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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILESTONE SENIOR LIVING NSD CBRF	4686 N SHORE DR RHINELANDER, WI 54501

(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 07/07/2025, Surveyors conducted a verification visit and complaint investigation (x4) at Milestone Senior Living NSD CBRF. Data collection continued through 07/10/2025. Two of 4 complaints were substantiated. Three deficiencies were identified. The deficiencies identified in statement of deficiency (SOD) MT9911, dated 01/28/2025, were corrected. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 18	{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	N 158		

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

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misappropriation of property. The CBRF shall maintain documentation of any investigation.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not take immediate steps to ensure the safety of all residents when the provider received allegations on 02/25/2025 that Caregiver C was mistreating and neglecting residents. The provider did not document the investigation or conclusion from 02/25/2025 until further allegations came in on 03/05/2025.

Findings include:

The provider is licensed to care for up to 22 residents in the client groups of advanced age and irreversible dementia/Alzheimer's disease.

On 03/18/2025 and 03/20/2025, the Department received complaints alleging staff mistreatment of residents.

On 07/07/2025, Surveyor reviewed the provider's policy, "Abuse, Neglect, Misappropriation, and Injuries of Unknown Source," dated 03/15/2022. The policy read, in part: "POLICY: It is the policy of the community to prevent abuse, neglect, misappropriation of property, and injuries of unknown sources and to report the same, as required by applicable law. Each staff member must communicate any such incidents to a Supervisor, regardless of whether a staff member witnessed an incident firsthand or was made aware of allegations of the incident ...
Investigation: If a team member suspects or has witnessed potential abuse, neglect, misappropriation of property or an injury of unknown source, the team member must notify

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N 158	Continued From page 2 Director/Designee immediately. The Director/Designee shall immediately investigate any credible reports or allegations of abuse, neglect, misappropriation of property, or injuries of unknown sources as follows: 1. Implement measures to protect the resident from possible further incident or injury; including immediate suspension of alleged perpetrator. 2. Interview and obtain a statement from staff, including the affected resident, the complainant, the accused perpetrator, any witnesses, and any other persons who may have firsthand knowledge of the incident. Document all findings. Please note: during interview process, ensure to not corroborate story with alleged abuser and that each interview is confidential ... 5. Document all findings about the incident, including the allegation; the statements of persons involved; the date, time, and location of the incident, including the location of persons and things; the effect of the incident on the resident; and any other information that may be helpful ... 7. Having collected all reasonably ascertainable facts surrounding the allegation, determine whether the incident meets the definition of abuse, neglect, misappropriation of property, or an injury of an unknown source. 8. Maintain documentation of the investigation and outcome." On 07/07/2025, Surveyor reviewed the provider's investigations into caregiver misconduct. One of the investigations involved allegations of Caregiver C mistreating the residents. The investigation included the following written statements by staff: On 02/23/2025, Caregiver I signed and dated the following statement:	N 158		

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"While walking out, a family asked me about the schedule. Upon finding out who was coming on [s/he] burst out into tears because the staff coming into shift had not dealt w (with) [Resident 1's] cares yet and the family was concerned if it'd (it would) be done right. I tried to calm [him/her] down and say we would find another way for the cares to be done by staff that knows the res. (resident). [Caregiver C] then started saying that we would not do that, we would not do extra things for [him/her] just because [s/he] wants it done. Making a fuss because the family does not want a [fe/male] to do cares. [S/he] said [s/he] would NOT be following that, that [s/he] does not care."

On 02/25/2025, Director A signed and dated this statement with the following response:

"[Caregiver C] does not recall that this is how the conversation went. [His/her] response is, 'We still have an obligation to clean [him/her] up. Regarding [Person H] stating leave [Resident 1] alone when [s/he's] upset.' [Caregiver C] verbalized understanding regarding resident rights."

On 02/23/2025, Caregiver I signed and dated another statement, which read:

"On Sat (Saturday) Feb (February) 22nd, I had two families come up to me regarding the behaviors of [Caregiver C]. One of the family members told me [s/he] saw [him/her] corner [Resident 2] near a chair and put [his/her] arms around the chair saying 'NO do not move' frightening the Res (resident). Another family said that [Caregiver C] needs retraining with how to talk to the res and how to hold them. They are concerned that [s/he] has been holding onto the

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res with too much force."

On 02/25/2025, Director A dated, but did not sign the following statement:

"[Caregiver C's] response - 'I don't recall the [Resident 2] situation.' Director asked [Caregiver C] if [s/he] is holding residents with too much force, [Caregiver C's] response, 'I don't believe I'm doing that at all.'"

On 02/25/2025, Caregiver J signed and dated the following statement:

[Person H] [Resident 1's daughter/son] witnessed [Caregiver C] being aggressive with [Resident 2]. Apparently [Person H] stated that [Resident 2] was trying to move a recliner and [s/he] got in front of the recliner and restricted it from moving and then proceeded to yell at [Resident 2] about it instead of redirecting."

The statement was dated 02/25/2025 by Director A, with no statement or signature.

On 02/23/2025, Caregiver J signed and dated another statement, which read:

"Multiple family members have been coming to myself [sic] and many others about [Caregiver C]. [Person H], [Person Q] and [Resident 3's] family have been very worried regaurding [sic] [his/her] behaviors and cares. [S/he] has been aggressive with residents as well as very arguementative [sic] [S/he] personally has showed these behaviors in front of me as well. [S/he] gets upset easily and is rude to the residents. [S/he] ignores residents when they ask for cares as well."

On 02/25/2025, Director A dated, but did not sign,

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N 158	Continued From page 5 the following statement: "Spoke w/ (with) [Caregiver C]. [Resident 3's) family on good terms. Spoke w/ [Person L] [Resident 3's] POA (power of attorney) 2/25/25. [Person L] states '[S/he's] always been very nice to us & nice to [Resident 3].' [Caregiver C's] response, 'I don't feel I'm argumentative, I feel its [sic] more of a teacher tone, I will work on noticing my tone." * Spoke w/ [Person M] re: [Person Q] > [Person M] is POA of [Resident 5], [Person M] not aware of concerns." On 07/10/2025 at approximately 2:00 p.m., Surveyor interviewed Director A on the phone. Director A confirmed Person M and Person Q are siblings. Person M is Resident 5's power of attorney. A "COUNSELING DOCUMENTATION FORM" with date of occurrence, 03/06/2025, for Caregiver C, read, in part: "Several concerns have come forward regarding [Caregiver C's] approach to the residents on the CBRF (community based residential facility) side. The first of the concerns arose 2/25 in the form of communications written out by fellow RAs (resident assistants), this was addressed with [Caregiver C] verbally and [s/he] stated understanding, [sic] staff mentioned they noticed improvement in [Caregiver C's] demeanor towards residents. 3/5/25 - Staff brought concerns to Directors attention regarding [Caregiver C's] approach towards residents, the way [s/he] is talking around the residents, using profanity, and physically handling residents, grabbing their arms or redirecting them physically. Concern regarding [Resident 6] - [Resident 6] standing in seating area MC (memory care) side -	N 158		

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N 158	Continued From page 6 [Caregiver C] grabbed [Resident 6] and pulled [him/her] down with force into [his/her] wheelchair." Concern regarding [Tenant P] - [Tenant P] was walking without [his/her] walker [Caregiver C] grabbed [Tenant P] by right bicep and started to pull [Tenant P]. Concern regarding [Resident 8] - [Resident 8] was in bathroom and [Caregiver C] was rushing [him/her]. [Resident 8] was getting agitated and told [Caregiver C] to 'keep his [expletive] hands off me.' [Caregiver C] then stated to [Resident 8] 'lose the [expletive] attitude' and left the bathroom. 3/7/25 - director suspended [Caregiver C] pending investigation. Spoke with [Caregiver C] on the phone regarding the above concerns addressing each individually ... Pending investigation if it is determined [Caregiver C] can return, in depth education will be conducted regarding Abuse and Neglect utilizing current policy. Shadowing of employee will be conducted ... further concerns regarding allegations of abuse will result in termination." There was a section for employee comments. There were no comments documented. Director A and Caregiver C signed and dated the form on 03/18/2025. On 03/11/2025, Director A submitted a misconduct incident report to the Department. On 07/07/2025 at approximately 10:30 a.m., Surveyor interviewed Caregiver N. Caregiver N told Surveyor the initial investigation into Caregiver C's misconduct was not handled properly. S/he said Caregiver C continued to work. Caregiver N said Caregiver C was removed from the schedule in the following investigation. Caregiver N explained to Surveyor the way	N 158		

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N 158	Continued From page 7 Caregiver C approached the residents "did not sit comfortable with me." S/he said when Caregiver C first started, s/he witnessed Caregiver C approach Resident 7 from behind and moved Resident 7 in his/her wheelchair. Caregiver N said Resident 7 is completely deaf. S/he said, "You could tell [s/he] was terrified." Caregiver N said Former Activity Director (FAD) O was present and witnessed this. S/he said since FAD O was part of the management team, FAD O would bring it to the director's attention. Caregiver N said s/he heard that Caregiver C threw Resident 6 onto the bed and Resident 6's spouse, Person K, witnessed this. Caregiver N also said Caregiver C would place residents in recliners and put their feet up so they could not get out of the recliner. Caregiver N said s/he tried to explain to Caregiver C that with dementia residents, you have to go into their reality. Caregiver N told Surveyor Caregiver C did not agree with that. On 07/07/2025, Surveyor reviewed Resident 7's individual service plan (ISP), effective date 05/17/2025. The ISP read, in part: "[Resident 7] is unable to hear Deaf [sic] since age 3." On 07/07/2025 at approximately 12:20 p.m., Surveyor interviewed Director A regarding the written statements, dated 02/23/2025. Director A said s/he first received the allegations of Caregiver C's misconduct on 02/25/2025. S/he said staff slipped the statements under his/her door. Surveyor asked if s/he had a written investigation into the allegations. Director A said the interviews on the statements were his/her written investigation. Surveyor asked what s/he did to immediately protect the residents. Director A said s/he completed the interviews that were on the statements. Director A said that staff's perception of abuse is not always accurate.	N 158		

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N 158	Continued From page 8 On 07/07/2025, Surveyor reviewed Caregiver C's employee file and timesheet. Caregiver C's date of hire was 01/29/2025. Caregiver C's caregiver background check included a Governmental Findings Report from the Department of Health Services, dated 01/31/2025, indicating Caregiver C had a finding of abuse, dated 09/19/2022. On 11/07/2024, Caregiver C did complete a rehabilitation review and was given a letter that allowed Caregiver C to seek employment at an assisted living facility with limitations, including working under direct supervision. Caregiver C's employee file did not contain documentation of orientation, prior to performing job duties, as required by Wis. Admin. Code § DHS 83.19, including training in preventing and reporting abuse and neglect and the provider's policies and procedures. Caregiver C's timesheet indicated s/he worked the following dates and times after Director A received the initial allegations of caregiver misconduct on 02/25/2025, until s/he received further allegations and suspended Caregiver C on 03/07/2025: 02/25/2025, 11:43 a.m. - 10:02 p.m. 02/26/2025, 12:43 p.m. - 10:03 p.m. 02/27/2025, 1:39 p.m. - 9:56 p.m. 02/28/2025, 1:41 p.m. - 10:00 p.m. 03/01/2025, 1:49 p.m. - 10:00 p.m. 03/02/2025, 1:48 p.m. - 10:05 p.m. 03/03/2025, 1:30 p.m. - 9:40 p.m. 03/04/2025, 9:34 a.m. - 10:06 p.m. 03/05/2025, 1:32 p.m. - 10:02 p.m. 03/06/2025, 1:40 p.m. - 10:03 p.m. A letter from Director A, dated 04/16/2025, to Caregiver C, read, in part: "This letter confirms	N 158		

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our discussion today informing you that your employment with Milestone of Rhinelander is terminated effective immediately due to Conduct [sic] including confronting a family member regarding allegations involving you in front of [his/her] [spouse] which is a resident on the CBRF side."

On 07/08/2025, from approximately 3:30 p.m. - 4:00 p.m., Surveyor interviewed Director A on the phone. Surveyor asked about Director A's investigation into the allegations that s/he reviewed on 02/25/2025. Surveyor asked if there was an assessment of Resident 2, as the allegations included Caregiver C restricting movement of Resident 2. Director A told Surveyor s/he would look in the computer. Director A said s/he did not locate the assessment in the computer and would look for a paper assessment. Surveyor requested Director A email the assessment. Surveyor asked Director A if s/he interviewed staff members and residents. Director A said s/he did interview staff and residents, but did not document his/her interviews. Director A told Surveyor s/he was aware that Caregiver C had previous findings of caregiver abuse and had gone through rehabilitation review. Surveyor asked what led to Caregiver C's termination. Director A said Caregiver C confronted Person K, Resident 6's spouse, about the allegations. Surveyor asked if s/he was aware of an incident when Caregiver C first started, when Caregiver C approached Resident 7 from behind and startled him/her. Director A said s/he was aware of that incident and Caregiver C was trained on approaching residents. Surveyor asked if there was any documentation related to that incident. Director A said s/he would look in his/her training binder. Surveyor requested documentation to be

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emailed. Director A confirmed there was no investigation report into the 02/25/2025 allegations. Director A told Surveyor s/he did not locate documentation of Caregiver C's orientation.

On 07/09/2025 at approximately 1:10 p.m., Surveyor interviewed Person H on the phone. Person H told Surveyor s/he would visit every day for 4 - 7 hours per day and on different shifts. S/he said Caregiver C did not belong working in a dementia unit. S/he explained a person needs to be able to "walk away." S/he said Caregiver C had short patience.

On 07/09/2025 at 1:27 p.m., Surveyor interviewed Person K on the phone. Person K said, "In my opinion, [Caregiver C] was rough with providing cares; [s/he] was rougher than [s/he] needed to be. [S/He's] gone now - thank God."

On 07/09/2025 at approximately 3:00 p.m., Surveyor interviewed Regional Director (RD) B, who was also the administrator, on the phone. Surveyor asked if s/he was aware of the allegations against Caregiver C that Director A received on 02/25/2025. RD B told Surveyor, "The February one doesn't come to mind." Surveyor emailed RD B the allegations and RD B told Surveyor, "I cannot recall that situation." Surveyor asked if Caregiver C should have been suspended during an investigation in February. RD B told Surveyor they do suspend the caregiver unless the caregiver is already off during the investigation. RD B told Surveyor s/he would have told Director A to report the misconduct as s/he always "errs on the side of caution." Surveyor explained concerns related to not immediately protecting the residents when allegations of caregiver misconduct were

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N 158	Continued From page 11 received and not completing a written report related to the allegations, with a conclusion. Surveyor also explained concerns that Caregiver C did not have orientation as required, including prevention and reporting of resident abuse and neglect, prior to Caregiver C performing job duties. As of 07/10/2025, Surveyor did not receive documentation of an assessment of Resident 2, Caregiver C's training on approaching a resident who is deaf, or Caregiver C's orientation training. The provider failed to immediately protect all residents when Director A received written reports of allegations of Caregiver C mistreating the residents on 02/25/2025. The provider did not document the investigation and conclusion of the allegations received on 02/25/2025. Cross Reference N0230 DHS 83.19 Orientation	N 158		
N 230	83.19 Orientation Before an employee performs any job duties, the CBRF shall provide each employee with orientation training which shall include all of the following: (1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); (5) CBRF policies and procedures; (6) Recognizing and responding to resident changes of condition.	N 230		

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N 230	Continued From page 12 This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide 1 of 3 (Caregiver C) caregivers reviewed with orientation training, including: prevention and reporting of resident abuse, neglect and misappropriation of resident property, emergency and disaster plan and evacuation procedures, Community Based Residential Facility policies and procedures, and recognizing and responding to resident changes of condition. Findings include: On 07/07/2025, Surveyor reviewed Caregiver C's employee file. Caregiver C's date of hire was 01/29/2025. Caregiver C's employee file did contain a signed job description and did not contain documentation to indicate s/he received training prior to performing job duties, in: Prevention and reporting of resident abuse, neglect and misappropriation of resident property. Emergency and disaster plan and evacuation procedures. Community Based Residential Facility policies and procedures. Recognizing and responding to resident changes of condition. On 07/08/2025 at approximately 3:30 p.m., Surveyor interviewed Director A on the phone. Director A told Surveyor s/he did not locate documentation of Caregiver C's orientation training. On 07/09/2025 at approximately 3:00 p.m., Surveyor interviewed Regional Director (RD) B on	N 230		

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	0017055	A. BUILDING: _____ B. WING _____	R-C 07/10/2025

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N 230	Continued From page 13 the phone. RD B was also the administrator for the facility. RD B told Surveyor that a lot of their training was done online. S/he said s/he would look for Caregiver C's training. As of 07/10/2025, Surveyor did not receive documentation to indicate Caregiver C received required orientation training prior to performing any job duties.	N 230		
N 397	83.36(1)(b) Qualified staff in charge, on duty and awake. The CBRF shall ensure all of the following: 1. An administrator or other designated qualified resident care staff in charge is on the premises of the CBRF daily to ensure the CBRF is providing safe and adequate care, treatment and services. 2. At least one qualified resident care staff is present in the CBRF when one or more residents are present in the CBRF. 3. At least one qualified resident care staff is on duty and awake if at least one resident in the CBRF is in need of supervision, intervention or services on a 24-hour basis to prevent, control or improve the resident ' s constant or intermittent mental or physical condition that may occur or may become critical at any time including residents who are at risk of elopement, who have dementia, who are self-abusive, who become agitated or emotionally upset or who have changing or unstable health conditions that require close monitoring. 4. At least one qualified resident care staff is on duty and awake if the evacuation capability of at least one resident is 4 minutes or more. This Rule is not met as evidenced by: Based on record review and interview, the	N 397		

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N 397	Continued From page 14	N 397		

provider did not ensure at least one qualified resident care staff was present and on duty during NOC (overnight) shifts (February 2025 to June 2025).

Multiple NOC shifts were staffed with caregivers who were not trained to administer medication.

Per Department of Health Services (DHS) Chapter 83 (83.02 (42)), a "Qualified resident care staff" means an employee who has successfully completed all of the applicable training and orientation under subch. IV.

Findings include:

The provider is licensed to care for up to 22 residents in the client groups of: advanced age and irreversible dementia/Alzheimer's disease. The facility is connected to the provider's licensed Residential Care Apartment Complex (RCAC).

On 03/18/2025, 03/20/2025, 03/27/2025 and 05/27/2025, the Department received 4 complaints alleging staffing concerns and staff mistreatment of residents.

On 07/07/2025, Surveyor reviewed the provider's schedule (February 2025 to June 2025). The schedule noted 2 caregivers (most times) worked the NOC shift.

On 07/07/2025 at approximately 1:25 PM, Surveyor interviewed Director A. Surveyor asked Director A about staffing and training. Director A reported that there were usually two staff working the NOC shift and there was not always a trained medication passer that worked on NOC shift. Surveyor asked Director A about medication pass (if needed) during NOC shift. Director A stated

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there would be a trained medication passer working on the RCAC side and the RCAC caregiver would come over from the RCAC and administer the medications if needed.

On 07/07/2025 at approximately 2:50 PM, Surveyor interviewed Caregiver D. Surveyor asked Caregiver D about staffing and training. Caregiver D reported that training was "not consistent" and staffing had gotten better with agency staff. Caregiver D stated that there was not always a medication passer working on NOC shift. Caregiver D reported that if a resident needed a medication, a caregiver who was trained on administering medication would come over from the RCAC side to administer the medications.

On 07/08/2025 at approximately 9:45 AM, Surveyor interviewed Caregiver E via telephone. Surveyor asked Caregiver E about staffing and training. Caregiver E stated, "There are times when the [CBRF]'s [NOC] shift is without a medication passer. This has been going on for a long time (several months)." Caregiver E reported that if a medication passer was not working the NOC shift, a medication passer from the RCAC side would come over to administer medications during the NOC shift.

On 07/08/2025 at approximately 2:20 PM, Surveyor interviewed Caregiver F via telephone. Surveyor asked Caregiver F about staffing and training. Caregiver F reported that there were several times where the NOC shift was staffed with two caregivers who were not trained to pass medications. Caregiver F stated, "It happens a lot." Caregiver F stated that the medication passer would have to come over from the RCAC side to administer medications. Caregiver F

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N 397	Continued From page 16 reported that the facility did not have a medication passer working the NOC shift on July 3, July 4, July 7 and July 8 (2025). Caregiver F commented, "It's a pain in the butt because there are medications that need to be given at 5:00 AM. It used to be 5 or 6 residents needing medications (during NOC shift) and now there are 3 residents that need medications on [NOC] shift." Caregiver F reported that the provider had been understaffed in the past and agency staff was currently helping out. Caregiver F stated, "There is no way to properly train people - we don't have the staff with knowledge to do the training due to staff coming and going." On 07/10/2025 at approximately 9:30 AM, Surveyor interviewed Caregiver G via telephone. Surveyor asked Caregiver G about staffing and training. Caregiver G reported that "pretty often" there were 2 caregivers (not trained to pass medications) working the NOC shift. Caregiver G stated that a caregiver (who was trained to pass medications) from the RCAC side would have to come over to the provider's side to administer the medications during NOC shift. Caregiver G stated, "This happens often." Caregiver G reported that there were no staffing concerns right now, but "It would be nice to have 3 people on [NOC] shift." Caregiver G stated, "I am happy with staffing right now; a few months ago we had a Norovirus outbreak and everyone kept getting sick. We tried to get agency staff but were denied agency staff. People started quitting. There was a time we were tight with staff, less than ideal."	N 397		