STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020514	A. BUILDING: _____ B. WING _____	C 05/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUSTWELL LIVING AT OAK CREEK PLACE	3829 S CHICAGO AVE SOUTH MILWAUKEE, WI 53172

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N 000	Initial Comments On 05/26/2026, Surveyor concluded a standard survey and two complaint investigations at Trustwell Living at Oak Creek Place. Two deficiencies were identified. One complaint was unsubstantiated. One complaint was substantiated. Census: 64	N 000		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation. This Rule is not met as evidenced by: Based on observation, record review, and	N 158		

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

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N 158	Continued From page 1 interview, upon learning of an incident of alleged misconduct, the provider did not take immediate steps to ensure residents were protected from potential subsequent episodes of misconduct and abuse for 1 of 1 resident (Resident 1). The provider did not document an investigation. On 04/15/2026, the provider became aware of an incident of alleged caregiver misconduct. Interim Executive Director (IED) B, Health Services Director (HSD) C and Assistant Health Director (AHD) D took Activated Healthcare Power of Attorney (AHCPOA) A and Family G's verbal report, alleging Caregiver F was the offender. The provider continued to allow Caregiver F to provide care and did not take steps to ensure residents were protected from potential subsequent episodes of misconduct. The provider did not start investigating the alleged misconduct until 05/18/2026, over 1 month after the initial notification of alleged caregiver misconduct. Findings include: On 04/24/2026, the department received complaint information alleging caregiver was rough with resident while moving a resident in bed. The provider continued to allow a caregiver to work and did not take steps to ensure residents were protected from subsequent episodes of misconduct. On 05/15/2026 at 9:05 a.m., Surveyor observed Resident 1 in his/her apartment. Resident 1's door was propped open, with a sign that indicated cameras were in the apartment. Resident 1 was in his/her chair, in front of the television, in the main living area. Surveyor observed cameras placed in Resident 1's living room and bedroom.	N 158		

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N 158	Continued From page 2 On 05/15/2026 at 12:30 p.m., Surveyor reviewed Resident 1's record. The following was identified: Resident 1 was admitted on 03/29/2024 with diagnosis including, but not limited to: vascular dementia, anxiety disorder, multiple falls, osteoarthritis, and degenerative disk disease. Resident 1 required manual wheelchair assistance for all mobility and used a mechanical lift for all transfers. Resident 1 had an activated healthcare power of attorney as of 09/13/2024. On 05/15/2026 at approximately 9:20 a.m., Surveyor reviewed current staff roster and observed Caregiver F with a start date of 09/22/2025. Business Office Director (BOD) I confirmed Caregiver F was working on the date of survey, on first shift. On 05/15/2026 at 12:00 p.m., AHD D provided resident/family concern form, dated 04/15/2026. On 04/15/2026, the documentation of concern reported by AHCPOA A and Family G stated Caregiver F used his/her phone and was being rough while changing Resident 1's undergarments. Family G reported Caregiver F had been rough before and ripped Resident 1's pants. AHD D wrote, "Video of phone usage substantiated. Awaiting video doc (documentation) on 'rough' accusation [IED B] to review and investigate." Documentation of community follow up: Individual designated to take action on this concern: IED B. Date assigned: 04/15/2026. Results of action taken: Surveyor observed section left blank. Staff member: Caregiver F. Resolution of concern: Corrective action given & signed for phone usage." Upon learning of an incident of alleged	N 158		

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N 158	Continued From page 3	N 158		

misconduct on 04/16/2026, the provider did not take immediate steps to ensure residents were protected from subsequent episodes of misconduct and abuse. Caregiver F continued to work shifts in the building.

On 05/15/2026 at 3:00 p.m., Surveyor reviewed Caregiver F's record. Caregiver F had a start date of 09/22/2025.

On 04/16/2026, Caregiver F was issued a performance deficiency notification/written warning for violation of company policy/procedure. The following was identified: "Cite infraction per employee handbook ...
-Using a cell phone or other portable electronic devices during work time, abusing the company's electronic resources, or violating the company's electronic resources policy.
-Using abusive, violent, threatening, or vulgar language on premises, whether or not it is directed at employees, residents, visitors, or other 3rd parties.
Facts or events briefly state facts or events leading to the filing of this report: On April 14th, 2026, Caregiver F was witnessed in a resident's room [sic] to be on the phone and carrying on a conversation with the person on the phone, also while in the room with Resident 1, Caregiver F used vulgar language."

On 05/18/2026 at 5:02pm, Surveyor received an email from Regional Nurse Consultant (RRNC) E, that stated, "After a comprehensive review of the concerns brought forward, it was determined that the initial response did not meet the expectations for a thorough and timely investigation. We recognize the seriousness of this breakdown and have taken immediate and decisive action to address both the specific incident and underlying

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N 158	Continued From page 4 process deficiencies. The following corrective measures have been implemented to ensure the safety, dignity, and protection of our residents: 1. Immediate Personnel Action: The employee identified in the allegation is currently suspended pending the investigation. This action was taken to mitigate any potential risk to resident safety while ensuring accountability. 2. Abuse Prevention and Resident Rights Education: All staff will undergo mandatory re-education on resident rights, with an emphasis on dignity, respect, and the prevention, identification, and mandatory reporting of abuse, neglect, and exploitation. This education will reinforce zero-tolerance expectations and staff accountability. 3. Leadership Training and Oversight: The community leadership team will receive targeted education on investigative protocols, including timely reporting requirements, documentation standards, and the necessity of completing thorough, unbiased investigations. Emphasis will be placed on compliance with regulatory requirements and internal policies. 4. Strengthening Reporting Processes: Clear expectations have been reinforced regarding immediate reporting of all allegations or concerns. Leadership has been directed to engage regional clinical and operational support teams promptly to ensure appropriate guidance, oversight, and follow-through. 5. Ongoing Monitoring and Compliance Assurance: The community will be subject to increased oversight, including audit of incident reports, investigation quality reviews, and monitoring of staff compliance with reporting protocols. Additional follow-up education or corrective actions will be implemented as needed based on audit findings."	N 158		

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N 158	Continued From page 5 On 05/19/2026 at 3:34 p.m., Surveyor received a forwarded email from Family G. On 04/16/2026 at 6:06 a.m., Family G forwarded an email to IED B with video evidence of Caregiver F providing cares to Resident 1 and pulling his/her pants down. Family G wrote, "Yanks on pants instead pulling off at waist. I am replacing to [sic] many pairs of pants because of this. They are tearing up his/her pants." Interviews On 05/15/2026 at 10:40 p.m., Surveyor interviewed HSD C, who stated that on 04/15/2026, s/he met with IED B, AHD D, Family G and AHCPOA A to discuss Family G's concerns. They stated Caregiver F was rough in handling Resident 1 during his/her care in bed. HSD C stated, "We can usually talk it out." HSD C stated that Resident 1's AHCPOA placed cameras in Resident 1's living room and bedroom. HSD C explained they felt Caregiver F was rough when they watched the video. HSD C stated there should be a write up somewhere. On 05/15/2026 at 10:40 p.m., Surveyor interviewed AHD D, who stated s/he was present when the provider became aware of the incident between Caregiver F and Resident 1. Family G indicated Caregiver F was overly rough with Resident 1. AHD D stated they did not see the video immediately. Family G stated s/he would send it to IED B via email. AHD D stated, "It was described that [Caregiver F] yanked [Resident 1's] pants down from his/her knees. In my experience, it is easier to pull pants down on a resident when you rotate them from side to side. It sounds like s/he just shimmied them down." AHD D explained that no one had seen the video during the meeting.	N 158		

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N 158	Continued From page 6 On 05/15/2026 at 2:15 p.m., Surveyor interviewed Family G, who stated AHCPOA A put cameras in Resident 1's apartment. Family G stated on 04/14/2026, Caregiver F, "yanked [Resident 1's] sweatpants straight down from his/her knees to his/her feet. Then, [Caregiver F] was on his/her phone while in the room, all in one day. [AHCPOA A] and I went into [IED B's] office to report our concerns. We sent the video the same day for his/her review." On 05/26/2026 at 8:28 a.m., Surveyor interviewed RRNC E, who confirmed IED B and his/her team looked at the video of Caregiver F and Resident 1 and determined Caregiver F was not rough. The facility management team made a judgement off the video and did not call the regional team to discuss next steps. The facility management team did discipline Caregiver F for foul language and telephone usage. RRNC E stated IED B did not utilize the complaint/grievance policy. RRNC E stated s/he saw the video and that was when s/he developed the action plan that was sent to the department. S/He stated anytime a reporter used a word, 'rough' or any of that verbiage, it should be investigated. RRNC E stated, "If that would have been my loved one, I would have been upset watching that too. Especially because s/he is unable to communicate what is going on." RRNC E informed Surveyor that on 05/18/2026, Caregiver F was suspended and on 05/19/2026, s/he was terminated. IED B is in process of sending a report to the Office of Caregiver Quality, which was due 05/26/2026.	N 158		
N 387	83.35(3)(b) Service plan development: parties involved	N 387		

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N 387	Continued From page 7 Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the resident and/or the resident's legal representative, as appropriate, were involved in developing the individual service plan (ISP) and signed the plan acknowledging their involvement in, understanding of, and agreement with the plan for 1 of 1 resident record reviewed (Resident 1). Findings include: On 05/15/2026 at 12:30 p.m., Surveyor reviewed Resident 1's record. The following was identified: Resident 1 was admitted on 03/29/2024 with diagnosis including, but not limited to: vascular dementia, anxiety disorder, multiple falls, osteoarthritis, and degenerative disk disease. Resident 1 required manual wheelchair assistance for all mobility and used a mechanical	N 387		

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N 387	Continued From page 8 lift for all transfers. Resident 1 had an activated power of attorney as of 09/13/2024. Resident 1's Individual Service Plan (ISP) dated 12/08/2025, was not signed by Resident 1's Activated Health Care Power of Attorney (AHCPOA) A. On 05/26/2026 at 1:25 p.m., Surveyor interviewed Health Services Director (HSD) C, who stated the last care conference for Resident 1's was on 12/14/2025. HSD C stated AHCPOA A and Family G wanted changes made. The ISP was not updated and signed yet. HSD C stated, "[Executive Director (ED) B was going to make some changes. Now s/he is out on leave." On 05/15/2026 at 2:15 p.m., Surveyor interviewed Family G, who stated, "They are still revising [Resident 1's] service/care plan. It has been over a year." Family G stated they met in December to go over a service plan but requested some edits. AHCPOA A had not heard from the facility that time, then with revisions.	N 387		