STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014504	A. BUILDING: _____ B. WING _____	C 06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREVIEW TRANSITIONAL CARE OF WESTOI	**7805 BIRCH ST WESTON, WI 54476**

(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 06/30/2026, Surveyors conducted a complaint (x5) investigation at Careview Transitional Care of Weston. One of 5 complaints were substantiated. Two deficiencies were identifed. Census: 52	N 000		
N 163	83.12(4)(a) Reporting when resident's whereabouts unknown A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time a resident ' s whereabouts are unknown, except those instances when a resident who is competent chooses not to disclose his or her whereabouts or location to the CBRF, the CBRF shall notify the local law enforcement authority immediately upon discovering that a resident is missing. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies or persons recovering from substance abuse. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report to the Department within 3 working days after Resident 1's whereabouts were unknown. Resident 1 eloped on 05/06/2026. Findings include: On 05/08/2026, the Department received a complaint related to a resident elopement and staffing concerns.	N 163		

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

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N 163	Continued From page 1	N 163		

The provider is licensed to serve up to 60 residents in the following client groups: advanced aged, physically disabled, terminally ill, and irreversible dementia/Alzheimer's disease.

On 06/30/2026, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 09/29/2025 and discharged on 06/25/2026. According to a progress note, dated 05/06/2026 at 3:51 AM, Caregiver C noted, in part, "aid [sic] needed help down on east d/t (due to) not being able to find resident. writer [sic] went out 60's door that is down the hall that leads to employee parking lot d/t hearing wander guard alarm going off. writer [sic] found resident in shirt and pants and tennis shoes by garbage bins. writer [sic] messaged to have someone let writer and resident in back employee entry way. other [sic] caretaker that was down on east was outside to [sic] looking for resident as well. Resident got back inside safely and was LOS (line of sight) rest of night."

On 06/30/2026 at approximately 11:30 AM, Surveyor interviewed Director of People Operations (DPO) B. Surveyor asked about Resident 1's elopement on 05/06/2026. DPO B confirmed Resident 1 eloped during the overnight shift on 05/06/2026. DPO B indicated that DPO was unsure if the elopement was reported to the Department. DPO B stated that Caregiver C was working the overnight shift on 05/06/2026 and found Resident 1 outside.

On 06/30/2026 at approximately 12:02 PM, Surveyor interviewed Caregiver C via telephone. Surveyor asked about Resident 1's elopement on 05/06/2026. Caregiver C reported that Resident 1 eloped around 1:10 AM on 05/06/2026. Caregiver C indicated that Resident 1 had left the building

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N 163	Continued From page 2 and Caregiver C went outside and located Resident 1 within 5 minutes. On 06/30/2026 at approximately 12:59 PM, Surveyor interviewed Director of Nursing (DON) A and DPO B. Surveyor asked DON A and DPO B about Resident 1's elopement and whether or not the elopement was reported to the Department. Both DON A and DPO B were unsure if Resident 1's elopement was reported to the Department. On 06/30/2026, Surveyor reviewed Department records. Department records did not include a facility self-report for Resident 1's elopement on 05/04/2026. The provider did not report to the Department within 3 working days after Resident 1 eloped on 05/06/2026.	N 163		
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	N 397		

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N 397	Continued From page 3	N 397		

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, on 05/06/2026, the provider did not ensure at least one qualified resident care staff was present in the facility when one or more residents were present in the facility. On 05/06/2026, the facility census was 55.

Findings include:

On 05/08/2026, the Department received a complaint related to a resident elopement and staffing concerns.

The provider is licensed to serve up to 60 residents in the following client groups: advanced aged, physically disabled, terminally ill, and irreversible dementia/Alzheimer's disease.

On 06/30/2026, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 09/29/2025 and discharged on 06/25/2026. According to a progress note, dated 05/06/2026 at 3:51 AM, Caregiver C noted, in part, "aid [sic] needed help down on east d/t (due to) not being able to find resident. writer [sic] went out 60's door that is down the hall that leads to employee parking lot d/t hearing wander guard alarm going off. writer [sic] found resident in shirt and pants and tennis shoes by garbage bins. writer [sic] messaged to have someone let writer and resident in back employee entry way. other [sic] caretaker that

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N 397	Continued From page 4	N 397		

was down on east was outside to [sic] looking for resident as well. Resident got back inside safely and was LOS (line of sight) rest of night."

On 06/30/2026, Surveyor reviewed the provider's 05/06/2026 NOC (overnight) schedule. The schedule noted that Caregiver C and Caregiver D worked 10:00 PM to 6:00 AM and Caregiver E was scheduled to work 10:00 PM to 2:00 AM.

On 06/30/2026 at approximately 12:02 PM, Surveyor interviewed Caregiver C via telephone. Surveyor asked about Resident 1's elopement on 05/06/2026. Caregiver C reported that Resident 1 eloped around 1:10 AM on 05/06/2026. Caregiver C indicated that Resident 1 had left the building and Caregiver C went outside and located Resident 1 within 5 minutes. Surveyor asked Caregiver C about the 05/06/2026 NOC schedule. Caregiver C reported that Caregiver C and Caregiver D worked the NOC shift on 05/06/2026. Caregiver C confirmed that Caregiver E did not work on 05/06/2026. Caregiver C indicated that when Resident 1 eloped, both Caregiver C and Caregiver D went outside to look for Resident 1, leaving the facility without care staff. Caregiver C reported that shortly after locating Resident 1 (approximately 5 minutes) and bringing him/her back inside, Caregiver C notified Caregiver D via phone. According to Caregiver C, Caregiver D was still outside looking for Resident 1.

On 06/30/2026 at approximately 12:59 PM, Surveyor interviewed Director of Nursing (DON) A and DPO B. Surveyor asked DON A and DPO B about Resident 1's elopement and schedule on 05/06/2026. DON A and DPO B verified that Caregiver C and Caregiver D worked the NOC shift on 05/06/2026. DON A and DPO B indicated

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N 397	Continued From page 5 that they would provide future staff training involving resident elopements and staff leaving the building unattended. The provider did not ensure at least one qualified resident care staff was present in the facility on 05/06/2026 when one or more residents were present in the facility.	N 397		