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CLOSE TO HOME SENIOR LIVING - BLUEMOU	12231 W BLUEMOUND ROAD MILWAUKEE, WI 53226

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N 000	Initial Comments On 04/14/2025, Surveyor concluded a complaint survey at Close to Home Senior Living -Bluemound. Four deficiencies were identified. Three complaints were substantiated. 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 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, upon learning of an incident of alleged misconduct, the provider did not take immediate steps to ensure	N 158		

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

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residents were protected from subsequent episodes of misconduct and abuse for 1 of 1 resident (Resident 2). The provider did not document an investigation.

Findings include:

On 03/11/2025, the department received a complaint alleging Caregiver D verbally abused and mistreated residents and resident rights were being violated.

On 04/04/2025 at 10:00 a.m., Surveyor reviewed resident records and observed the following:

Resident 2 was admitted on 10/11/2022 with diagnosis including, but not limited to: alcohol abuse, major depressive order, anxiety disorder and borderline personality disorder. Resident 2 was her/his own person and did not have a guardian.

Surveyor reviewed Resident 2's BSP, signed by Resident 2 and Executive Director (ED) B and dated 10/07/2024. Resident 2's managed care team did not sign the BSP. Environmental considerations read, "[Resident 2] participates in dining and activity programs. However, due to the reoccurring rude and verbally inappropriate comments towards his/her peers, administration has had to move his/her seating three times since admission. [Resident 2] is now aware that if s/he makes inappropriate comments or exhibits verbally inappropriate behavior towards any peer during mealtimes, s/he will eat his/her next meal in the upstairs activity area. S/He will be given three opportunities to correct his/her behavior prior to the above being instituted. If s/he exhibits the behavior again, the same plan will be followed. Administration makes the final decision

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on when this form of redirection occurs ... Types of behavior: demanding behavior during meals. Intervention for behavior ... React to rude comments and requests with politeness and calmness. Do not allow him/her to bait you into argument. Always remain professional. Enlist another staff to assist if needed."

Surveyor reviewed Resident 2's observation notes from 03/20/2024 to 03/10/2025 and observed the following:

"11/27/2024. [Resident 2] came to [ED B] this morning and started to complain of [sic] about a particular worker. Witer [sic] told [Resident 2] to ignore him/her and let him/her do his/her work and act like s/he is not there [sic]."

"11/29/2024. [Resident 2] came to [ED B] immediately after breakfast [sic] looked at [ED B] and stated, 'I don't know why [Caregiver D] is still here.' [ED B] stopped him/her and said that we are not discussing this today. Every day it is the same complaint [sic] and you have been told by staff, your car [sic] worker, your therapist and myself [sic] not to talk to him/her. Just ignore him/her, let him/her do his/her work, and you do what you must do. [Resident 2] always responds with , (sic) "Yes, Honey" and wheels away."

Caregiver D's Record

On 04/04/2025 at approximately 9:45 a.m., Surveyor reviewed employee records and identified the following:

Surveyor reviewed staff roster and identified Caregiver D was hired on 11/13/2024. Caregiver D did not have a complete caregiver background check (CBC) on file.

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N 158	Continued From page 3 At minimum, a CBC contains 3 parts: 1) Background information disclosure form (BID) 2) Criminal history report from the Department of Justice (DOJ) 3) A report from the Department of Health Services integrated background information system (IBIS) On 01/02/2025, Caregiver D received a written warning for attendance. Caregiver D did not show up for scheduled shift on 01/01/2025. On 02/07/2025, Caregiver D received a written warning for attendance, communication skills, not being a team player and for not following policies and procedures. Caregiver D was late 5 out of nine shifts. On 03/10/2025, Caregiver D received a written warning for attendance, not being a team player and for not following policies and procedures. Caregiver D did not show up for scheduled shift on 03/10/2025. On 03/23/2025, Caregiver D received a written warning for communication skills, interaction with coworkers, being a team player and following policies and procedures. The employer comments read, "[Caregiver D] engaged in a verbal altercation with another staff member in or on premises which is a violation of company policy. Any verbal altercation with your fellow coworkers is a major misconduct. Management instructed you to stop and you refused to stop and let management deal with the other employee. We expect that you will look into your behavior and take the required actions for improvement accordingly."	N 158		

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N 158	Continued From page 4 On 04/04/2025, provider terminated Caregiver D's employment. Surveyor reviewed termination letter, which read, "Throughout your employment, we have received numerous complaints regarding your attitude and how you communicate with residents. The Facility Executive Director, Resident Service Manager, and Resident Care Coordinator have discussed these concerns with you on multiple occasions. You were issued a warning on March 27, 2025, indicating that a further complaint would result in termination. On Friday, April 4, 2025, the Resident Service Manager and Resident Care Coordinator received an additional complaint about your attitude from a family member of one of our residents. Consequently, you are not eligible for rehire. Thus, you are terminated effective immediately." On 03/25/2025 at 3:50 p.m., Surveyor interviewed Resident Service Manager (RSM) H, who stated, "[Caregiver D] was terminated at the Bluemound location and [ED B] hired him/her back. S/He was transferred from the Grantosa location for getting into a verbal altercation with a family member." RSM H could not confirm if Caregiver D was disciplined for his/her behavior. On 03/25/2025 at 3:55 p.m., Surveyor interviewed ED B, who stated, Caregiver D got into an altercation over the weekend with another staff member while working on the floor. ED B stated, "Caregiver D was suspended for three days and written up." On 04/04/2025 at 4:38 p.m., Surveyor interviewed ED B, who stated s/he had not investigated	N 158		

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N 158	Continued From page 5 Caregiver D's misconduct or report any information to the Office of Caregiver Quality. ED B explained Caregiver D was transferred from another location due to poor verbal interactions with residents and families. Caregiver D was terminated from current location on 04/04/2025. A resident reported Caregiver D's interaction with another resident, where the resident asked for something from Caregiver D, and s/he responded, "Go to your room. Your voice annoys me." ED B stated Caregiver D was terminated and s/he would document and complete that right away. On 04/04/2025 at 4:40 p.m., ED B stated s/he was not sure if the background check was done for Caregiver D. ED B confirmed s/he would send Caregiver D's complete background checks including BID, DOJ report, and IBIS report by 8:00 a.m. on 04/07/2025. On 04/08/2025, as of 8:00 a.m., Surveyor had not received Caregiver D's completed BID, DOJ report, or an IBIS report. On 04/14/2025, Surveyor contacted the Office of Caregiver Quality Investigation Supervisor (OCQIS) K, who confirmed the office did not receive a report from the facility involving Resident 2 or Caregiver D. Cross Reference N0219 DHS 83.17(1) Licensee Conduct Caregiver Background Check Cross Reference N0348 DHS 83.32(3)(d) Rights of Residents: Free from Mistreatment	N 158		
N 162	83.12(3)(b) Documentation of investigations of injuries.	N 162		

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N 162	Continued From page 6 Investigating injuries of unknown source. The CBRF shall maintain documentation of each investigation of an injury referenced under par. (a). The CBRF shall report the incident as required under sub. (2). This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure documentation was maintained for investigations related to 1 of 1 resident's (Resident 1) injuries. Resident 1 had unexplained bruising on his/her left arm and shoulder. The provider did not have documentation of an investigation or cause of the bruises. Findings include: On 03/07/2025, the department received a complaint that regarding a resident suffered injuries of unknown origin. On 03/26/2025, at approximately 11:40 a.m., Surveyor observed Resident 1 with a light pink mark on his/her left upper shoulder, the size a quarter. Resident 1 was unable to tell Surveyor how the mark occurred or how long the mark had been present. On 03/26/2025 at approximately 12:45 p.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 02/18/2021 with diagnosis including, but not limited to: vascular dementia with behavioral disturbance, depressive disorder, and personality disorder. Resident 1 had an activated healthcare power of attorney. Resident 1's record did not include documentation regarding bruises to his/her upper extremities.	N 162		

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N 162	Continued From page 7 On 03/27/2025 at approximately 11:45 a.m., Surveyor emailed Executive Director (ED) B and requested Resident 1's discharge summary from hospitalization in February. On 03/28/2025 at 10:13 a.m., Surveyor received an email from ED B that stated Resident 1 left the facility on 02/17/2025 between 7:00 p.m. and 8:00 p.m. and Resident 1 returned to the facility on 02/19/2025 between 4:30 p.m. and 6:00 p.m. Surveyor received Resident 1's discharge summary from Froedtert hospital dated 02/17/2025 to 02/18/2025. On 03/28/2025 at approximately 11:45 a.m., Surveyor reviewed Resident 1's discharge summary dated 02/17/2025 to 02/18/2025. Emergency Room Physician (ER MD) I wrote, "[Resident 1] has left shoulder bruise. It is very small and appears old ...S/He has a small pressure wound over his/her left scapula." Interviews On 03/26/2025, at 11:45 a.m., Surveyor interviewed Caregiver E, who stated s/he was not sure where the pink mark originated on Resident 1's left shoulder. Caregiver E stated family took Resident 1 to the hospital in February overnight to do a welfare check. Caregiver E stated the family felt Resident 1 was neglected. Caregiver E confirmed there were no incident reports between 02/01/2025 to 02/17/2025 in Resident 1's file. On 03/26/2025, at approximately 12:25 p.m., Surveyor reviewed concern with Executive Director (ED) B. Resident 1 was observed with unexplained bruising on left arm and shoulder, but there was no documentation including an investigation related to the bruises. ED B stated	N 162		

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N 162	Continued From page 8 s/he was unaware of any bruising on Resident 1. ED B stated s/he did not receive an after-visit summary after Resident 1 was hospitalized on 02/17/2025. At approximately 1:00 p.m., Surveyor requested Resident 1's "Body Check" forms, dated 02/01/2025 to 02/17/2025, from Resident Service Manager (RSM) A. RSM A confirmed that Resident 1 did not have any body checks in his/her record between 02/01/2025 to 02/17/2025. On 04/04/2025 at 7:30 a.m., Surveyor interviewed Police Officer (PO) J, who stated s/he witnessed a light-yellow bruise on Resident 1's left, upper arm and a small, scabbed over sore. On 04/04/2025 at 4:30 p.m., Surveyor interviewed Executive Director (ED) B at 4:15 p.m. ED B stated s/he did not document an investigation related to the unexplained bruising on left arm and shoulder. ED B stated, "If the caregivers and managers don't tell me about it, I cannot investigate it."	N 162		
N 348	83.32(3)(d) Rights of Residents: Free from mistreatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from mistreatment. Be free from physical, sexual and mental abuse and neglect, and from financial exploitation and misappropriation of property.	N 348		

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N 348	Continued From page 9 This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure 1 of 1 resident (Resident 2) was free from mistreatment. Resident 2 was sent to his/her apartment during verbal altercations with Caregiver D. Findings include: On 03/11/2025, the department received a complaint alleging Caregiver D verbally abused and mistreated residents and resident rights were being violated. On 04/04/2025, at 10:00 a.m., Surveyor reviewed resident records and observed the following: Resident 2 was admitted on 10/11/2022 with diagnoses including, but not limited to: alcohol abuse, major depressive order, anxiety disorder and borderline personality disorder. Resident 2 was her/his own person and did not have a guardian. Resident 2's Individual Support Plan (ISP), dated 08/01/2022, under "Behavior Patterns" stated, "[Resident 2] requires staff assistance to manage/redirect aggressive behaviors. [Resident 2] can be verbally abusive at times and has been known to use racial slurs (recently and in the past) and requires verbal redirection immediately when this occurs ...Update 10/2024 Resident will "target" new staff and attempt to bully them into doing what s/he wants and will deny s/he has a behavior support plan (BSP) and/or procedures in place to alleviate his/her behaviors." Surveyor reviewed Resident 2's BSP, signed by Resident 2 and Executive Director (ED) B and dated 10/07/2024. Resident 2's managed care	N 348		

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team did not sign the BSP. Environmental considerations read, "[Resident 2] participates in dining and activity programs. However, due to the reoccurring rude and verbally inappropriate comments towards his/her peers, administration has had to move his/her seating three times since admission. [Resident 2] is now aware that if s/he makes inappropriate comments or exhibits verbally inappropriate behavior towards any peer during mealtimes, s/he will eat his/her next meal in the upstairs activity area. S/He will be given three opportunities to correct his/her behavior prior to the above being instituted. If s/he exhibits the behavior again, the same plan will be followed. Administration makes the final decision on when this form of redirection occurs ... Types of behavior: demanding behavior during meals. Intervention for behavior ... React to rude comments and requests with politeness and calmness. Do not allow him/her to bait you into argument. Always remain professional. Enlist another staff to assist if needed."

Surveyor did not observe documentation of staff or the administration moving Resident 2's seating to the upstairs dining room as an intervention.

Interviews

On 03/26/2025 at 1:40 p.m., Surveyor interviewed Resident Services Manager (RSM) A, who stated Caregiver D was transferred to another facility due to complaints about how s/he treats residents. RSM A stated, "[Caregiver D] was like a little bully. There was a time when [Resident 2] was being rude. [Resident 2] wanted ice water and asked [Caregiver D] for the ice water. [Caregiver D] walked over to the freezer and dumped all the ice into the sink." Surveyor asked RSM A if Caregiver D was talked to or written up

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for that situation. RSM A stated s/he was not aware of that being addressed in an official capacity.

On 03/26/2025 at 2:45 p.m., Surveyor interviewed Resident 4, who stated Caregiver D gets loud and rude during meal service. S/He seems to target Resident 2. Caregiver D and Resident 2 have shouting matches in front of the whole dining room. Caregiver E is verbally aggressive, argumentative and bossy. Caregiver D has sent Resident 2 up to his/her apartment multiple times. Resident 4 stated it appeared to be punishment. Resident 4 stated, "[Caregiver D] talks down to us, like we are children. S/He yells at residents. It is so uncomfortable. I feel frozen. There is a blind resident who cannot always find his/her chair at mealtime. They yell at him/her and tell him/her to get in his/her seat, instead of assisting him/her." Resident 4 stated, "It's like [Caregiver D] has contempt for us when s/he's in a bad mood." Resident 4 stated, "[Caregiver D] picks on [Resident 5]. They [expletive] at him/her and talk down to him/her. I've witnessed [Resident 5] get very upset." Resident 4 stated Executive Director B was distant and hard to talk too. S/He tried to talk to him/her, but s/he was always busy in his/her office.

On 03/26/2025 at 3:05 p.m., Surveyor interviewed Resident 3, who stated Caregiver D yells at Resident 2 often. Resident 3 stated Resident 2 had challenging behaviors. Resident 3 found Caregiver D's behavior to be, "Rude and I did not like it. S/He could have said things much differently. [Caregiver D] was very unprofessional."

Surveyor asked Resident 3 to be more specific about what s/he witnessed. Resident 3 stated

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within the past month, Caregiver D would accuse Resident 2 of talking back or arguing with him/her. Caregiver D would make Resident 2 eat in his/her apartment. When Surveyor asked for approximately how often during each meal service Resident 2 was sent to his/her apartment, Resident 3 stated, within the past month, s/he witnessed [Resident 2] sent to his/her apartment 3-4 times during breakfast, 3-4 times during lunch, and approximately 3-4 times during dinner. Resident 3 stated, "I did not think it was appropriate to confine him/her to his/her apartment. We are not children. There is a lot of rudeness around here. Nobody does anything about it. It's really tough to live here."

On 03/26/2025 at 3:25 p.m., Surveyor interviewed ED B, who stated, "I have talked to [Resident 2] about his/her difficulties with [Caregiver D]. I did document two interactions between [Resident 2] and [Caregiver D] in [Resident 2's] chart. [Caregiver D] was trained on resident rights. I assumed s/he knew how to do his/her job. I do the best I can to stay on top of things."

On 04/03/2025 at 3:25 p.m., Surveyor interviewed Caregiver D, who stated s/he was trained in resident rights. Surveyor asked Caregiver D about Resident 2 and what s/he needed for care. Caregiver D stated, "[Resident 2] has behavioral issues. I just do what management directs me to do." Caregiver D stated s/he was not sure what Resident 2's official diagnosis was. Caregiver D stated, "I have not read his/her ISP, so that's on me."

On 04/03/2025 at 4:25 p.m., Surveyor interviewed ED B, who stated Resident 2's BSP directed staff to call management after three attempts of redirection during Resident 2's behavioral

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017379	A. BUILDING: _____ B. WING _____	C 04/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOSE TO HOME SENIOR LIVING - BLUEMOU	12231 W BLUEMOUND ROAD MILWAUKEE, WI 53226

(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 348	Continued From page 13 incidents. Surveyor asked where the documentation was from staff regarding interventions. ED B stated caregivers were supposed to document when Resident 2 had behaviors and when they needed to call management for further intervention. ED B stated, "Caregivers would call us, and we would give them permission to send [Resident 2] to the upstairs dining room." ED B stated, "I meant to document calls every time, but I always got busy and forgot." Cross Reference N0219 DHS 83.17(1) Licensee Conduct Caregiver Background Check Cross Reference N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse and Neglect	N 348		
N 489	83.44(2)(a) Rooms clean and free from odors. The CBRF shall keep all rooms clean and shall make reasonable attempts to keep all rooms free from odors. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 1 of 1 resident's (Resident 1's) bedroom was free from odor. Resident 1's bedroom had a very strong smell of urine. Findings include: On 02/20/2025, the Department received a complaint alleging Resident 1's room smelled of urine. On 03/26/2025 at approximately 11:40 a.m., Surveyor toured Resident 1's bedroom with Caregiver E. Surveyor observed Resident 1's bedroom. Surveyor walked into Resident 1's bedroom and the smell of urine was strong.	N 489		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CLOSE TO HOME SENIOR LIVING - BLUEMOU	12231 W BLUEMOUND ROAD MILWAUKEE, WI 53226

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N 489	Continued From page 14 Surveyor walked into Resident 1's bathroom and the smell of urine was strong. In the middle of the room, Surveyor observed a tall, osculating fan, with an absorbent bed pad that appeared to be wet with urine, hanging on it. Surveyor pulled back Resident 1's bedding and observed what appeared to be dried rings of urine in different sizes. Surveyor could feel through medical gloves, that the bedding was till damp. Surveyor observed tall laundry basket, without a lid, containing 4 absorbent bed pads that appeared to be wet, draped over the side of the basket. Surveyor toured the bathroom and observed two pajama bottoms and one T-shirt hanging over the grab bar. The pajama bottoms appeared to be dirty. On 03/26/2025 at approximately 11:50 a.m., Surveyor interviewed Caregiver E, who stated, "Sometimes the urine sells so bad in [Resident 1's] room, I have to wear a surgical mask." Caregiver E explained that Resident 1 would take his/her wet clothing off and hang it in the bathroom or wherever s/he could dry them. S/He would also take her urine-soaked clothing from his/her wash basket and hang them all over the room. Caregiver E stated, "I don't know. Maybe s/he is trying to dry them. But it smells so bad." Caregiver E stated, "Third shift is in charge of changing the bedding in the morning. It doesn't look like it was done." On 03/26/2025 at approximately 1:50 p.m., Surveyor interviewed Executive Director (RD) B, who stated Resident 1 was very incontinent but was not on a toileting schedule. The caregivers were supposed to be checking their residents. ED B stated, "[Resident 1] will just take his/her dirty clothes off and hang them all over the room. We	N 489		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017379	A. BUILDING: _____ B. WING _____	C 04/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 489	Continued From page 15 do his/her laundry at least twice a day. I don't know why his/her room was in that condition. My managers are not doing their rounds."	N 489		