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	0012625	A. BUILDING: _____ B. WING _____	10/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTHERMERE MANOR	7000 N 44TH ST MILWAUKEE, WI 53223

(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 000	Initial Comments On 10/28/2025, Surveyor completed an abbreviated survey at Esthermere Manor. As a result, 12 deficiencies were identified. Census: 4	N 000		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis (TB), within 90 days before the start of employment for 1 of 1 caregiver reviewed (Caregiver D). Caregiver D was not screened for communicable diseases. Findings include:	N 220		

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

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N 220	Continued From page 1 On 10/24/2025, at 1:00 PM, Surveyor reviewed Caregiver D's record. Caregiver D was hired on 08/24/2022. Caregiver's record contained a TB test on 08/01/2022. Caregiver D's record did not contain any evidence of a communicable disease screening. On 10/24/2025, at 1:35 PM, Surveyor interviewed House Manager A. House Manager A reported s/he was aware of the screening but was unaware staff needed a communicable disease screening. House Manager A reported s/he thought a TB test was all staff needed. House Manager A reported s/he would ensure staff received all screenings required.	N 220		
N 223	83.18(1) Employee records maintained and current. A separate record for each employee shall be maintained, kept current, and at a minimum, include: (a) Written job description including duties, responsibilities and qualifications required for the employee; (b) Beginning date of employment; (c) Educational qualifications for administrators; (d) Completed caregiver background check following procedures under s. 50.065, Stats., and ch. HFS 12; (e) Documentation of training, or exemption verification. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 employee (Caregiver C) record was maintained. Caregiver C's record was not maintained and available for review.	N 223		

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N 223	Continued From page 2 Findings Include: On 10/24/2025, at 1:00 PM, Surveyor requested to review Caregiver C's employee record. Caregiver C was hired on 06/30/2025. Caregiver C's record was not available for review. On 10/24/2025, at 1:00 PM, Surveyor interviewed House Manager A. House Manager A confirmed the code requirement. House Manager A reported s/he was unable to locate Caregiver C's record. House Manager A reported s/he would need to locate the file or need to recreate the file.	N 223		
N 277	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 caregiver (Caregiver D) reviewed received 15 hours annual training in all required areas. Caregiver D did not receive training in standard precautions, medications and fire safety, 1st aid and	N 277		

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N 277	Continued From page 3	N 277		

emergency procedures in 2023. Caregiver D did not receive continuing education training in 2024.

Findings include:

On 10/24/2025, at 1:00 PM, Surveyor reviewed Caregiver D's record. Caregiver D was hired 08/24/2022. Caregiver D's record indicated in 2023 s/he received 15 hours of training in client group with advance age, dementia/Alzheimer's, developmental disabilities, health insurance portability and accountability act, information regarding assessed needs and individual services, dietary needs in assisted living, providing personal cares, prevention and reporting resident abuse, neglect, misappropriation and injury of unknown sources, recognizing and responding to resident changes in condition, recognizing, preventing, managing and responding to challenging behaviors, resident rights, proper resident lifting and transferring skills, safety practices in assisted living, and vital measurements. Caregiver D's record did not indicate s/he received training in standard precautions, medications and fire safety, 1st aid and emergency procedures in 2023.

Caregiver D's record did not contain any evidence of continuing education training in 2024.

On 10/24/2025, at 1:35 PM, Surveyor interviewed House Manager A. House Manager A confirmed the code requirement but was unaware of all the areas required by the code. House Manager A confirmed staff did not receive any continuing education in 2024 due to a scheduling error with the company they used for continuing education. House Manager A reported they were unable to get training scheduled by the end of 2024.

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N 401	Continued From page 4	N 401		
N 401	83.37(1)(b) Medication label permanently attached. Medications. Prescription medications shall come from a licensed pharmacy or a physician and shall have a label permanently attached to the outside of the container. Over-the-counter medications maintained in the manufacturer ' s container shall be labeled with the resident ' s name. Over-the-counter medications not maintained in the manufacturer ' s container shall be labeled by a pharmacist. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure medications were labeled to ensure proper and safe usage for 2 of 2 residents. Findings include: On 10/24/2025, at 10:15 AM, Surveyor observed the medication closet. Each resident had their own plastic basket. Surveyor observed the following medications without labels attached: Resident 1 3 nebulizer treatment vials Resident 2 4 nebulizer treatment vials On 10/24/2025, at 2:00 PM, Surveyor interviewed House Manager A. House Manager A confirmed the code requirement. When Surveyor showed House Manager A the vials in Resident 1's and Resident 2's medication basket, House Manager A inquired if Surveyor found nebulizer vials in Resident 2's basket. Surveyor confirmed s/he	N 401		

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N 401	Continued From page 5 found the 4 nebulizer vials in Resident 2's basket. House Manager A moved the vials from Resident 2's basket, to Resident 1's basket. Surveyor relayed concerns regarding the medication not containing a label, House Manager A agreed with Surveyor's concerns.	N 401		
N 406	83.37(1)(g) Disposition of medications. Disposition of medications. 1. When a resident is discharged, the resident ' s medications shall be sent with the resident. 2. If a resident ' s medication has been changed or discontinued, the CBRF may retain a resident ' s medication for no more than 30 days unless an order by a physician or a request by a pharmacist is written every 30 days to retain the medication. 3. The CBRF shall develop and implement a policy for disposing unused, discontinued, outdated, or recalled medications in compliance with federal, state and local standards or laws. The CBRF shall arrange for the stored medications to be destroyed in compliance with standard practices. Medications that cannot be returned to the pharmacy shall be separated from other medication in current use in the facility and stored in a locked area, with access limited to the administrator or designee. The administrator or designee and one other employee shall witness, sign, and date the record of destruction. The record shall include the medication name, strength and amount. This Rule is not met as evidenced by: Based on observation and interview, the provider did not establish an effective procedure for proper destruction and disposal of expired medications.	N 406		

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N 406	Continued From page 6 Expired medications were observed store with resident's non-expired medications in 1 of 1 medication storage cabinet. Findings include: On 06/13/2025, at 12:55 PM, Surveyor observed the medication filing cabinet. Surveyor observed the following expired medications: -Resident 1 2 packages, 5 vials in each package of ipratropium albuterol vials with an expiration date of 05/28/2024 -Resident 2 Ketoconazole 2% cream with an expiration date 09/20/2024 Ventolin inhaler with an expiration date 07/22/2024 On 10/24/2025, at 1:35 PM, Surveyor interviewed House Manager A. House Manager A confirmed the code requirement. House Manager A reported s/he used to go through the medication closet every 3-4 months, but they had a nurse who would go through the medication closet weekly. Surveyor relayed concerns regarding the expired medications. House Manager A reported s/he was unsure why medications were expired in the closet if the nurse was reviewing medications, and they had a pharmacy audit of the medication closet in June 2025.	N 406		
N 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and	N 499		

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N 499	Continued From page 7 toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure cleaning compounds and toxic substances were securely stored in 7 of 7 areas. Findings include: The facility is licensed as a Class CNA (non-ambulatory) Community Based Residential Facility which may serve up to 5 advanced aged, emotionally disturbed/mentally ill, traumatic brain injury, physically disabled, and developmentally disabled residents. On 10/24/2025, at 10:15 AM, Surveyor toured the facility and observed the following: A desk in the living room had a can of Lysol disinfectant. The bathroom on the north side of the facility had a can of Febreze air freshener and an unlabeled spray bottle with a clear liquid on the sink counter. The kitchen counter, next to the sink had a bottle of Clorox bleach. On the other side of the sink was an unlabeled spray bottle which contained purple liquid. The counter next to the medication closet had a bottle of Windex, a can of Homeline air freshener, a can of Homeline disinfectant spray, a can of Febreze air freshener and an unlabeled spray bottle which contained clear liquid. A closet on the south end of the facility was open.	N 499		

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N 499	Continued From page 8 The door contained a locking mechanism which was not engaged. Inside the closet was a bottle of Fabuloso cleaner, a bottle of Greased Lightning cleaner and degreaser, 2 containers of Members Mark disinfecting wipes, a bottle of Off bug spray, and a bottle of Cutter backyard bug control spray. The bathroom on the east side of the facility had a bottle of Febreze air freshener on a shower chair. Surveyor observed residents moving freely throughout the facility. On 10/242025, at 1:35 PM, Surveyor interviewed House Manager A. House Manager A confirmed the code requirement. Surveyor relayed concerns of the toxic substances, House Manager A reported s/he was not aware cleaning supplies and air fresheners were considered toxic substances. House Manager A reported toxic substances were locked under the kitchen sink.	N 499		
N 504	83.46(1)(c) Heating system maintenance. Heating. The CBRF shall maintain the heating system in a safe and properly functioning condition. The CBRF shall ensure that a heating contractor or local utility company completes all of the following maintenance and makes available to the facility documentation of the maintenance performed: 1. An oil furnace shall be serviced at least once each year. 2. A gas furnace shall be serviced at least once every 3 years. 3. The CBRF shall have a chimney inspected at intervals corresponding with the heating system service under subd. 1. or 2.	N 504		

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N 504	Continued From page 9 This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure 2 of 2 gas furnaces were inspected at least every 3 years. The furnace was due to be inspected in 2023. Findings include: On 10/24/2025, at 11:00 AM, Surveyor reviewed facility safety code documentation. The last furnace inspection was completed on 10/12/2020. Surveyor did not review evidence a furnace inspection was completed in 2023. On 10/24/2025, at 1:35 PM, Surveyor interviewed House Manager A. House Manager A reported the furnace inspection was not completed since 2020. House Manager A reported s/he was unaware of the code requirement but reported Licensee B was responsible for scheduling the inspections. House Manager A reported Licensee B scheduled the furnace inspection for the end of October.	N 504		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may	N 525		

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N 525	Continued From page 10	N 525		

be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure quarterly fire drills were conducted for 2 of 2 years (2023 and 2024). Two drills were not conducted in 2024. A nighttime drill was not documented in 2023 and 2024.

Findings include:

On 10/24/2025, at 11:00 AM, Surveyor reviewed facility safety code documentation and identified the following:

2023
Quarter 1 01/09/2023 at 9:30 PM, evacuation time 15 minutes
Quarter 2 04/13/2023 6:15 PM, evacuation time 1 minute
Quarter 3 No drill documented
Quarter 4 No drill documented

2024
Quarter 1 03/31/2024 at 5:00 PM, evacuation time 1 minute, 36 seconds
Quarter 2 06/27/2024, at 5:39 PM, evacuation time 1 minute, 33 seconds
Quarter 3 09/21/2024 at 2:19 PM, evacuation time 2 minutes, 51 seconds
Quarter 4, 12/31/2024 at 4:59 (AM/PM), no

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N 525	Continued From page 11 evacuation time documented Surveyor was unable to establish compliance with a drill which simulates the conditions of usual sleeping hours. On 10/24/2025, at 12:00 PM, Surveyor interviewed House Manager A. House Manager A confirmed the code requirement. House Manager A reported s/he thought all drills conducted were in the binder but was unsure if some were in a different spot.	N 525		
N 526	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure tornado, flooding, or other emergency or disaster drills were conducted semi-annually for 2 of 2 years. There were no other emergency or disaster drills conducted in 2023 or 2024. Findings include: On 10/24/2025, at 11:00 AM, Surveyor reviewed facility safety code documentation. A tornado drill was conducted on 06/30/2025, 10/12/2022 and 09/20/2022. Surveyor did not review evidence of other evacuation drills for 2023, 2024 and to date in 2025. On 10/24/2025, at 1:35 PM, Surveyor interviewed House Manager A. House Manager A confirmed	N 526		

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N 526	Continued From page 12 s/he was unaware of the code requirement. House Manager A reported s/he thought only 1 other drill was required a year. House Manager A reported s/he was unsure why there were no other drills in 2023 and 2024.	N 526		
N 530	83.47(3) Fire inspection. Fire inspection. The CBRF shall arrange for an annual inspection by the local fire authority or certified fire inspector and shall retain fire inspection reports for 2 years. This Rule is not met as evidenced by: Based on record review and interview, the provider did not arrange for an annual fire inspection for 2 of 2 years reviewed (2023, 2024, and to date in 2025). Findings include: On 10/24/2025, at 11:00 AM, Surveyor reviewed facility safety code documentation. The last fire inspection was completed 07/14/2021. Surveyor did not review evidence of a fire inspection conducted in 2023 and 2024. On 10/24/2025, at 12:00 PM, Surveyor interviewed House Manager A. House Manager A reported Licensee B indicated the fire inspections were not completed. House Manager A reported Licensee B was responsible for scheduling the inspections. House Manager A reported they would ensure the fire inspection was completed immediately.	N 530		

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N 633	Continued From page 13	N 633		
N 633	83.59(1)(c) Exit doors, passageways 32 inches clear All habitable floors shall have at least 2 exits providing unobstructed travel to the outside. Small class AA CBRFs licensed on or before the effective date of this section with no more than 2 habitable floors may have one exit from the second floor. Exit doors and doors in exit passageways shall have a clear opening of at least 32 inches in width and 76 inches in height. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure 1 of 3 exits doors had a clear opening of at least 32 inches. The rear door in the kitchen, had a clear opening of 29.5 inches. Findings include: The facility is licensed as a Class CNA (non-ambulatory) Community Based Residential Facility which may serve up to 5 advanced aged, emotionally disturbed/mentally ill, traumatic brain injury, physically disabled, and developmentally disabled residents. On 10/24/2025, at 10:30 AM, Surveyor toured the facility. The rear door, located in the kitchen had a clear opening of 29.5 inches. On 10/24/2025, at 10:39 AM, Surveyor reviewed the facility emergency exit diagram. The rear door in the kitchen was identified as an emergency exit. On 10/24/2025, at 1:35 PM, Surveyor interviewed	N 633		

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N 633	Continued From page 14 House Manager A about the exit door passageways. House Manager A reported s/he was not aware of the clear opening requirement. House Manager A reported s/he would let Licensee B know about the door.	N 633		
Z 014	50.065(2)(d) MAINTAIN BACKGROUND INFORMATION Every entity shall maintain, or shall contract with another person to maintain, the most recent background information obtained on a caregiver under par. (b). The information shall be made available for inspection by authorized persons, as defined by the department by rule. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 caregiver (Caregiver D) background check was maintained. Caregiver D's background check was not maintained by the provider and was unavailable for review upon Surveyor's request. Findings include: On 10/24/2025, at 1:00 PM, Surveyor reviewed Caregiver D's record. Caregiver D was hired on 08/24/2022. Caregiver D's record contained a Background Information Disclosure (BID), dated 08/15/2022. Caregiver B's record did not contain a Department of Justice (DOJ) report or an Integrated Background Information System (IBIS)	Z 014		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012625	A. BUILDING: _____ B. WING _____	10/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTHERMERE MANOR	7000 N 44TH ST MILWAUKEE, WI 53223

(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
Z 014	Continued From page 15 letter from the department. On 10/24/2025, at 1:35 PM, Surveyor interviewed House Manager A. House Manager A reported Licensee B may have the DOJ report and the IBIS letter for Caregiver D with her/him in Arizona. House Manager A confirmed the information should be kept in Caregiver D's record and s/he would talk with Licensee B.	Z 014		