STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010403	A. BUILDING: _____ B. WING _____	C 10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM WISCONSIN II INC NICHOLSON	1009 NICHOLSON AVE SOUTH MILWAUKEE, WI 53172

(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 10/29/2025, Surveyors concluded an abbreviated survey and a complaint investigation at REM Wisconsin II INC Nicholson. 6 deficiencies were identified. One complaint was substantiated. Census: 6	N 000		
N 161	83.12(3)(a) Investigate injuries of unknown source. Investigating injuries of unknown source. A CBRF shall investigate any of the following: 1. An injury that was not observed by any person. 2. The source of an injury to a resident that cannot be adequately explained by the resident. 3. An injury to a resident that appears suspicious because of the extent of the injury or the location of the injury on the resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure all injuries of unknown source were investigated for 1 of 1 resident reviewed. Resident 1 sustained injuries of unknown origin. Resident 1 was not able to adequately explain the source of his/her injury. Findings include: The facility is licensed to serve irreversible dementia/Alzheimer's, advanced aged, terminally ill, and physically disabled. On 8/11/2025, the department received a	N 161		

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N 161	Continued From page 1	N 161		

complaint alleging administration did not report a resident's injury of unknown origin.

On 10/29/2025, between 12:15 p.m. and 3:00 p.m., Surveyor reviewed Resident 1's record and identified the following:

Resident 1 was admitted to the facility on 12/16/2020 with diagnoses including profound intellectual disability, cerebral palsy and epilepsy. Resident 1's Individual Service Plan (ISP), dated 7/25/2025, documents Resident 1 utilizes a wheelchair. Resident 1 is non-verbal and is unable to communicate their needs and wants.

Surveyor reviewed Resident's 1's medical record including progress notes and ISP. A progress noted, dated 8/5/2025, by Registered Nurse H documented the following: "I took a look at [Resident 1's] scratches on the left side of their neck and the one near his/her nose which appear to be self-inflicted. There is a red area to their left jawline and cheek. The cheek redness may be due to how wet [his/her] shirt is and [s/he] falls asleep resting [his/her] face on it or it could be an abrasion at this point. It is difficult to say. [S/he] also has a small narrow bruise on over [his/her] clavicle (collar bone) from unknown origin." Surveyor reviewed Resident 1's ISP. Surveyor could not identify any documentation related to Resident 1's history of scratching or self-inflicted injuries. There was no additional documentation identifying how Resident 1 may have received the bruise on his/her clavicle.

On 10/29/2025 at 3:02 p.m., Surveyor conducted interview with Registered Nurse H. Surveyor asked Registered Nurse H what the process would be for investigating an injury of an unknown origin. Registered Nurse H responded that they

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N 161	Continued From page 2 would follow an investigation protocol including documentation. Surveyor asked Registered Nurse H if there was a reason Resident 1's scratches and bruising to the clavicle on 8/5/2025 was not thoroughly investigated. Registered Nurse H responded that they know that Resident 1 has a history of scratching themselves. Surveyor asked Registered Nurse H if a resident has a history of scratching themselves or self-inflicting harm whether that should be reflected on a resident's ISP. Registered Nurse H responded that type of information should be included on a resident's ISP. On 10/29/2025 at 4:00 p.m., Surveyor conducted interview with Program Director A and Program Supervisor B, Surveyor shared concern related to Resident 1 sustaining multiple scratches and bruising to the clavicle of unknown origin on 8/5/2025. Surveyor shared concern that Resident 1's injuries were not thoroughly investigated by the provider. No additional information was made available by the provider at this time.	N 161		
N 383	83.35(1)(c) Listed areas for assessments. Assessment. Areas of assessment. The assessment, at a minimum, shall include all of the following areas applicable to the resident: 1. Physical health, including identification of chronic, short-term and recurring illnesses, oral health, physical disabilities, mobility status and the need for any restorative or rehabilitative care. 2. Medications the resident takes and the resident ' s ability to control and self-administer medications. 3. Presence and intensity of pain. 4. Nursing procedures the resident needs and the number of hours per week of nursing care the resident needs. 5. Mental and emotional health,	N 383		

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N 383	Continued From page 3 including the resident ' s self-concept, motivation and attitudes, symptoms of mental illness and participation in treatment and programming. 6. Behavior patterns that are or may be harmful to the resident or other persons, including destruction of property. 7. Risks, including, choking, falling, and elopement. 8. Capacity for self-care, including the need for any personal care services, adaptive equipment or training. 9. Capacity for self-direction, including the ability to make decisions, to act independently and to make wants or needs known. 10. Social participation, including interpersonal relationships, communication skills, leisure time activities, family and community contacts and vocational needs. This Rule is not met as evidenced by: Based observation, record review, and staff interview, the provider did not complete an assessment for the use of durable medical equipment (DME) devices. Resident 3 had a bed bar on his/her bed and Resident 2 had a raised toilet seat in the bathroom. The provider did not identify the reason for the use, assess for risk and safety of the devices. Findings include: On 10/29/2025 at 9:25 a.m., Surveyors toured the facility with Program Supervisor B and observed the following: Example 1 Surveyors observed an attached, raised toilet	N 383		

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N 383	Continued From page 4	N 383		

seat, in the large, shower and tub bathroom. Surveyors requested Program Supervisor B pull on the arm of the raised toilet seat, to check for its sturdiness. Surveyors observed the attached, raised toilet seat loose enough to lift off toilet.

On 10/29/2025 at 9:34 a.m., Program Supervisor B stated, "This is for [Resident 2]. [Maintenance H] put an order in for it. When it came in, s/he installed it." Program Supervisor B stated s/he did not know if there was a needs/safety assessment done for the raised toilet seat.

On 10/29/2025 at 12:10 p.m., Surveyors toured the facility with Program Supervisor B and Program Coordinator C. Program Supervisor B lifted the raised toilet seat off the toilet, to demonstrate its sturdiness. Program Coordinator C stated, "Oh my gosh!"

Surveyors asked Program Supervisor B and Program Coordinator C who put the attached, raised toilet seat on. Program Supervisor B stated, "[Maintenance H] installed it for us."

Program Supervisor B and Program Coordinator C confirmed the raised toilet seat was a safety risk for Resident 2.

Surveyors reviewed Resident 2's record and noted the record did not contain an assessment related to the use of the device.

Surveyor reviewed the Individual Service Plan (ISP) dated 09/05/2025. The ISP did not address the raised toilet seat.

Example 2

Surveyors observed Resident 3's room and noted

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N 383	Continued From page 5 Resident 3's bed contained a bed bar device. The device was loose from the bed. On 10/29/2025 at 9:40 a.m., Program Supervisor B stated, "[Resident 3] ordered this for his/her bed. [Maintenance H] put it on for him/her. It's been there for seven to eight months." Program Supervisor B stated s/he did not know if there was a needs/safety assessment done for the bed bar device. On 10/29/2025 at 12:10 p.m., Surveyor interviewed Area Director G, who stated Resident 3 had the bed bar for about one year, but did not recall if an assessment was done. Surveyors reviewed Resident 3's record and noted the record did not contain an assessment related to the use of the device. Surveyor reviewed the ISP dated 07/14/2025. The ISP did not address the bed bar device. Surveyor interviewed Program Director A and Program Supervisor B regarding the assessment and inclusion of the devices on Resident 2's and Resident 3's ISPs. Program Director A stated they would complete an assessment to ensure safety and include the use of the devices on the residents' ISPs.	N 383		
N 425	83.38(1)(a) Personal care. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident's highest level of functioning. In addition to the assessed needs as determined under s.	N 425		

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N 425	Continued From page 6 DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Personal care. Personal care services shall be designed and provided to allow a resident to increase or maintain independence. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure 1 of 1 resident (Resident 1) was provided assistance to maintain his/her highest level of functioning with activities of daily living. Findings include: Wis. Admin. Code § DHS 83.02 (37) defines personal care as, "Assistance with activities of daily living but does not include nursing care." On 10/29/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 12/16/2020 with diagnoses including profound intellectual disability, cerebral palsy and epilepsy. Resident 1's Individual Service Plan (ISP), dated 7/25/2025, documents Resident 1 utilizes a wheelchair. Resident 1 is non-verbal and unable to communicate their needs and wants. On 10/29/2025 at 2:30 p.m., Surveyor observed Resident 1 in the facility's activity room. Resident 1's fingernails were noted to be untrimmed at this time.	N 425		

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N 425	Continued From page 7 On 10/29/2025, between 12:15 p.m. and 3:00 p.m., Surveyor reviewed Resident 1's medical record including progress notes and ISP. A progress noted dated 8/5/2025 by Registered Nurse H documented the following: "I took a look at [Resident 1's] scratches on the left side of their neck and the one near [his/her] nose which appear to be self-inflicted. There is a red area to their left jawline and cheek. The cheek redness may be due to how wet [his/her] shirt is and [s/he] falls asleep resting [his/her] face on it or it could be an abrasion at this point. It is difficult to say. [S/he] also has a small narrow bruise on over [his/her] clavicle (collar bone) from unknown origin." Surveyor reviewed Resident 1's ISP. Surveyor could not identify any documentation related to Resident 1's history of scratching or self-inflicted injuries. On 10/29/2025 at 3:10 p.m., Surveyor interviewed Program Supervisor B. Surveyor asked Program Supervisor B if instructions for how to provide nail care to residents should be included in their ISP. Program Supervisor B told Surveyor that it would probably depend. Surveyor asked Program Supervisor B if there is any instructions for how to provide nail care to Resident 1 in their ISP. Program Supervisor B told Surveyor that they would have to "look into" this. On 10/29/2025 at 4:00 p.m., Surveyor conducted interview with Program Director A and Program Supervisor B, Surveyor shared concern related to observations of Resident 1's untrimmed fingernails and their ISP not addressing Resident 1's history of self-inflicted scratches or who was responsible for providing Resident 1's nail care. No additional information was made available to by the provider at this time.	N 425		

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N 627	83.58(1)(c) Self-closing 1-3/4-inch solid core wood door Attached garage. A self-closing 1-3/4-inch solid core wood door or an equivalent self-closing fire-resistive rated door shall protect openings between an attached garage and the CBRF. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that the door between the attached garage and the CBRF (community-based residential facility) was self-closing. Findings include: On 10/29/2025 at 10:00 a.m., Surveyors toured the facility with Program Supervisor B and observed the door between the garage and the CBRF. When Surveyor opened the door and let it close, the door did not fully close securely. Surveyor pressed on the door to determine if it would securely close with pressure; it did not. At approximately 10:04 a.m., Surveyors interviewed Program Supervisor B, who stated the door had not been self-closing since s/he started, four months ago. On 10/29/2025 at 4:20 p.m., Surveyors shared the findings with Program Director A and Program Supervisor B, who stated they were unaware of the code requirement. Program Director A stated s/he would work with the corporate office to come into compliance.	N 627		
N 631	83.59(1)(a) Class AS, ANA, CS, CNA 2 grade level exits	N 631		

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N 631	Continued From page 9 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. Class AS, class ANA, class CS and class CNA CBRFs shall have at least 2 grade level or ramped exits to grade. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the Community Based Residential Facility (CBRF) had at least 2 exits providing unobstructed travel to the outside for 1 of 2 exits. The side exit identified as emergency exit and was not to grade. The side door, off the television room, was identified as an emergency exit. It contained a 2-inch rise between the inside floor and the outside ramp. In addition, there was a second, wood ramp pressed up against the outside wall of the door. At the end of the ramp, touching the sidewalk, there was a 1-inch rise. The secondary exit was not ramped to grade. Findings include: On 10/29/2025 at 9:28 a.m., Program Supervisor B confirmed all six residents utilized wheelchairs. On 10/29/2025, at 10:05 a.m., Surveyors toured the facility with Program Supervisor B and observed the following: Located on the wall of the facility was a diagram of the emergency exits. Surveyor observed two ramped exits from the home.	N 631		

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N 631	Continued From page 10 The side exit door, off the television room, was identified as an emergency exit. Surveyor observed a 2-inch rise between the inside floor of the home and the outside ramp. In addition, there was a second, wood ramp pressed up against the outside wall of the door. At the end of the ramp, there was a 1-inch rise, touching the sidewalk. The secondary exit was not ramped to grade. On 10/29/2025, at 10:05 a.m., Surveyors interviewed Program Supervisor B, who stated, "When we do fire drills through this door, it's much harder to get the residents out and much harder to get them all back in because of that step."	N 631		
N 666	83.59(7)(a) Emergency egress lighting provided All exit passageways and stairways shall be provided with emergency egress lighting with a stand-by power source. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 4 of 5 exit passageways and stairways were provided with emergency egress lighting with a stand-by power source. The emergency egress lighting in the east hall to the bedrooms, the north hall to the bedrooms, the living-room/common area, and the television room/common area emergency egress lighting did not function when the test button was pressed. Findings include: On 10/29/2025 at 9:45 a.m., Surveyors toured the facility with Program Supervisor B and observed	N 666		

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N 666	Continued From page 11 the following: Program Supervisor B pushed emergency egress lighting test button in the living-room/common area. The emergency egress lighting did not function. Program Supervisor B and Surveyors tested the emergency egress lighting in the east hall to the bedrooms, the north hall to the bedrooms, and the television room/common area emergency egress lighting. Four of the lighting fixtures did not function when pressed. On 10/29/2025 at 9:58 a.m., Program Supervisor B stated, "I have no idea when these lights were checked last. The only ones that sort of work are the ones in the kitchen. We will be sure to call [Maintenance H] in to take care of this." On 10/29/2025 at 10:53 a.m., Surveyor requested documentation on the maintenance of the emergency egress lighting. As of 11/04/2025 at 12:00 p.m., Surveyor had not received any additional information.	N 666		