Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011359	A. BUILDING: _____ B. WING _____	R-C 05/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN VIEW	6526 W BLUEMOUND RD MILWAUKEE, WI 53213

(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 04/14/2025, with informatin gathered through 05/19/2025, Surveyor conducted 2 complaint investigations, and a verification visit at Golden View, a CBRF located in Milwaukee, WI. One deficiency was identified. This is a repeat violation, see Statement of Deficiency (SOD) CU9L1B dated 11/18/2024. One complaint was unsubstantiated. One complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 29	{N 000}		
{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 that all rooms were kept free from odors. There was a strong smell of urine outside Resident 28's and Resident 29's rooms. This is a repeat violation. See Statement of Deficiency (SOD) CU9L1B, dated 11/18/2024. Findings include: On 04/14/2025 at approximately 12:30 PM, Surveyor toured the facility with Administrator O. The hallways outside Residents 28's and 29's rooms smelled strongly of urine.	{N 489}		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011359	A. BUILDING: _____ B. WING _____	R-C 05/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN VIEW	**6526 W BLUEMOUND RD MILWAUKEE, WI 53213**

(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 489}	Continued From page 1 On 04/14/2025 at approximately 1:00 PM, Surveyor interviewed Administrator O. Administrator O confirmed the hallways had an odor of urine. Per Administrator O, Resident 28 was incontinent and had yet to have been changed. Administrator O stated Resident 29 is known to sleep in late and is incontinent. Administrator O acknowledged this is a repeat deficiency and the staff would work harder to clean and sanitize the facility.	{N 489}		