STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017055	A. BUILDING: _____ B. WING _____	R-C 10/01/2025

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 09/30/2025, Surveyor conducted a verification visit and complaint investigation at Milestone Senior Living NSD CBRF. Data collection continued through 10/01/2025. The complaint was substantiated. One deficiency was identified. The deficiency is a repeat deficiency, cited for the 2nd time. See statement of deficiency (SOD) I3F112, dated 09/27/2023. The deficiencies identified in SOD MT9912, dated 07/10/2025, were corrected. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 17	{N 000}		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on record review and interview, the provider did not follow Resident 1's individual service plan (ISP) as written and as a result Resident 1 experienced a fall. The deficiency is a repeat deficiency, cited for the 2nd time. See statement of deficiency (SOD) I3F112, dated 09/27/2023. Findings include:	N 388		

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

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N 388	Continued From page 1	N 388		

On 07/14/2025, the Department received a complaint alleging training and care concerns.

The facility is licensed to serve up to 22 residents in the client groups irreversible dementia/Alzheimer's disease and advanced aged.

On 09/30/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 05/17/2024. Resident 1 discharged on 07/24/2025. According to a progress note, dated 7/13/2025 (0928), "Staff called to report witnessed fall. Staff reports while assisting resident in bathroom [sic] resident fell. Resident was wearing shoes on both feet and attempting to put [his/her] feet through [his/her] pant leg when [s/he] lost [his/her] balance and fell back hitting [his/her] head on the sink..."

Resident 1's ISP, dated 05/17/2025, read, in part:

-"Dressing - Level of Assistance-Dressing: Moderate.
Ensure resident is wearing walking shoes during the daytime. Resident can dress/undress and select clothing with physical assistance. Assistance of one staff to dress upper and lower body in AM and HS. Resident is able to assist..."

- "Falls - Fall interventions are (specify): 4/29/25 [sic] reminded staff to make sure resident is sitting down before removing shoes. 7/4/25 [sic] Educated staff on dressing assistance policy and procedure. 7/6/2025: Ensure resident is wearing proper footwear when ambulating [sic] 7/6/25 [sic] ensure staff have eyes on resident while getting ready for the day [sic] 7/8/25 [sic] Referral sent for PT eval [sic] 7/13/2025 [sic] Encourage resident to remove shoes prior to putting on pants [sic] 7/23/25 [sic] Keep all

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N 388	Continued From page 2 resident doors closed at all times." - "Dressing - Level of Assistance-Dressing: Extensive Resident requires assistance with dressing, caregiver dresses/undresses and selects clothing but resident is able to assist in task." An Incident Form, dated 07/13/2025 (9:40 AM), read in part, "07/13/2025 (0928): Staff called to report witnessed fall. Staff reports while assisting resident in bathroom resident fell. Resident was wearing shoes on both feet and attempting to put [his/her] feet through [his/her] pant leg when [s/he] lost [his/her] balance and fell back hitting [his/her] head on the sink. Denies any further injuries, admits to discomfort on the back of [his/her] head. No open areas or bumps noted to back of head. Resident states [s/he] would like to go to the ER to get looked at. Call placed to [family member]. [Family Member] in route to community to transport to ER for eval (evaluation). Mechanical lift with 2 person assist used to assist resident from floor." According to a Counseling Documentation Form, dated 07/13/2025, "0928: Staff called Triage to report a witness [sic] fall for [Resident 1]. [Caregiver B] was assisting resident in bathroom. Resident was wearing shoes on both feet and attempting to put [his/her] feet through [his/her] pant leg when resident lost [his/her] balance and fell back hitting[his/her] head on the sink. Resident's POA [family member] was called to take resident to the ED (emergency department). [Caregiver B] violated delegation 2.02 Dressing Assistance procedure. [Caregiver B] violated steps for dressing [sic] which as follows: undergarments, shirt, pants, socks & shoes then jackets/sweater.	N 388		

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N 388	Continued From page 3 The Counseling Documentation Form, dated 07/13/2025, noted, "Goals/Corrective Action: "[Caregiver B] will have residents sitting down when assisting with cares. [Caregiver B] will follow the 2.02 Dressing Assistance Competency. Any further disciplinary action will lead to written violation and up to termination." On 09/30/2025 at approximately 10:35 AM, Surveyor interviewed Caregiver C. Surveyor asked Caregiver C about Resident 1's fall on 07/13/2025. Caregiver C stated that Caregiver C came in on the morning after the fall happened; the fall happened on a weekend. Caregiver C reported, "[Caregiver B] changed [Resident 1] with his/her shoes on while Resident 1 was standing up and [Resident 1] fell and hit [his/her] head on the bathroom sink." Caregiver C informed Surveyor that Residents should not be changed while standing up with shoes on. Caregiver C stated, "We are trained to take the resident to the bathroom, toilet resident, change the resident's brief, provide peri care, put pants and shirt on the resident, put shoes and socks on the resident and then stand the resident up." Caregiver C commented, "We are not trained to change people standing up with shoes on (and) care plans should address each resident's transfer status and abilities." On 09/30/2025 at approximately 2:10 PM, Surveyor interviewed Caregiver D. Surveyor asked Caregiver D about Resident 1's fall on 07/13/2025. Caregiver D reported that Caregiver B worked the NOC (overnight) shift on 07/13/2025 and s/he tried to put pants on Resident 1 while Resident 1 was standing up. Caregiver D was unaware of whether Resident 1 was wearing shoes at the time of the fall on	N 388		

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N 388	Continued From page 4 07/13/2025. Caregiver D stated that staff are not trained to change residents while standing up with shoes on. Caregiver D indicated that staff are trained to sit a resident down, take the resident's shoes off, change the brief and pants, put shoes on the resident and then stand the resident up. On 09/30/2025 at approximately 2:42 PM, Surveyor interviewed Caregiver E. Surveyor asked Caregiver E about Resident 1's fall on 07/13/2025. Caregiver E stated that Caregiver E worked on Saturday and Sunday, July 12, and July 13, 2025. Caregiver E reported that Caregiver B did not have Resident 1 sit down while being changed on 07/13/2025 and changed Resident 1 while Resident 1 was standing up with shoes on. Caregiver E stated, [Caregiver B] did not have any common sense, and [Caregiver B] was no longer working at the facility." Caregiver E reported that residents should be sitting down, with shoes off while being changed. On 10/01/2025 at approximately 9:05 AM, Surveyor interviewed Administrator A. Surveyor asked Administrator A about Resident 1's fall on 07/13/2025. Administrator A verified that Resident 1 fell on 07/13/2025 while being changed by Caregiver B. Administrator A confirmed that Caregiver B tried changing Resident 1 while Resident 1 was standing up with shoes on. Administrator A indicated that Caregiver B received counseling and a verbal warning for not following the proper changing procedures. Administrator A verified that Caregiver B did not follow Resident 1's ISP on 07/13/2025. Administrator A verified that Caregiver B was no longer employed at the facility.	N 388		