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 06/02/2026

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 05/28/2026, Surveyor conducted a verification visit and complaint investigation at Milestone Senior Living NSD CBRF. Data collection continued through 06/02/2026. The deficiency identified in Statement of Deficiency MT9913, dated 10/01/2025, was corrected. The complaint was substantiated. One deficiency was identified. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 22	{N 000}		
N 454	83.42(1) Resident record maintained. The CBRF shall maintain a record for each resident at the CBRF. Each record shall include all of the following: (a) Resident ' s full name, sex, date of birth, admission date and last known address; (b) Name, address and telephone number of designated contact person, and legal representative, if any; (c) Medical, social, and, if any, psychiatric history; (d) Current personal physician, if any; (e) Results of the initial health screening under s. DHS 83.28(4) and subsequent health examinations under s. DHS 83.38(1)(g); (f)Admission agreement; (g) Documentation of significant incidents and illnesses, including the dates, times and circumstances; (h) Assessments completed as required under s. DHS 83.35(1); (i) Individual service plan and resident satisfaction evaluation; (j) Documentation to accurately describe the	N 454		

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

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N 454	Continued From page 1 resident's condition, significant changes in condition, changes in treatment and response to treatment; (k) Results of the annual resident evacuation evaluation; (l) Documentation of sensory impairment of the resident as required under s. DHS 83.48(7)(b); (m) Summary of discharge information as required under s.DHS 83.31(7); (n) Any department-approved resident-specific waiver, variance or approval; (o) Physician ' s orders or other authorized practitioner ' s written orders for nursing care, medications, rehabilitation services and therapeutic diets; (p) Current list of the type and dosage of medications or supplements; (q) Results of the quarterly psychotropic medication assessments as required in s. DHS 83.37(1)(h)1; (r) Documentation of administration of all medications, supplements, the person administering the medications or supplements, any side effects observed by the employee or symptoms reported by the resident, the need for PRN medications and the resident ' s response, refusal to take medication, omissions of medications, errors in the administration of medications and drug reactions; (s) Photocopy of any court order or other document authorizing another person to speak or act on behalf of the resident, or other legal documents as required which affect the care and treatment of a resident; (t) Documentation of all other services including rehabilitation services, treatments and therapeutic diets; (u) Completed notice of pre-admission assessment requirement under s. DHS 83.30; (v) Nursing care procedures and the amount of time spent each week by a registered nurse or licensed practical nurse in performing the nursing care procedures. Only time actually spent by the nurse with the resident may be included in the calculation of nursing care time;	N 454		

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N 454	Continued From page 2 (w) Plans of care for terminally ill residents; (x) Date, time and circumstances of the resident's death, including the name of the person to whom the body is released. This Rule is not met as evidenced by: Based on record review and interview, the provider did not maintain Resident 1's record by not having do not resuscitate (DNR) paperwork. Findings include: On 05/22/2026, the Department received a complaint alleging Resident 1 received CPR (cardiopulmonary resuscitation), despite a DNR code status. The facility is licensed to serve up to 22 residents in the client groups irreversible dementia/Alzheimer's disease and advanced aged. On 05/28/2026, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 06/24/2025. Resident 1's face sheet noted Resident 1's code status was DNR. A progress note, dated 05/19/2026 (8:31 PM), read in part, "At approximately 7:05 AM, the writer received a phone call from [Caregiver C] regarding [Resident 1]. [Caregiver C] reported that triage had been contacted prior to calling the writer due to a change in the resident's condition, and staff had been instructed to call EMS. Staff reported that while awaiting EMS arrival, the resident got up and began walking toward the bathroom. Staff stated that once the resident entered the bathroom, [s/he] became lethargic and unresponsive, and staff guided [him/her] to the floor. Staff believed the resident had passed;	N 454		

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N 454	Continued From page 3	N 454		

however, EMS arrived on scene and was actively performing CPR during the call with the writer. The writer instructed staff to continue providing updates as the situation progressed. At approximately 7:30 AM, staff member, [Care Coordinator B], contacted the writer and reported that the resident's chart indicated [s/he] was a DNR, and EMS was requesting the DNR documentation in order to discontinue CPR per protocol. [Care Coordinator B] stated that no DNR form was located in the resident's emergency packet. The writer instructed [him/her] to check the resident's electronic/digital records. [Care Coordinator B] said [s/he] would review the records and return the call. A few minutes later, [Care Coordinator B] called back and reported that no DNR form could be located in the resident's file. The writer reviewed the resident's records and was also unable to locate a DNR form. [Care Coordinator B] then disconnected the call to notify EMS. [S/He] later called the writer back and reported that the resident's time of death had been pronounced and EMS was notifying the coroner..." A progress note, dated 05/20/2026, indicated, "Writer received notification from [Regional Director of Operations (RDO) F] that the coroner was requesting a copy of the resident's DNR form. [RDO F] was unable to locate a copy of the form in the resident's chart..."

On 05/28/2026 at approximately 12:00 PM, Surveyor interviewed Caregiver D. Surveyor asked about Resident 1's cares, code status, and death that occurred on 05/19/2026. Caregiver D reported that on 05/19/2026, Resident 1 was lying in another resident's room around 6:30 AM and staff had taken Resident 1 back to his/her room and assisted Resident 1 in the bathroom. Caregiver D stated that Resident 1 became pale

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N 454	Continued From page 4	N 454		

and lethargic. Caregiver D indicated that staff called triage and then called 911. Caregiver D stated, "[Resident 1] was in [his/her] room and EMTs came and applied oxygen and put [Resident 1] on a gurney. [S/He] was gasping for air. EMTs took [Resident 1] off the gurney and did chest compressions (while Resident 1 was lying on the floor in the hallway)." Caregiver D reported that Resident 1 was a DNR and the EMTs had asked for the DNR paperwork in order to discontinue CPR. Caregiver D indicated that Care Coordinator B looked for Resident 1's DNR paperwork but could not find the DNR paperwork. Caregiver D commented that the EMTs told staff that without DNR paperwork and/or a DNR bracelet, EMTs had to perform CPR. Caregiver D reported that Resident 1 died while lying on the floor in the hallway and EMTs instructed staff to leave Resident 1 on the floor (undisturbed and uncovered) until the medical examiner arrived. Caregiver D indicated that Resident 1 lied on the floor for about an hour until the medical examiner arrived. In regards to Resident 1's code status, Caregiver D stated, "It said DNR on the tablet (computer face sheet)."

On 05/28/2026 at approximately 12:36 PM, Surveyor interviewed Care Coordinator B. Surveyor asked about Resident 1's cares, code status, and death that occurred on 05/19/2026. Care Coordinator B stated that staff contacted Care Coordinator B between 6:30 AM and 7:00 AM on 05/19/2026 and reported that staff could not get vitals on Resident 1 and 911 was called. Care Coordinator B stated that EMTs arrived and staff had informed the EMTs Resident 1 was a DNR. Care Coordinator B indicated that the EMTs requested Resident 1's DNR paperwork. Care Coordinator B indicated that Resident 1 did not have DNR paperwork in his/her file. Care

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N 454	Continued From page 5 Coordinator B stated that the EMTs performed CPR on Resident 1 because Resident 1 did not have the DNR paperwork on file or available. Care Coordinator B reported that Resident 1 died and the EMTs instructed staff to leave Resident 1 on the floor in the hallway (undisturbed and uncovered) until the medical examiner arrived. According to Care Coordinator B, the medical examiner arrived about an hour later on 05/19/2026. Care Coordinator B indicated that since 05/19/2026, Care Coordinator B had ensured the code status off all residents and paperwork had been updated and and would be available if requested in the future. On 05/28/2026 at approximately 1:51 PM, Surveyor interviewed Director A. Director A confirmed that Resident 1 did not have DNR paperwork on 05/19/2026. Director A stated, "[S/He] should have had DNR paperwork." On 06/01/2026 at approximately 9:08 AM, Surveyor interviewed Caregiver G via telephone. Surveyor asked about Resident 1's cares, code status, and death that occurred on 05/19/2026. Caregiver G stated, "I got there at 6:50 AM. I checked on [Resident 1] with [Caregiver C]. We got [Resident 1] on the floor with a pillow. [EMS] came and put [him/her] on a gurney." Caregiver G indicated that while EMS was transporting Resident 1, Resident 1 stopped breathing and EMS placed Resident 1 on the floor (in the hallway) and performed CPR. Caregiver G reported that staff told EMS Resident 1 was a DNR (noted on Resident 1's face sheet). Caregiver G stated that EMS requested Resident 1's DNR paperwork and the DNR paperwork was unavailable. Caregiver G reported that Resident 1 died and EMS instructed staff to leave Resident 1's body lying on the floor (undisturbed and	N 454		

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N 454	Continued From page 6 untouched) until the medical examiner arrived which was about an hour to an hour and a half later. On 6/01/2026 at approximately 3:40 PM, Surveyor interviewed Medical Examiner (ME) E via telephone. Surveyor asked about Resident 1's death that occurred on 05/19/2026. ME E verified the following: Resident 1 coded on 05/19/2026 at the facility; ME E was notified about Resident 1's death at 7:25 AM and ME E arrived at the facility between 8:10 AM and 8:30 AM; ME E had instructed EMS to leave Resident 1's body "undisturbed and uncovered" per policy until ME E arrived. ME E reported, "I ruled out negligence." ME E stated that ME E requested Resident 1's DNR paperwork and DNR paperwork was not provided. The provider did not maintain Resident 1's record by not having DNR paperwork.	N 454		