STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018152	A. BUILDING: _____ B. WING _____	R-C 10/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE SENIOR LIVING	2525 WARD AVE HUDSON, WI 54016

(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 09/22/2025, Surveyor conducted a complaint investigation and verification visit at Cambridge Senior Living. Data was collected through 10/03/2025. One of 4 complaints was substantiated. Three violations were identified. Two violations were repeat deficiencies. See Statement of Deficiencies (SOD) SCQV11, dated 04/18/2023; SCQV12, dated 08/02/2023; SCQV13, dated 05/14/2024; and SCQV14, dated 04/15/2025. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 39	{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 observation, record review, and interview, the provider did not ensure individual service plans (ISPs) were implemented as written for 2 of 2 residents sampled (Resident 1 and Resident 2). This is a repeat deficiency. See Statement of Deficiencies (SOD) SCQV11, dated 04/18/2023; SCQV12, dated 08/02/2023; SCQV13, dated 05/14/2024; and SCQV14, dated 04/15/2025. Findings include: RESIDENT 1	{N 388}		

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

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{N 388}	Continued From page 1 On 09/22/2025 at 10:23 AM, Surveyor observed Resident 1 sleeping in his/her wheelchair in the common area. Resident 1 had visible facial hair (stubble). At 10:24 AM, Surveyor interviewed Caregiver A about Resident 1's services. Caregiver A stated the provider assisted Resident 1 with personal grooming tasks. Surveyor asked if staff shaved Resident 1's facial hair. Caregiver A stated they did this daily in the morning. Surveyor asked if Resident 1 received this service today and Caregiver A stated s/he was unsure because Resident 1 was already up when Caregiver A arrived. At 11:25 AM, Surveyor observed Resident 1 in the dining room chatting with Caregiver A and Caregiver C. Surveyor asked the caregivers about Resident 1's services. Caregiver C stated staff shaved Resident 1's face 1 to 2 times per week. Caregiver C looked at Resident 1 and stated, "[S/he's] definitely due to have it done." Caregiver A confirmed Resident 1 had visible whiskers on his/her chin. At 12:05 PM, Surveyor interviewed Caregiver D. Caregiver D stated Resident 1's hospice team was responsible for Resident 1's routine showers. Surveyor asked who was responsible for shaving Resident 1's face. Caregiver D stated s/he believed hospice provided this service during routine showers. On 09/22/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 07/13/2023 with diagnoses that included dementia. Surveyor reviewed Resident 1's ISP, updated 07/07/2025. The ISP read: "GROOMING/ORAL HYGIENE...	{N 388}		

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{N 388}	Continued From page 2 [Resident 1] has personal grooming device/s to assist with specific grooming tasks... Staff will provide physical assistance during grooming/oral hygiene." The ISP also indicated Resident 1 would receive assistance with all activities of daily living outlined in the ISP on a daily basis. Resident 1's record did not indicate Resident 1's grooming services were refused. According to Resident 1's progress notes, s/he last received a shower on 09/19/2025 via hospice. RESIDENT 2 On 09/22/2025 at 11:50 AM, Surveyor interviewed Resident 2's private personal care worker (PCW), PCW E. PCW E stated s/he was hired by Resident 2's family to provide care and companionship to Resident 2 6 days per week. PCW E stated s/he was at the facility between 8:30 AM to 3:00 PM Monday through Saturday. PCW E stated s/he was concerned with the care Resident 2 was receiving when s/he was not onsite. PCW E stated s/he came in and often found Resident 2's bed soaked with urine. PCW E stated staff typically made Resident 2's bed, but when PCW E pulled back the comforter, s/he often found a soiled soaker pad and sheets. PCW E stated other times, staff would change the soiled bedding but leave the urine-soaked sheets and soaker pads in Resident 2's hamper so Resident 2's room smelled of urine. Resident 2 stated s/he came in today and found Resident 2's soiled soaker pad on his/her bedroom floor and blood on Resident 2's sheets. PCW E said, "They (staff) just covered it up." PCW E stated this was a "constant issue." PCW E stated s/he felt that if s/he was not at the facility to address these issues, staff would put Resident 2 in a soiled bed. At 12:05 AM, Surveyor interviewed Caregiver D. Caregiver D stated NOC (nighttime) staff were	{N 388}		

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{N 388}	Continued From page 3	{N 388}		

responsible for getting Resident 2 up in the morning, dressed, and to breakfast. Caregiver D said staff were also responsible for Resident 2's laundry on scheduled laundry days and as needed. Caregiver D said Resident 2 was frequently incontinent in the mornings, and staff was supposed to change Resident 2's bedding and wash it if it was soiled. Caregiver D stated PCW E did Resident 2's laundry daily.

Surveyor reviewed Resident 2's record. Resident 2 was admitted to the facility on 10/26/2022 with diagnoses that included rhabdomyolysis and dementia.
Resident 2's assessment, dated 07/18/2025, read:
"[Resident 2] is an early riser and will be assisted with AM cares by the NOC shift... [Resident 2] has a personal caregiver who provides care for [him/her] including toileting, dressing, bathing, grooming, meals and activities - common hours are 8am-3pm Monday-Friday. Cambridge staff communicate directly with caregiver for updates in care needs as needed."

Resident 2's ISP, updated 7/18/25 read:
"Staff will provide physical assistance for all incontinence cares after incontinence episodes and provide assistance with changing incontinence products... [Resident 2] prefers to have a reusable soaker pad placed under [his/her] fitted sheet and a second one on top of the fitted sheet to protect the mattress in the event of a significant incontinence...Housekeeping will complete all routine cleaning tasks, laundry, and linen changes on scheduled bath day and as needed."

Resident 2's record included notes from his/her last care 2 conferences:

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{N 388}	Continued From page 4 - 11/21/2024, "Resident's personal companion caregiver stated that she has noticed some concerns. She noted that sometimes when she comes in the morning, the resident would be soaked... POA agreed and stated that they would like a good way to track that tasks are being completed." - 10/31/2023, "Changes/concerns addressed and discussed: Soaker pads that are soiled must either be immediately washed, or placed in a bag, not put in a laundry basket." On 10/01/2025 at 3:00 PM, Surveyor interviewed Power of Attorney (POA) F. POA F stated s/he visited the facility weekly, on PCW E's day off. POA F stated s/he had concerns about the care Resident 2 received from the provider. POA F said s/he noticed basic care tasks were not completed whenever s/he visited. POA F gave the following examples: - Resident 2's teeth usually were not brushed, and his/her toothbrush was dry. POA F stated Resident 2 used to be particular about his/her oral health; s/he was an avid tooth brusher. - Resident 2 typically did not have undergarments on. - Resident 2's room usually smelled of urine. POA F stated s/he frequently found Resident 2's bedding soaked with urine. POA F stated s/he brought up these concerns at Resident 2's last care conference, but POA F had not seen consistent improvement. POA F stated the provider implemented a check-off sheet for a short time, but that "fell flat." POA F stated Resident 2 was happy at the facility, but POA F wished the provider would ensure Resident 2's basic cares were completed.	{N 388}		

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N 399	Continued From page 5	N 399		
N 399	83.36(2) Maintain current written staffing schedule Staffing schedule. The CBRF shall maintain a current written schedule for staffing the CBRF. The schedule shall include each employee ' s full name, job assignment and time worked. This Rule is not met as evidenced by: Based on record review and interview, the provider did not maintain an accurate written staff schedule for August 2025. Findings include: On 09/22/2025, Administrator in Training (AIT) G provided Surveyor with the August 2025 employee schedule. The schedule included the amount of time each employee worked during each of the provider's shifts. For instance, typical caregiver shifts were 7:00 AM to 3:15 PM, 3:00 PM to 11:15 PM, and 11:00 PM to 7:15 AM. The schedule indicated if a caregiver worked 7.8 hours, 4 hours, 4.3 hours, etc. during a shift; however, the schedule did not indicate what times the caregiver was onsite. Surveyor requested timecards for 6 noc shifts to determine if the provider had an adequate number of staff between the hours of 11:00 PM and 7:15 AM. Between 09/30/2025 and 10/03/2025, AIT G sent Surveyor timecards for all staff who worked noc shift hours on the following dates: 08/03/2025, 08/04/2025, 08/08/2025, 08/10/2025, 08/11/2025, and 08/16/2025. Surveyor compared the timecards with the	N 399		

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provider's schedule and found the following discrepancies:
- The schedule showed Caregiver H work 4 hours on the noc shift on 08/11/2025. Caregiver H's timecard indicated s/he did not work noc shift on 08/11/2025.
- The scheduled showed Caregiver I worked 7.8 hours on noc shift on 08/07/2025. Caregiver I's timecard indicated s/he did not work noc shift on 08/07/2025.
- Timecards indicated 1 staff member was onsite between the hours of 3:05 AM and 4:55 AM on 08/08/2025. The schedule showed 3 staff worked during the overnight shift.

Surveyor received the following emails from AIT G:
- 10/2/25 at 4:23 PM: "[Caregiver H] - Scheduled to work 11P - 3AM on 8/11 NOC due to [him/her] picking up 11 am [s/he] worked until 10PM & [Caregiver J] worked from 2:56PM - 3:18AM. We have identified that the schedule does not reflect this change."

- 10/3/25 at 10:06 AM: "8/7/25:...the schedule reflected [Caregiver I] as working, after further review...it shows that [s/he] was out...Unfortunately, this was not accurately reflected on the schedule...

To clarify, it is correct that [Caregiver B] left at 3:05 and [Caregiver A] arrived at 4:55, but both [AIT G] (Myself / Manager on Duty) and [Registered Nurse (RN) K] were also at the facility during this time. For your reference, I've attached a snip of [RN K's] timecard showing that [s/he] punched in at 2:55am."

Surveyor reviewed the schedule. The schedule did not reflect RN K or AIT G working at the

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N 399	Continued From page 7 facility during noc shift hours any day in August. {Y3244} 50.09(1)(L) Care (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to (l) Receive adequate and appropriate care within the capacity of the facility. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident reviewed (Resident 3) received adequate and appropriate services that were within the provider's capacity. Resident 3 missed his/her colonoscopy on 09/04/2025 because the provider did not adequately prepare Resident 3 for the procedure. This is a repeat deficiency. See Statement of Deficiencies (SOD) SCQV14, dated 04/15/2025. Findings include:	N 399 {Y3244}		

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{Y3244}	Continued From page 8	{Y3244}		

On 09/05/2025, the Department received a complaint related to the care a resident received leading up to a medical procedure. The complaint was substantiated.

On 09/22/2025 at 9:15 AM, Surveyor interviewed Resident 3. Resident 3 stated his/her physician wanted Resident 3 to have colonoscopies every 2 or 3 years due to family history of colon cancer and personal history of polyp removal. Resident 3 stated his/her last colonoscopy was August 2022.

On 09/22/2025, Surveyor reviewed Resident 3's record. Resident 3 admitted to the facility on 10/22/2024.

Resident 3's individual service plan (ISP), updated 10/24/2024, indicated staff provided assistance with medication management. The ISP also read, "Staff will assist with coordinating MD (medical doctor) appointments and transportation. Staff will communicate with guardian and MCO (managed care organization) for coordinating transportation needs as necessary."

Resident 3's record included an after-visit summary (AVS) from an appointment on 07/30/2025. The AVS indicated Resident 3 had a colonoscopy scheduled for 09/04/2025 with Physician L. Resident 3's record did not include any additional information regarding this appointment.

On 09/22/2025 at 3:55 PM, Surveyor interviewed Administrator in Training (AIT) G. AIT G stated Resident 3 did not attend his/her colonoscopy appointment. AIT G stated Resident 3's guardian, Guardian M, scheduled the colonoscopy and Resident 3's MCO provided bowel preparation

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{Y3244}	Continued From page 9	{Y3244}		

instructions for 09/04/2025. AIT G said Resident 3 did not make it to this appointment for 2 reasons: 1) the provider did not receive Resident 3's bowel preparation supplies from the pharmacy, and 2) there was miscommunication with transportation. AIT G explained that the provider sent the bowel prep instructions to the pharmacy, but the pharmacy never sent the supplies listed in the bowel prep instructions because the instructions were not a valid order. AIT G provided Surveyor with the bowel prep instructions that the provider sent to the pharmacy. The instructions read, "Please read these instructions carefully at least 7 days prior to your colonoscopy procedures. Be sure to follow all directions completely. The inside of your colon must be clean to allow for a complete examination for the presence of any growths, polyps, and/or abnormalities, as well as their biopsy or removal." The instructions indicated bowel prep needed to begin with diet and medication alterations 7 days before the procedure. At 2 days before the procedure, Resident 3 was supposed to begin a clear liquid diet and a specific regimen of laxatives. Six hours prior to the procedure, Resident 3 was supposed to drink 1 8oz glass of GoLYTELY mixture every 15 minutes, and 2 hours prior to the procedure, Resident 3 was not supposed to consuming anything. The bowel prep instructions did not include a physician's signature or Resident 3's information; meaning, the instructions were not valid physicians orders.

Resident 3's record did not include documented communication between the provider and Resident 3's physician regarding bowel preparation for the colonoscopy.

On 09/24/2025 at 9:00 AM, Surveyor interviewed

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{Y3244}	Continued From page 10 Guardian M. Guardian M stated Resident 3 did not have a colonoscopy on 09/04/2025 because the provider did not prepare Resident 3 for the procedure. Guardian M stated Resident 3's bowel preparation should have started 1 week before his/her appointment. Guardian M contacted Assistant AIT (AAIT N) 2 days before the procedure to ensure Resident 3's bowel prep was in process. Guardian M said s/he was not made aware of any concerns at that time. Guardian M stated s/he contacted AAIT N again on 09/04/2025 around 7:30 AM to find out why Resident 3 did not make it to his/her appointment. Guardian M said AAIT N shared that s/he found out on 09/03/2025 around 4:30 PM that the pharmacy did not send Resident 3's bowel prep supplies. Guardian M stated Resident 3's appointment was not yet rescheduled because the clinic did not have any available appointments. Surveyor reviewed emails provided by Guardian M. 09/04/2025 at 8:49 AM Guardian M sent the following message to the provider and Resident 3's care team: "Just an update that [Resident 3] did not make it to [his/her] appointment this morning and this will need to be rescheduled. This is very frustrating ... as these are needed appointments that had a long wait time to get scheduled. - Boyd Transport arrived at 6:20 and were not able to get staff to the door for 20-25 minutes. At this point, staff went to check on [Resident 3] and returned 10-15 minutes later to say [s/he] was still sleeping and not ready for [his/her] appointment. Boyd waited a bit longer and then left. - I drove to Minneapolis this morning to meet [Resident 3]. I did not learn [s/he] would not be attending until I reached out to [Driver O] from the hospital.	{Y3244}		

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- I then spoke with Cambridge staff, who indicated they planned to reschedule this appointment as [Resident 3] did not take [his/her] bowel prep as no drink was provided from the pharmacy. Please note I checked the status of the bowel prep earlier this week and staff indicated it was in place/started with no noted concerns. [AAIT N] reported [s/he] learned there was no drink provided with the prep at 4pm yesterday (9/3/25). I believe the drink should have started prior to this time, so this is further concerning....
This appointment was scheduled March 10th and this was the soonest they could get [Resident 3] in (6 months later)."

On 09/04/2025 at 12:07 PM Resident 3's case manager (CM), CM P, responded with the following message: "I just want to add to the concerns... Boyd transportation reached out to me today with concern that people are often not ready when they arrive to get members and that they will not continue to provide services to Cambridge location if there is not some improvement. I am very concern about this on behalf of our members as securing transportation for them is not an easy task, and they need to be able to see the doctors that they choose to see... I also want to let you know that this particular case is very upsetting as I had also talked with [AAIT N] on 8/28 and sent the prep instructions via email as I knew that [Registered Nurse (RN) K] was no longer there and wanted to make sure that everything was in place."

On 09/24/2025 at 10:35 AM, Surveyor interviewed Driver O. Driver O stated s/he was the owner of the non-emergency medical transportation company. Driver O stated his/her employee (driver) arrived at the facility on

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{Y3244}	Continued From page 12 09/04/2025 at 6:30 AM. The driver waited outside for over 20 minutes, and then someone came outside for a cigarette break. The driver explained to the person that s/he was there for Resident 3. The person went inside and a staff member came out about 10 minutes later to report that Resident 3 was asleep and would not be attending his/her appointment. Driver O stated s/he typically had trouble getting staff to answer the door, so much so that s/he scheduled his/her drivers to arrive 15 minutes early to the facility. Driver O said it was a common occurrence that staff did not have residents ready when transport arrived because staff did not know about the transportation. Driver O stated s/he had communicated his/her concerns with the provider in the past, but things had not improved. Driver O stated s/he threatened to end services with the provider after the 09/04/2025 incident, and transports since were smoother. On 10/02/2025 at 11:00 AM, Surveyor interviewed AIT G, AAIT N, and Vice President (VP) Q. AAIT N stated s/he received the bowel prep instructions from CM P on 08/28/2025 via email. S/he stated s/he reviewed them and sent them to the pharmacy. AAIT N stated s/he was unaware Resident 3 had a colonoscopy until s/he received the email from CM P. AAIT N stated s/he did not reach out to Resident 3's physician to get clarification or additional documentation. AAIT N stated staff were not made aware of the bowel prep because the information was not added to Resident 3's medication administration record (MAR) because the order was not filled by pharmacy. AAIT N stated it was his/her role to send the order to pharmacy and to communicate the appointment notice to the nurse. AAIT N stated s/he informed Regional Licensed Practical Nurse and Clinical Care Coordinator (CCC) Q	{Y3244}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018152	A. BUILDING: _____ B. WING _____	R-C 10/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{Y3244}	Continued From page 13 about the appointment. VP Q stated the provider experienced a breakdown in communication because they were experiencing a staff transition at the time; VP Q indicated the provider's registered nurse recently left. VP Q stated if the same scenario occurred on 10/02/2025, AAIT N would have sent the information to the pharmacy, the pharmacy would have reached out to let us know it was not a valid order, and the provider would reach out to Resident 3's physician to get clarification. VP Q stated after the order was filled, bowel prep directions would be added to Resident 3's MAR. On 10/02/2025 at 4:22 PM, Surveyor received an email that read: "Bowel Prep Documentation: In reviewing this, we completed our due diligence and did send what was received via email to pharmacy on 8/28/25... In addition, on the documentation that was provided to you prior as it relates to the Golytely Extended Bowel Prep it states, 'Pickup Prescription at the Pharmacy...The Endoscopy team will order this before the scheduled procedure.' This paperwork also states that we will receive a call from the nurse to go over the appointment in detail with prep instructions. We never received a call from the nurse, and we never received the physical order. I am not sure if this call was received by [Guardian M] but had the call been received by our clinical team, this would have also prompted us to request the physical order from said nurse. In addition, the Pharmacy states they never received the order described in this paperwork either."	{Y3244}		

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