STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017380	A. BUILDING: _____ B. WING _____	R-C 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOSE TO HOME SENIOR LIVING - GRANTOS	4265 N 104TH STREET MILWAUKEE, WI 53222

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{N 000}	Initial Comments On 01/12/2026, Surveyor concluded a verification visit and two complaint investigations at Close to Home Senior Living-Grantosa Home. Three deficiencies were identified. One of 3 was a repeat deficiency (see Statement of Deficiency 9HYF11, dated 04/04/2025). One compliant was substantiated. One compliant was unsubstantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 14	{N 000}		
N 165	83.12(4)(c) Reporting incidents with serious injury A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not submit a written report to the department within 3 working days after an incident or accident resulting in serious injury requiring emergency room (ER) treatment and hospitalization for 2 of 2 resident (Resident 7 and Resident 8) reviewed. On 11/19/2025, Resident 7 sustained a fall, hit a table and sustained a laceration on the bridge of	N 165		

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

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N 165	Continued From page 1	N 165		

his/her nose and scratches on his/her back. Resident 7 was sent to the ER. Resident 7 did not return to the facility. Resident 7's file did not contain evidence that the facility reported this incident to the State Agency.

On 10/23/2025, the department received a complaint that Resident 8 suffered a fall at the facility. The next day, Resident 8 went to West Allis Memorial Hospital, who transferred him/her to Aurora Summit. Resident 8 died on 01/15/2025. Resident 8's file did not contain evidence that the facility reported this incident to the department.

Findings include:

On 01/02/2026, Surveyor reviewed resident record. The following was identified:

Resident 7

Resident 7 was admitted on 08/22/2023. Resident 7's diagnosis included history of falling, frontotemporal neurocognitive disorder, cerebral infarction (stoke), and dementia with agitation.

On 11/19/2025 at 7:30 a.m., Resident 7's observation note indicated s/he had a fall at about 6:50 a.m. Caregiver G wrote, "A table fell down [sic] hit him/her in the nose area [sic] s/he is bleeding profusely by his/her nose and under eye." Caregiver G stated s/he could not get Resident 7 off the floor, and s/he called the paramedics.

Resident 8

Resident 8 was admitted to facility on 03/22/2023. Resident 8 was decisional. Resident 8's diagnosis

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	0017380	A. BUILDING: _____ B. WING _____	R-C 01/12/2026

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N 165	Continued From page 2	N 165		

included chronic respiratory failure, chronic obstructive pulmonary disease (COPD), tobacco use, severe emphysema, type 2 diabetes mellitus, and history of falls. Resident 8 required 4-liters of oxygen at rest and 6-liters of oxygen with activity.

On 01/02/2026 Surveyor reviewed RSM A emails to Care Manager (CM) I, Nurse Care Manger (RNCM) J and Executive Director (ED) B. Three falls dated 12/02/2024, 12/12/2024 and 01/13/2025, were documented in emails to Resident 8's care team. The following was identified:

-12/02/2024: RSM A wrote, "I just wanted to let you all know that [Resident 8] had a fall on 11-30-24 trying to put his/her pants on. S/He refused medical attention. S/He stated that s/he is fine."

-12/12/2024: RSM A wrote, "I just wanted to let you know that [Resident 8] had a fall. S/He stated s/he slipped while getting up from the bed. S/He is fine and refused medical attention."

-01/13/2025: RSM A wrote, "Good morning, I just wanted to let you know that [Resident 8] is in the hospital. S/He was complaining of chest pains last night and was sent out. Unfortunately, s/he suffered 3-4 broken ribs and will be transferred to another hospital in summit to be treated in intensive care [sic] icu [sic] per his/her guardian."

Legal Documentation- Final Fall

On 05/07/2025, The Milwaukee County medical examiner report stated the immediate cause of death was complications of blunt trauma of the chest. Final manner of death stated, "Accident."

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CLOSE TO HOME SENIOR LIVING - GRANTOS	4265 N 104TH STREET MILWAUKEE, WI 53222

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N 165	Continued From page 3 On 09/29/2025, the Milwaukee County Medical Examiner investigation report stated Resident 8 had unwitnessed fall on 01/12/2025. S/He began to complain about chest, abdomen and shoulder pain and was taken to the ER. Resident 8 was diagnosed with 3-5 right rib fractures, a left clavicle fracture and a right breast hematoma. Resident 8 complained of severe pain and was taken to the ICU where s/he was intubated on the morning of 01/13/2025. Resident 8 died in the ICU on 01/15/2025. On 12/30/2025, Surveyor reviewed the provider's self-report history. The following was identified: The Department did not receive a self-report for Resident 7's fall on 11/19/2025, resulting in an ER visit. Resident 7 did not return to the facility. The Department did not receive a self-report for Resident 8's fall on 01/12/2025, resulting in an ER visit. Resident 8 did not return to the facility. On 01/02/2026, at approximately 3:55 p.m., Surveyor interviewed Executive Director B and asked when the two incidents were reported to the department. Executive Director B stated, "I didn't know I had to report them. Now I know. I saved the link on my computer." Cross Reference: N0389 DHS 83.35(3)(d) Service Plans Updated Annually or on Changes	N 165		
N 219	83.17(1) Licensee conduct caregiver background check Caregiver background check. At the time of hire, employment or contract and every 4 years after,	N 219		

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N 219	Continued From page 4 the licensee shall conduct and document a caregiver background check following the procedures in s. 50.065, Stats., and ch. DHS 12. A licensee shall not employ, contract with or permit a person to reside at the CBRF if the person has been convicted of the crimes or offenses, or has a governmental finding of misconduct, found in s. 50.065, Stats., and ch. DHS 12, Appendix A, unless the person has been approved under the department ' s rehabilitation process as defined in ch. DHS 12. This Rule is not met as evidenced by: Based on record review and staff interview, the provider permitted 1of 1 caregiver to work at the Community Based Residential Facility (CBRF) with substantiated findings of abuse. On Caregiver F's Government Findings Report (GFR) it was documented Caregiver F was placed on the Wisconsin Caregiver Misconduct Registry on 09/05/2017. Findings include: A complete background check consists of a Background Information Disclosure (BID) form by the employee, a report of findings from the DOJ findings, and the GFR document of findings from the Department of Health Services. On 01/02/2026 at 3:00 p.m., Surveyor reviewed Caregiver H's records. The following was identified: Caregiver H was hired on 02/28/2025 and started working on the floor with the residents on 03/20/2025. Caregiver H's termination date was	N 219		

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N 219	Continued From page 5 11/19/2025. Surveyor reviewed Caregiver H's filled out and signed BID document, dated 02/28/2025. The BID did not contain information of findings of abuse/neglect. Surveyor reviewed Caregiver H's GFR, from the Department of Health Services. It included findings of abuse, or neglect of a client, or misappropriation of client property in Wisconsin, dated 09/05/2017. On 01/02/2026 at approximately 4:10 p.m., Surveyor interviewed Executive Director (ED) B, who stated both s/he and Resident Services Manager (RSM) F managed the employee files. Surveyor asked ED B why Caregiver H was hired when s/he was placed on the Wisconsin Caregiver Misconduct Registry on 09/05/2017. ED B stated they removed Caregiver H from the floor on 11/19/2025 after Resident 7 had a fall and was sent to the emergency room. ED B stated, "I run the background checks. I must have overlooked that. That's terrible. How did we miss that?" On 01/08/2026 at 3:30 p.m., Surveyor searched Wisconsin Public Misconduct Registry with Caregiver H's name. Under his/her name, it read, "Has a history of misconduct." Under, 'show record detail', Surveyor was taken to another page, with Caregiver H's name on the top, left hand side of the page. The page read, "A substantiated finding of abuse was placed on the Wisconsin Caregiver Misconduct Registry for this individual. Because a substantiated finding is on file, this individual cannot work as a caregiver in DHS regulated facilities in Wisconsin, except those specifically approved under the rehabilitation review process." Caregiver H had been working in the facility from 03/20/2025 to	N 219		

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N 219	Continued From page 6 11/19/2025, almost eight months, while on the Wisconsin Caregiver Misconduct Registry. On 01/12/2026 at 2:14 p.m., Surveyor received a copy of Caregiver H's case summary from the Office of Caregiver Quality (OCQ) confirming decision of abuse dated 09/05/2017. On 09/05/2017, Caregiver H was placed on the Wisconsin Caregiver Misconduct Registry. OCQ confirmed with the rehabilitation review area, and Caregiver H did not have approval to work in an assisted living facility.	N 219		
{N 389}	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not update the Individual Service Plan (ISP) when there was a change in needs, abilities, or condition for 1 of 1 resident (Resident 8) reviewed.	{N 389}		

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	0017380	A. BUILDING: _____ B. WING _____	R-C 01/12/2026

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CLOSE TO HOME SENIOR LIVING - GRANTOS	4265 N 104TH STREET MILWAUKEE, WI 53222

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{N 389}	Continued From page 7 Resident 8 was admitted to the provider on 03/22/2023. Resident 8 had twelve documented falls from 11/30/2024 to 01/12/2025. The fall on 01/12/2025 resulted in an emergency room (ER) visit where Resident 8 was diagnosed with 3-5 right rib fractures, a left clavicle fracture and a right breast hematoma. Resident 8 was taken to the intensive care unit (ICU) where s/he was intubated on the morning of 01/13/2025. Resident 8 died in the ICU on 01/15/2025. Resident 8's ISP dated 6/21/2024, did not identify Resident 8's fall needs, desired outcomes, frequency and approaches the facility would provide, established measurable goals, specific methods for delivering needed care and who is responsible for delivering the care to minimize falls from occurring. Resident 8's ISP was not updated to reflect transfer and ambulation status or fall risk after the twelve documented falls. This is a repeat deficiency. See Statement of Deficiency 9HYF11 dated 04/04/2025. Findings include: Resident 8 was admitted to facility on 03/22/2023. Resident 8 was decisional. Resident 8's diagnosis included chronic respiratory failure, chronic obstructive pulmonary disease (COPD), tobacco use, severe emphysema, type 2 diabetes mellitus, and history of falls. Resident 8 required 4-liters of oxygen at rest and 6-liters of oxygen with activity. Individualized Service Plan Resident 8's ISP dated 06/21/2024, indicated Resident 8 required some assistance with rollator. Later in ISP, under, 'ADL's- mobility and	{N 389}		

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{N 389}	Continued From page 8	{N 389}		

transferring,' Resident 8's needs were labeled, "independent with ambulation. Resident uses a rollator to ambulate." Resident 8's ISP dated 06/21/2024, did not contain complete information related to ambulation and transfer status, nor did the ISP contain information regarding Resident 8's fall risk and interventions the facility was utilizing to minimize the fall risk. Resident 8's ISP did not have his/her signature or date indicating date of agreement. Additionally, the ISP was not updated to address Resident 8's twelve documented falls. The ISP did not contain information regarding falls or fall prevention.

Facility Incident Reports

Three falls dated 11/30/2024, 12/04/2024 and 12/26/2024, were documented in the facility incident reports. The following was identified:

-11/30/2024: Caregiver K, wrote, "At 5:51 a.m., [Resident 8] fell onto the floor trying to put pants on."

-12/04/2024: Caregiver K, wrote, "At 5:51 a.m., [Resident 8] fell onto the floor, in his/her bedroom. [Resident 8] stated s/he fell out of bed."

-12/26/2024: Caregiver G, wrote, "At 9:15 a.m., staff found [Resident 8] sitting on bedroom floor by the TV stand." Resident 8 told caregiver s/he only slid down and did not need to see anyone.

Resident 8's file did not contain an incident report that documented his/her fall on 01/12/2025.

Facility Observation Notes

Seven falls dated 12/12/2024, 12/14/2024, 12/16/2024 (3:15 p.m., and 6:15p.m.), 12/27/2024

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	0017380	A. BUILDING: _____ B. WING _____	R-C 01/12/2026

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CLOSE TO HOME SENIOR LIVING - GRANTOS	4265 N 104TH STREET MILWAUKEE, WI 53222

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{N 389}	Continued From page 9 (9:45 p.m. and 10:45 p.m.), and 12/31/2024 were documented in the facility observation notes. The following was identified: -12/12/2024: Caregiver G, wrote, "[Resident 8] slid off the bed [sic] staff keep telling resident to get all the way in bed ..." -12/14/2024: Caregiver G, wrote, "[Resident 8] slide [sic] out of the bed to floor [sic] staff ask him/her was s/he hurt [sic] staff had him/her do ROM (range of motion exercise) [sic] s/he stated nothing hurts [sic] staff call manger [sic]." -12/16/2024: Two falls. At 3:15 p.m., RSM A wrote, "[Resident 8] had a fall coming into the building from an appointment." At 6:15 p.m., RSM A wrote, "[Resident 8] had a fall trying to get up. S/He stated s/he was fine ..." -12/27/2024: Two falls. At 9:45 p.m., RSM A wrote, "[Resident 8] has fall today [sic] refused medication attention." At 10:45 p.m., Caregiver G wrote, "When doing rounds [sic] notice [Resident 8] was on the floor [sic] staff did ROM [sic] [Resident 8] was fine [sic] staff call manger [sic]." -12/31/2024: RSM A wrote, "[Resident 8] has [sic] a fall [sic] s/he tripped over his/her oxygen cord [sic] s/he stated s/he is fine." Resident 8's file did not contain an observation note that documented his/her fall on 01/12/2025. Emails to Care Team On 01/02/2026 Surveyor reviewed RSM A emails to Care Manager (CM) I, Nurse Care Manger (RNCM) J and Executive Director (ED) B. Three falls dated 12/02/2024, 12/12/2024 and	{N 389}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017380	A. BUILDING: _____ B. WING _____	R-C 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOSE TO HOME SENIOR LIVING - GRANTOS	4265 N 104TH STREET MILWAUKEE, WI 53222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 389}	Continued From page 10 01/13/2025, were documented in emails to Resident 8's care team. The following was identified: -12/02/2024: RSM A wrote, "I just wanted to let you all know that [Resident 8] had a fall on 11-30-24 trying to put his/her pants on. S/He refused medical attention. S/He stated that s/he is fine." -12/12/2024: RSM A wrote, "I just wanted to let you know that [Resident 8] had a fall. S/He stated s/he slipped while getting up from the bed. S/He is fine and refused medical attention." -01/13/2025: RSM A wrote, "Good morning, I just wanted to let you know that [Resident 8] is in the hospital. S/He was complaining of chest pains last night and was sent out. Unfortunately, s/he suffered 3-4 broken ribs and will be transferred to another hospital in summit to be treated in intensive care [sic] icu [sic] per his/her guardian." Legal Documentation- Final Fall On 05/07/2025, The Milwaukee County medical examiner report stated the immediate cause of death was complications of blunt trauma of the chest. Final manner of death stated, "Accident." On 09/29/2025, the Milwaukee County Medical Examiner investigation report stated Resident 8 had unwitnessed fall on 01/12/2025. S/He began to complain about chest, abdomen and shoulder pain and was taken to the ER. Resident 8 was diagnosed with 3-5 right rib fractures, a left clavicle fracture and a right breast hematoma. Resident 8 complained of severe pain and was taken to the ICU where s/he was intubated on the morning of 01/13/2025. Resident 8 died in the	{N 389}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CLOSE TO HOME SENIOR LIVING - GRANTOS	4265 N 104TH STREET MILWAUKEE, WI 53222

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{N 389}	Continued From page 11 ICU on 01/15/2025. Interviews On 01/02/2025 at 12:55pm, Surveyor interviewed Executive Director (ED) B who stated, "[Resident 8] had several falls at the facility. S/He was decisional, and s/he kept refusing to get help when we found him/her on the floor. After s/he had a couple of falls, I told him/her it was time to get checked out." Surveyor asked what date that was. ED B stated it was the date Resident 8 went to the ER and did not return. ED B confirmed whenever Resident 8 had a fall, either RSM A or ED B would notify Resident 8's care team. On 01/02/2025 at 2:25pm, Surveyor reviewed Resident 8's falls with Executive Director (ED) B, who stated, s/he did not realized Resident 8 had so many falls, so close together. ED B stated, "That should have stuck out to us." ED B confirmed, "Nothing changed in [Resident 8's] care plan to put the staff in high alert and watch for falls and check on him/her more often." Resident 8's ISP did not include all his/her needs, program services the CBRF would provide, specific methods for delivering needed care, and who was responsible for delivering the cares nor did the ISP contain information regarding Resident 8's fall risk and interventions the facility was utilizing to minimize the fall risk.	{N 389}		