 7:22 AM, Surveyor observed R8's tube feeding bottle and flush bag hanging on a pole in R8's room. Surveyor noted R8 not in the room, the tube feeding was not running and was dated 5/12/2026 at 8PM at 69 ml/hr and had 900 to 1000 ml remaining in the bottle.On 05/13/2026, at 7:39 AM, Surveyor asked Licensed Practical Nurse (LPN)-G about R8's tube feeding. LPN-G informed Surveyor that R8 was already off the tube feeding when LPN-G started at 6:45 AM. Third shift informed LPN-G that they got R8 up at 3 AM this morning because R8 was pulling at R8's tube feeding. Surveyor asked what the process is if R8 doesn't receive the full ordered nutrition via tube feeding. LPN-G indicated that R8 just doesn't get the tube feed because R8 was pulling on tube and no notifications made.Surveyor was unable to locate any documentation in R8's electronic health record that R8 was disconnected from R8's tube feed prior to 8 AM, that R8's physician was notified or any refusals by R8 to receive tube feedings from 5/11/2026 to 5/13/2026. On 05/13/2026, at 7:45 AM, Surveyor informed Unit Manager (UM)-L of Surveyors observations of R8's tube feedings being almost full since start of Survey and today had 900 out of 1000 remaining in R8's tube feeding bottle. Surveyor asked UM-L what the expectation is when R8 does not receive the full ordered tube feeding. Unit Manager-L informed Surveyor that the provider should be notified to let the physician know how much was missed and to see if they want to have the feeding administered. Unit Manager-L indicated that any missed or refused tube feedings should be documented in R8's electronic health record and if it is not documented in chart, there is (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	also a platform used to contact providers but most of the time this is communicated via verbal communication while providers are in the facility. UM-L informed Surveyor UM-L would investigate it and get back to Surveyor with more information.R8's progress noted dated 5/13/2026, at 08:32 AM by UM-L documents: Nurse Practitioner (NP)-M was notified that R8 was disconnected from tube feed around 3 AM this morning due to refusing the tube feed and as result did not complete the tube feed until 8am as ordered. No new orders and NP-M is not concerned at this time since R8 does eat 3 meals throughout the day as well as snacks, Registered Dietician to be updated.Surveyor noted that if R8 was connected to tube feeding from 8PM to 3AM, R8 would have received approximately 483 mls per R8's order rate. Surveyor observed only 100 ml were administered from R8's tube feed. 05/13/2026 2:16 PM UM-L informed Surveyor that NP-M was notified of R8's missing tube feedings and what UM-L found through UM-L's investigation. UM-L spoke with staff and was told R8 was disconnected around 3 AM and only received 7 hours of tube feeding. UM-L indicated R8's tube feed is for supplemental nutrition since R8 does eat every meal. UM-L indicated UM-L needs to reach out to night shift staff to find out why R8 wasn't receiving the full tube feed, since there was no documentation in R8's electronic health record. UM-L indicated NP-M was updated that R8 only received 100 mls last night after seeing R8's tube feed bottle.On 05/13/2026, at 2:48 PM, Surveyor interviewed Director of Nursing (DON)-B regarding Surveyor's observations of R8's tube feedings. DON-B informed Surveyor that DON-B would expect the provider to be notified and updated of missed tube feeds and if a resident refuses tube feeds. DON-B informed Surveyor they are currently investigating the concern. On 05/14/2026, at 7:11 AM, Surveyor interviewed NP-M. UM-L informed NP-M of R8's missing tube feed yesterday morning. NP-M indicated R8 eats about 50% during the day with tube feed as a supplement. NP-M informed Surveyor that NP-M would expect to be notified of missed or refused tube feeds and that maybe adjustments need to be made. NP-M indicated the team would investigate why feeds were not being given as ordered and discuss R8 needsOn 5/14/2026, at 11:56 AM, Surveyor informed the facility of the above findings. No additional information was provided.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 3 (R7, R12, & R91) of 3 residents reviewed for post-traumatic stress disorder (PTSD) received trauma informed care in accordance with professional stands of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization. R7, R12, and R91 were admitted to the facility with a diagnosis of PTSD, and the facility did not develop a person-centered care plan identifying triggers, interventions, or monitoring for PTSD. Findings include: The facility policy titled Trauma Informed Care with implemented date March 2026 documents: The facility will use a multi-pronged approach to identifying a resident's history of trauma, as well as his or her cultural preferences. This will include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event, as well as screening and assessment tools such as the Resident Assessment Instrument (RAI), admission Assessment, the history and physical, the social history/assessment, and others. The facility will collaborate with resident trauma survivors, and as appropriate, the resident's family, friends, the primary care physician, and any other health care professionals (such as psychologists and mental health professionals) to develop and implement individualized care plan interventions. The facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger-specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident, and will be added to the resident's care plan. The facility will evaluate whether the interventions have been able to mitigate (or reduce) the impact of identified triggers on the resident that may cause re-traumatization. The resident and/or his or her family or representative will be included in this evaluation to ensure clear and open discussion and better understand if interventions must be modified. In situations where a trauma survivor is reluctant to share their history, the facility will still try to identify triggers which may re-traumatize the resident, and develop care plan interventions which minimize or eliminate the effect of the trigger on the resident. 1.). R7 was admitted to the facility 1/26/24 with diagnoses including post-traumatic stress disorder (a mental health condition in people who have experienced or witnessed a traumatic event), depression, and other schizoaffective disorders (a chronic mental health condition that is marked by a mix of hallucinations and delusions and mood disorder symptoms). R7 had an activated power of attorney (POA) to make healthcare decisions. R7's Minimum Data Set (MDS) assessment dated [DATE] documented that R7 had a brief interview for mental status (BIMS) score of 8, indicating moderate cognitive impairment, and R7 did not demonstrate any behaviors within the lookback period. R7's Care Area Assessment (CAA) for mood state dated 3/30/26 documented R7 has a diagnosis of depression and is on medication for depression and sees in-house psychiatric services, family visits and is supportive. Surveyor noted the CAA did not address R7's PTSD diagnosis. R7's admission Trauma Informed Care assessment dated [DATE] documented: Instructions: listed below are a number of difficult or stressful thing that sometimes happen to people. For each event (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	choose one or more of the options to indicate that: (1) it happened to you personally; (2) you witnessed it happen to someone else; (3) you learned about it happening to a close family member or close friend; (4) you were exposed to it as part of your job (for example, paramedic, police, military, or other first responder); (5) you're not sure if it fits; (6) it does not apply to you . The assessment documents the following 17 scenarios:1. Natural disaster (for example, flood, hurricane, tornado, earthquake): answered does not apply2. Fire or explosion: answered does not apply3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash): answered does not apply4. Serious accident at work, home, or recreational activity: answered does not apply5. Exposure to toxic substance (for example, dangerous chemicals or radiation): answered does not apply6. Physical assault (for example, being attached, hit, slapped, kicked, beaten up): answered does not apply7. Assault with a weapon (for example, being shot, stabbed, threatened with knife, gun, or bomb): answered does not apply8. Sexual assault (for example, rape, attempted rape, made to perform any sexual act through force or threat of harm): answered does not apply9. Other unwanted or uncomfortable sexual experience: answered does not apply10. Combat exposure to a warzone in the military or as a civilian: answered does not apply11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war): answered does not apply12. Life threatening illness or injury: answered does not apply13. Severe human suffering: answered does not apply14. Sudden violent death (for example, homicide or suicide): answered does not apply15. Sudden accidental death: answered does not apply16. Serious injury, harm, or death you caused to someone else: answered does not apply17. Any other very stressful event or experience: answered does not applyPart 2 of the assessment documents cannot think of any traumatic events that have happened. R7's Trauma Informed Care assessment dated [DATE] documented the same 17 scenarios as the admission Trauma Informed Care Assessment, all answered does not apply with the exception of the following:14. Sudden violent death (for example, homicide or suicide): answered as happened to me. Part 2 of the assessment documents girlfriend was killed long ago. R7's Social Service assessment dated [DATE] documented in section D: Psychosocial status/current life stressor/grief issues the following questions and responses:. 3. Have you ever been through anything life threatening or traumatic? Answered: No. 6. Are you aware of any particular triggers that may make this worse for you? Answered: No. Surveyor reviewed R7's care plan and was unable to locate a care plan specific to R7's PTSD diagnosis to include potential triggers for R7's trauma, individualized care plan interventions for R7's trauma, or specific interventions to decrease R7's exposure to triggers or ways to decrease the effect of the triggers. In an interview on 5/14/26 at 8:47 AM, Licensed Practical Nurse (LPN)-K stated the facility has not really talked to nursing staff about R7's PTSD or any triggers R7 may have related to R7's PTSD. In an interview on 5/14/26 at 9:34 AM, Social Services (SS)-I confirmed SS-I primarily completes trauma assessments for residents at the facility, and the assessments are completed on admission, annually, and if there is any sort of change in resident condition. SS-I stated if a resident has a diagnosis of PTSD, SS-I still performs the trauma assessment on admission and annually, unless there is a reason warranting a new assessment such as new resident behaviors or symptoms. SS-I stated if the resident answers that any of the scenarios occurred to them on the trauma assessment, SS-I asks more about the scenario, such as how long ago it occurred, if the resident is willing to share. SS-I stated if the traumatic event is recent, the resident's care plan would be updated, but if the traumatic event occurred in the past, the facility does not add it to the resident's care plan. SS-I (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated the Social Services Assessment touches on resident triggers for PTSD, which are completed on a quarterly basis for all residents. SS-I stated if there are any relevant triggers on the Social Services Assessments, those would be added to the resident's care plan. SS-I confirmed R7 first mentioned his girlfriend was killed to SS-I on the Trauma Informed Care assessment dated [DATE]. SS-I stated the event occurred a long time ago to R7 and R7 did not seem upset by sharing the information, so SS-I did not add anything to R7's care plan. SS-I confirmed SS-I completed R7's Social Service assessment dated [DATE] and confirmed no was answered for the question have you ever been through anything life threatening or traumatic?. SS-I stated even though R7 disclosed the information about R7's girlfriend being killed to SS-I on 3/17/26, R7 gave the answer of no to any traumatic events on 3/26/26, so SS-I answered the question as no. In an interview on 5/14/26 at 10:37 AM, Director of Nursing (DON)-B stated social services completes assessments quarterly on all residents and completes a Trauma Informed Care Assessment annually and on an as needed basis. DON-B stated information from those assessments should be communicated to nursing staff so resident care cards and care plans can be updated accordingly. DON-B stated if there are specific interventions or monitoring needed for a resident based on those assessments, the resident care plan would be updated with those specific interventions. Surveyor shared concern with DON-B that R7 has a history of PTSD, and specific triggers, individualized interventions, and ways to decrease R7's exposure to triggers which may re-traumatize R7 were not identified or put into R7's care plan. No additional information was provided. In an interview on 5/14/26 at 10:56 AM, Director of Social Services (DSS)-J stated the facility completes a trauma assessment annually and if needed for a resident with PTSD. DSS-J stated a resident's care plan would only be updated if the resident currently shows symptoms or behaviors related to the resident's PTSD, and if the resident is not currently displaying symptoms or behaviors related to PTSD impacting their care, the facility does not add any interventions to the resident's care plan. DSS-J stated the facility does not really determine a resident's triggers and would involve psychiatric services to delve deeper into resident triggers for PTSD. Surveyor shared concern with DSS-J that R7 has a history of PTSD, and specific triggers, individualized interventions, and ways to decrease R7's exposure to triggers which may re-traumatize R7 were not identified or put into R7's care plan. No additional information was provided. 2.) R91 was admitted to the facility on [DATE] with diagnoses including Post Traumatic Stress Disorder (PTSD). R91's Annual Minimum Data Set (MDS), dated [DATE], documents that R91 was assessed to have a Brief Interview for Mental Statue score of 14, indicating intact cognition. The MDS documents that R91 was assessed to have a traumatic brain injury, anxiety, psychotic disorder and Post Traumatic Stress Disorder. R91's Trauma Care Assessments, dated 6/16/25 documented: Flood and hurricane many years ago, was hit by a car and almost died, had abusive husband, assaulted with a weapon and knew many teenagers and adults that died of an overdose. Surveyor reviewed R91's Trauma Care Assessments, dated 10/20/25 documented: Experienced a tornado long ago, had a fire as a kid, hit by a car a couple years ago broke arm regularly as a kid, husbands were abusive, had a couple bad sicknesses and heart trouble a while ago, being homeless, knew some kids who over dosed and committed suicide years ago (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525659	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Grande Prairie	10330 Prairie Ridge Blvd. Pleasant Prairie, WI 53158

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed R91's Care Plan and noted the following: Impaired neurological status related to: Traumatic brain injury causing hallucinations; Resident does have episodes of hallucinations, accusations, increased agitation d/t (due to) visions she sees or impaired thoughts. Interventions included: - Provide redirection to resident during episodes of hallucinations- Psychologist and psychiatrist to assess and follow resident as needed.-Encourage family to visit and bring in photos and momentous-Explain all procedures and reason before performing-Involve in activities that don't depend on patient's ability to communicate: music, parties, games-Listen to patient when verbalizing concerns over disease symptoms and address issues raised-Pleasant interaction which reassures patient when confused R91's anxiety care plan dated 6/20/25 documents: Resident has anxiety disorder; Interventions included: -encourage resident to express feelings-Monitor behaviors and update MD if symptoms occur more frequently or are unmanaged-Encourage resident to participate in activities-Encourage resident to walk or talk with fellow peers-Redirect resident as appropriate -The resident is verbally aggressive r/t (related to) Mental / Emotional illness4-3-25: threats towards staff, agitation, hallucinations.5/16/25: verbal altercation with family member. 5/16/25: removed resident from situation, monitoring resident mood/behavior. Date Initiated: 05/16/2025-Analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document.-Assess and anticipate resident's needs: food, thirst. toileting needs, comfort level, body positioning, pain etc.-Assess resident's coping skills and support system.-Assess resident's understanding of the situation. Allow time for the resident to express self and feelings towards the situation.-Provide positive feedback for good behavior. Emphasize the positive aspects of compliance. -Psychiatric/Psychogeriatric consult as indicated. The resident has behavior problems related to allegations against peers. 10/20/25: No male caregivers/aides10/20/25: Updated psych provider on new allegations.-Caregivers to provided opportunity for positive interaction, attention. Stop and talk with him/her as passing by.-If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident.-Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed.-Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes.-Praise any indication of the resident's progress/improvement in behavior. -The resident has a behavior problem r/t allegations against peers.-Provide a program of activities that is of interest and accommodates residents status. Surveyor was unable to locate a Trauma Informed care plan relating to R91's Post-Traumatic Stress and triggers. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/13/2026, at 1:27 PM, Surveyor spoke with Social Services-I regarding R91's Trauma Assessments and care plans. Social Services-I informed Surveyor that R91 has a history of allegations/telling stories of things that would occur, which after following up did not have any validity. Social Services-I was not completing care plans at that time R91's Trauma Assessment was completed and believe it would have been placed by nursing. Social Services-I stated that R91 had a care plan created by nursing in October 2025 for behavior problems with allegation against peers. Social Services-I stated that trauma assessments are completed annually and as needed and every resident has one completed. Social Services-I indicated that If someone has diagnosis of PTSD they will still only do yearly assessments unless there is an incident. Social Services-I will ask about how long-ago incident occurred and if the trauma happened in the past, they do not care plan and is only there for our knowledge but will care plan if there is a recent event. On admission and quarterly, Social Services-I asks about triggers under the Social Services assessment, which is different than trauma assessment. Social Services-I stated that if the resident has a relevant trigger, it would be care planned if needed. On 05/14/2026, at 10:37 AM, Surveyor interviewed Director of Nursing (DON)-B. DON-B stated that trauma informed care assessments are done on an as needed basis and is not necessary annually. DON-B stated that Social Services does the assessments quarterly and that the expectation is that Social Services should be communicating those assessment findings to nursing staff so that they can update care plans and care cards. DON-B stated that if the resident needs something then it should be on the care plan but added that just because they have a diagnosis of PTSD, does not mean they have behaviors, if they have behaviors then staff are monitoring for that specific behavior. DON-B stated that if only if something was still triggering for that resident, then it would be added to the care plan. DON-B stated that if a behavior shows up on a resident's assessment, then DON-B would consider that to be a trigger. On 05/14/2026, at 11:09 AM, Surveyor informed Director of Social Services and the facility of the above concerns. No additional information was provided. 3.) R12 was admitted to the facility on [DATE] with diagnoses including Post-Traumatic Stress Disorder and Depression. R12's Annual MDS, dated [DATE], indicates R12 has a Brief Interview for Mental Status score of 11, indicating intact cognition and has Post-Traumatic Stress Disorder. R12's trauma assessment dated [DATE] documents: and noted the following: Car accident 2 years ago where car was totaled, accident while working on car fell from jack onto resident 3 years ago, exposed to unknown toxic substances during desert storm, exposure to combat zone during desert storm, suicide in family. R12's trauma assessment dated [DATE] documents: Experienced Fire in Army, has been in many car accidents, 3 years ago hit by a plow and flipped car, exposed to substances in desert storm, was in a scuffle 5 years ago after car ran out of gas, family suicide years ago R12's trauma assessment dated [DATE] documents: Had many car accidents, served in desert storm, warzone and toxic substances, family suicide. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R12's Depression care plan dated as revised 3/25/26 documents: -Administer medications as ordered. Monitor/document for side effects and effectiveness.-Arrange for psych consult, follow up as indicated.-Assist the resident in developing /provide the resident with a program of activities that is meaningful and of interest. Encourage and provide opportunities for exercise,physical activity.-Discuss with the resident/family/caregivers any concerns, fears, issues regarding health or other subjects.-Monitor/document/report as needed adverse reactions to ANTIDEPRESSANT therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidalthoughts, withdrawal; decline in activities of daily living ability .-Monitor/document/report PRN any risk for harm to self: suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving awaypossessions or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgment or safety awareness.-Monitor/document/report as needed any signs/symptoms of depression, including: hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing, negative statements, repetitive anxious or health-related complaints, tearfulness. -Monitor/record/report to MD prn risk for harming others: increased anger, labile mood or agitation, feels threatened by others or thoughts of harming someone, possession of weapons or objects that could be used as weapons Surveyor was unable to locate a Trauma Informed care plan relating to R12's Post-Traumatic Stress and triggers. On 05/13/2026, at 1:27 PM, Surveyor spoke with Social Services-I regarding R12's Trauma Assessments and care plans. Social Services-I stated that trauma assessments are completed annually and as needed and every resident has one completed. Social Services-I indicated that If someone has diagnosis of PTSD they will still only do yearly assessments unless there is an incident. Social Services-I will ask about how long-ago incident occurred and if the trauma happened in the past, they do not care plan and is only there for our knowledge but will care plan if there is a recent event. On admission and quarterly, Social Services-I asks about triggers under the Social Services assessment, which is different than trauma assessment. Social Services-I stated that if the resident has a relevant trigger, it would be care planned if needed. On 05/14/2026, at 10:37 AM, Surveyor interviewed Director of Nursing (DON)-B. DON-B stated that trauma informed care assessments are done on an as needed basis and is not necessary annually. DON-B stated that Social Services does the assessments quarterly and that the expectation is that Social Services should be communicating those assessment findings to nursing staff so that they can update care plans and care cards. DON-B stated that if the resident needs something then it should be on the care plan but added that just because they have a diagnosis of PTSD, does not mean they have behaviors, if they have behaviors then staff are monitoring for that specific behavior. DON-B stated that if only if something was still triggering for that resident, then it would be added to the care plan. DON-B stated that if a behavior shows up on a resident's assessment, then DON-B would consider that to be a trigger. On 05/14/2026, at 11:09 AM, Surveyor informed Director of Social Services and the facility of the above concerns. No additional information was provided.