STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018893	A. BUILDING: _____ B. WING _____	08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHI CARES MUSKEGO	S68 W12699 BRISTLECONE LANE MUSKEGO, WI 53150

(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 08/07/2025 to 08/11/2025, Surveyor conducted a standard survey at Chi Cares Muskego. Four deficiencies were identified. Census: 4	N 000		
N 165	83.12(4)(c) Reporting incidents with serious injury A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not report a serious injury resulting in emergency room treatment to the Department within 3 days for Resident 1. Resident sustained a fall on 07/20/2025 resulting in him/her receiving staples to their scalp. Findings include: On 08/07/2025, Surveyor reviewed Resident 1's record and identified the following: On 08/07/2025 at 11:17 AM, Surveyor interviewed Resident 1 in their room. Resident 1 shared about a recent fall that occurred in the bathroom. Resident 1 showed Surveyor the 3 staples on the top of their scalp. Resident 1 stated they should be removed soon.	N 165		

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

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N 165	Continued From page 1	N 165		

Resident 1 was admitted to the facility on 12/15/2021 with diagnoses including diabetes mellitus, hypercholesterolemia, arthritis/chronic pain, amputation-multiple fingers, depression, and wheelchair bound. Resident 1 had an activated healthcare power of attorney. Resident 1's individual service plan (ISP) dated 07/30/2025 identified "Physical Disabilities: Monitor resident and document fall observation and vitals. Report the incident to the administrator immediately."

Resident 1's progress notes documented: "[Resident 1] was taking a shower and lost [his/her] balance. [S/he] fell and hit the back of [his/her] head. The staff heard a bang in the other room and went to see if one of the resident had fallen and told [Resident 1] to sit on the shower chair and don't move until staff came back, [Resident 1] refused to listen and stood up anyway; by the time staff got back into the bathroom [Resident 1] was falling. [S/he] hit the back of [his/her] head when [s/he] went down. The staff checked [him/her] over and noticed that the back of [his/her] head was bleeding. Staff told [Resident 1] to sit on the floor until EMT's arrive to help [him/her] up, but [s/he] got up anyway. EMT's arrived and transported [him/her] to Waukesha Memorial. No other concerns to report."

Resident 1's after visit summary dated 07/29/2025 documented: "Diagnoses: Fall-initial encounter, Injury of head-initial encounter, Laceration of scalp-initial encounter ....ED Triage HPI: The pt presents to the department via Tess Corners EMS from a group home [provider's name] with the c/o an unwitnessed ground level fall while in the shower. Pt denies LOC. The pt has a hx of a TBI which is why [s/he] lives at a group home. The pt is able to

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N 165	Continued From page 2 speak in full sentences and is A&Ox4 but has a hx of short term memory loss ....Procedure note: Laceration repair. This was a 2.5 cm laceration. The wound area was irrigated with sterile saline and draped in a sterile fashion by department standard ....The wound was repaired with 3 staples." On 08/07/2025, Surveyor reviewed Department records, which indicated no self-reports were submitted regarding Resident 1's laceration to his/her scalp. On 08/08/2025 at 4:27 AM, Surveyor received the following email from Licensee A: " ...Regarding [Resident 1's] fall, we completed an in-house incident report form and reported the fall to [his/her] care team members, relatives, and PCP. We could not find the injury report form online and staff assigned forgot to call DQA for assistance. I will be calling this morning for assistance to file the report." On 08/11/2025 at 10:59 AM, Surveyor interviewed Licensee A regarding the above concern. Licensee A confirmed the provider did not submit a self-report for Resident 1's injury. Licensee A reported the provider could not find the self-report form online and staff never reached out to the Department for assistance. Licensee A stated s/he will ensure self-reports are submitted to the regional office going forward.	N 165		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual	N 389		

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N 389	Continued From page 3 service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on observation, record review, and interview, the individual service plan (ISP) was not updated for Resident 1 when there was a change in resident needs and abilities. Resident 1's ISP was not updated to include use of bed rails. Findings include: According to the Food and Drug Administration, "National surveys of patient deaths occurring in the bed environment demonstrate the risk of entrapment when a patient slips between the mattress and bed rail or when the patient becomes entrapped in the bed rail itself. The population at risk for entrapment are patients who are frail or elderly or those who have conditions such as agitation, delirium, confusion, pain, uncontrolled body movement, hypoxia, fecal impaction, and acute urinary retention that cause them to move about the bed or try to exit from the bed. The absence of timely toileting, position change, and nursing care are factors that may also contribute to the risk of entrapment. The risk may also increase due to technical issues such	N 389		

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N 389	Continued From page 4	N 389		

as the mis-sizing of mattresses, bed rails with winged edges, loose bed rails, or design elements such as wide spaces between vertical bars in the rails themselves..." (Source: U.S. Food and Drug Administration (FDA) Hospital Bed Safety Workgroup, Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings, April 2003, https://www.fda.gov/media/88765/download (retrieval date - June 5th, 2025).)

On 08/07/2025 at 11:17 AM, Surveyor interviewed Resident 1 in their room. Surveyor observed Resident 1's hospital bed which had quarter-length bed rails up and attached to each side of the bed. Resident 1 reported s/he used the bed rails for repositioning.

Resident 1 was admitted to the facility on 12/15/2021 with diagnoses including diabetes mellitus, hypercholesterolemia, arthritis/chronic pain, amputation-multiple fingers, depression, and wheelchair bound. Resident 1 had an activated healthcare power of attorney. Resident 1's individual service plan (ISP) dated 07/30/2025 documented: "Mobility and Transferring: Uses wheelchair to move around independently. Able to transfer without assistance. Physical Disabilities: Wheelchair bound, contracted hands/fingers and multiple amputated fingers." The ISP did not contain any information regarding his/her bedrails.

On 08/11/2025 at 10:59 AM, Surveyor interviewed Licensee A regarding the above concern. Surveyor questioned why Resident 1's ISP did not identify the use of bed rails. Licensee A reported s/he was responsible for updating resident ISP's but was unaware Resident 1 was using bed rails.

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N 389	Continued From page 5 Licensee A stated s/he would assess Resident 1 and if deemed safe, would add bed rails to Resident 1's ISP.	N 389		
N 617	83.55(6)(b) Bath and toilet areas: water temperature The CBRF shall set the temperature of all water heaters connected to sinks, showers and tubs used by residents at a temperature of at least 140°F. The temperature of water at fixtures used by residents shall be automatically regulated by valves and may not exceed 115°F, except for CBRFs serving residents recovering from alcohol or drug dependency or clients of a government correctional agency. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the bath and toilet areas had a safe water temperature affecting 2 of 2 resident sinks checked. Findings include: On 08/07/2025, Surveyor toured the facility. Surveyors tested the water temperature in 2 community bathrooms. The following was found: -At 10:10 AM, the bathroom sink temperature reading was 126 degrees Fahrenheit. -At 10:15 AM, the second bathroom sink temperature reading was 126 degrees Fahrenheit. On 08/11/2025 at 10:59 AM, Surveyor interviewed Licensee A regarding the above concern.	N 617		

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N 617	Continued From page 6 Licensee A acknowledged an understanding of the concern and stated staff had already turned the water heater down. Exposure to hot water is a potential environmental danger for residents. Elderly residents and residents with mental and physical disabilities may have neurological conditions that prevent instant recoil from hot water. Because these individuals do not instantly react to dangerous temperature levels, they are at particular risk for injury. Hot water can cause scalding, e.g., second and third degree burns in which the skin blisters and swells. In such instances, skin does not return to normal and forms scar tissue upon healing. These burns may lead to permanent disability. (DQA Publication-01942, Hot Water Temperatures in Adult Family Homes, August 2017.)	N 617		
N 637	83.59(1)(g) Proper exit locations, sidewalks, driveways. All habitable floors shall have at least 2 exits providing unobstructed travel to the outside. Small class AA CBRFs licensed on or before the effective date of this section with no more than 2 habitable floors may have one exit from the second floor. Exits, sidewalks and driveways used for exiting shall be kept free of ice, snow, and obstructions. For facilities serving only ambulatory residents, the CBRF shall maintain a cleared pathway from all exterior doors to be used in an emergency to a public way or safe distance away from the building. For facilities serving semi-ambulatory and non-ambulatory residents, a CBRF shall maintain a cleared, hard surface, barrier-free walkway to a public way or safe distance away from the building for at least 2	N 637		

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N 637	Continued From page 7 primary exits from the building. All other required exits shall have at least a cleared pathway maintained to a public way or safe distance from the building. An exit door or walkway to a cleared driveway leading away from the CBRF also meets this requirement. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 1 of 2 exits was maintained to have a cleared, hard surface, barrier-free walkway to a public way or safe distance away from the building. The facility had 2 emergency exits that were ramped to the outside. One of the 2 exits, the back ramp exit had 3 wooden sections that were loose, including handrails. Two wood boards going down the slope of the ramp were warped/peeling upwards. The transition piece from the ramp to the sidewalk was rusted and damaged. The back patio ramp exit had multiple obstructions limiting the ability to exit in an emergency to the designated safe space. Findings include: The provider is licensed as a class ANA (non-ambulatory) CBRF to provide services for up to 6 residents who may be advanced age, emotionally disturbed/mental illness, traumatic brain injury, developmentally disabled, and physically disabled. On 08/07/2025, Surveyor conducted a standard survey and identified the following: On 08/07/2025 at 10:02 AM, Surveyor exited the back door of the facility and down the ramp.	N 637		

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N 637	Continued From page 8 Surveyor observed the following damage to the ramp: -Along the left side of the ramp exiting to a patio area, Surveyor observed a wooden section that was approximately 21 inches long and 43 inches in height, that was loose and could easily be moved side to side by the Surveyor. -At the first platform that turns behind the garage, Surveyor observed a wooden section that was approximately 80 inches long and 43 inches in height, that was loose. The Surveyor was able to move the wooden section side to side. The wooden posts appeared deteriorated. -Connected to the first platform going down the slope of the ramp, Surveyor observed a wooden section along the left side that was approximately 123 inches long and 24 inches in height, that was loose. Surveyor observed 3 spindles that were not attached to the frame of the ramp. Surveyor was able to move the wooden section side to side. -While walking down the first slope of the ramp, Surveyor observed a single wooden board that was approximately 82 inches long that was not attached to the frame. The second slope of the ramp going behind the garage, Surveyor observed a single wooden board that was approximately 62 inches long that was warped and peeling upwards. -At the bottom of the ramp, Surveyor observed a metal transition piece from the wooden frame to the concrete sidewalk, that was approximately 56 inches long by 24 inches wide. The transition piece was badly rusted, evidence of holes throughout, and did not provide a barrier free	N 637		

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N 637	Continued From page 9 walkway away from the building. The condition of the ramp with loose wooden sections, warped wooden boards, and the transition piece posed a risk to residents in wheelchairs in the event of an emergency. On 08/07/2025, Surveyor reviewed the home's exit diagram. The diagram identified the back ramp exit as one of home's exits identified for evacuation. On 08/11/2025 at 10:59 AM, Surveyor interviewed Licensee A regarding the above concern. Licensee A acknowledged an understanding of the concerns. Licensee A did not know how long the ramp was in the above condition. Licensee A reported the ramp concerns had been fixed over the past weekend.	N 637		