

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014200	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/05/2026
NAME OF PROVIDER OR SUPPLIER HERITAGE COURT MIDDLETON		STREET ADDRESS, CITY, STATE, ZIP CODE 6234 MAYWOOD AVE MIDDLETON, WI 53562		
(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 08/05/2026, Surveyor conducted a complaint investigation at Heritage Court Middleton. One deficiency was identified. One of 1 deficiency was a repeat violation. See Statements of Deficiency (SOD) 8IBL11, dated 04/04/2023, SOD TRW411, dated 02/17/2023, and SOD 5KQO11, dated 10/07/2020. The complaint was substantiated. Census: 36	N 000		
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 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 provider did not ensure the Individual Service Plan (ISP) was updated when there was a change in needs and physical or mental condition for 1 of 1 resident reviewed.	N 389		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014200	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/05/2026
NAME OF PROVIDER OR SUPPLIER HERITAGE COURT MIDDLETON		STREET ADDRESS, CITY, STATE, ZIP CODE 6234 MAYWOOD AVE MIDDLETON, WI 53562		
(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 389	Continued From page 1 Resident 1's ISP was not updated to include who was responsible for monitoring skin integrity after repeated incidents of bruising found on Resident 1. This deficiency is being cited for the 4th time. See Statements of Deficiency (SOD) 8IBL11, dated 04/04/2023, SOD TRW411, dated 02/17/2023, and SOD 5KQO11, dated 10/07/2020. Findings include: On 08/05/2026 at 11:20 AM, Surveyor interviewed Private Caregiver E. Private Caregiver E reported s/he was hired by Resident 1's family to provide caregiving services to Resident 1 for 6 days/week and 2 hours/day. Private Caregiver E reported s/he gave Resident 1 showers on Mondays and Fridays, and the facility did not assist with this task. Private Caregiver E stated Resident 1 and him/her would often go into the community and socialize during their time together. Private Caregiver E reported concerns with discovering bruising on Resident 1 during showers or while assisting him/her to the bathroom. Private Caregiver E provided photos of timestamped photos of bruising s/he discovered on Resident 1's body since s/he admitted. The first photo was dated 04/24/2026, revealing a dark purple discoloration on the left arm (above elbow crease) transitioning to yellow as it extends halfway up Resident 1's upper extremity. The second photo was dated 05/04/2026, revealing a reddish-purple discoloration above the right elbow crease. The border was irregular and the edges show what appears to be linear pressure marks. The third photo was dated 05/25/2026, revealing 2 circular discolorations on Resident 1's left forearm and discoloration on the backside of	N 389		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014200	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 08/05/2026
NAME OF PROVIDER OR SUPPLIER HERITAGE COURT MIDDLETON			STREET ADDRESS, CITY, STATE, ZIP CODE 6234 MAYWOOD AVE MIDDLETON, WI 53562		
(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 389	Continued From page 2 Resident 1's right forearm. The fourth photo was dated 05/28/2026, revealing a large circular discoloration on the top of Resident 1 right wrist. Private Caregiver E reported Resident 1's family met with the facility regarding their concerns in June and s/he thought things were getting better until discovering bruises on Resident 1 this morning that were not there yesterday. Surveyor observed additional discoloration on Resident 1's left wrist and knee, and scratches to Resident 1's right arm. Private Caregiver E stated s/he's not sure how the injuries occurred but thought it could be due to incorrect transfer techniques. Private Caregiver E reported if s/he observed any injuries s/he informed Legal Representative F. On 08/05/2026, Surveyor reviewed Resident 1's record and identified the following: Resident 1 was admitted to the facility on 03/31/2026 with diagnoses including type 2 diabetes and dementia. Resident 1 had an activated healthcare power of attorney. Resident 1's ISP dated 03/31/2026 documented the following: "Skin integrity: staff will check my skin weekly after showers/bathing. They will inform the nurse of any changes. Bathing: I require physical assistance with bathing: transfers in/out, assistance to wash/dry self, assistance to wash & dry hair, & apply lotion. I have a private caregiver to help me with shower." Resident 1's geriatrics clinical notes dated 05/26/2026 documented: "Assessment: [Resident 1] has past medical history significant for DM2, hyperlipidemia (HLD), osteoporosis, history of breast cancer Alzheimer's disease with behavioral disturbance, moderately severe stage. Progressive dementia with behavioral symptoms	N 389			

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014200	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 08/05/2026
NAME OF PROVIDER OR SUPPLIER HERITAGE COURT MIDDLETON			STREET ADDRESS, CITY, STATE, ZIP CODE 6234 MAYWOOD AVE MIDDLETON, WI 53562		
(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 389	Continued From page 3 including evening agitation, sun downing, and wandering, worsened after recent facility transition. Currently stage 6E (moderately severe) with functional decline and safety concerns. Urinary and fecal incontinence, worsening incontinence with episodes of soiling and removal of briefs likely multifactorial due to dementia progression and possible urinary tract infection. Increased falls due to impaired mobility and inconsistent walker use, with risk of injury and bruising. Family also brings up concerns of recurrent unexplained ecchymoses, including ...handprint/thumbprint pattern, in the context of frequent falls and aspirin use," Resident 1's progress notes documented: "-04/23/2026 15:17 LATE ENTRY: Resident returned to facility in the afternoon after outing with private caregiver on 04/22/2026. During night assessment, resident was noted to have a superficial purple discoloration around the left arm. Area appears intact with no open skin, swelling, or signs of acute injury. Resident assessed and found to be calm, pleasant, and at baseline mental status. [S/he] was unable to recall any incident that may have caused the discoloration. Denies pain or discomfort upon assessment. Range of motion intact. No tenderness noted. Vital signs within normal limits and at baseline. Facility staff on duty were interviewed no falls, injuries, or incidents were reported during the shift. Education provided to facility staff to continue monitoring for any changes in skin condition, including increased discoloration, swelling, pain, or other signs of injury. -05/17/2026: Resident continues entering other residents' personal space throughout the shift.	N 389			

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014200	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 08/05/2026
NAME OF PROVIDER OR SUPPLIER HERITAGE COURT MIDDLETON			STREET ADDRESS, CITY, STATE, ZIP CODE 6234 MAYWOOD AVE MIDDLETON, WI 53562		
(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 389	Continued From page 4 Redirection was effective when attempted by nurse; however, some caregivers reported difficulty redirecting resident at times. No injuries notes. Plan to meet with resident's POA to discuss goals of care and current behaviors. Will also collaborate with PCP regarding possible medication adjustments/interventions. Staff encouraged to continue redirection techniques and maintain resident safety. 06/05/2026: Care conference held today with resident's POA Family agreed that moving forward they will communicate directly with nursing team regarding any clinical concerns or changes in resident condition. They will also instruct the private caregiver to report any clinical concerns directly to facility nursing staff. Education provided to staff regarding resident care and safety measures. Staff instructed to approach resident calmly and gently, allowing adequate time for processing and response. Reinforced the importance of utilizing safe transfer techniques and following established fall prevention interventions. Staff encouraged to promote adequate fluid intake throughout the day and remind resident to use [his/her] walker during ambulation for safety." Resident 1's record did not include information related to discoloration observed on 05/04, 05/25, 05/28, and 08/05/2026 (day of survey). Resident 1's ISP did not include updates on who was responsible for monitoring skin integrity after repeated incidents of discoloration observed on Resident 1. Interviews: On 08/05/2026 at 10:00 AM, Surveyor interviewed Caregiver G. Caregiver G discussed	N 389			

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014200	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 08/05/2026
NAME OF PROVIDER OR SUPPLIER HERITAGE COURT MIDDLETON			STREET ADDRESS, CITY, STATE, ZIP CODE 6234 MAYWOOD AVE MIDDLETON, WI 53562		
(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 389	Continued From page 5 Resident 1's level of support and described Resident 1 as pleasantly confused. Caregiver G reported Resident 1 will exhibit verbal aggression and will often enter other resident rooms. Caregiver G stated Resident 1 did have 1 incident of throwing glass figurines s/he had. Caregiver G reported Resident 1 had a private caregiver who completed showers. Caregiver G stated s/he was not aware of any bruising on Resident 1 in April or May. On 08/05/2026 at 10:35 AM, Surveyor interviewed Director of Nursing (DON) B. DON B reported Resident 1 had a private caregiver that completed his/her showers. DON B reported Resident 1 had a bruise on his/her arm in April, appeared it could be fingerprints, but the provider was not sure. DON B reported the provider investigated the incident but could not determine the cause because Resident 1 goes out into the community and bumps into things at the facility. DON B reported staff were retrained on safe patient handling after the incident and the provider met with Resident 1's legal representatives in June to discuss concerns. On 08/05/2026 at 10:49 AM, Surveyor interviewed Legal Representative F. Legal Representative F reported during the first month of Resident 1's admission, a bruise was discovered and reported to the facility. Legal Representative F reported another month went by and a new bruise was discovered. Legal Representative F stated s/he reported this to the facility, met with them, and was satisfied with the plan going forward. On 08/05/2026 at 11:59 AM, Surveyor interviewed Executive Director A and DON B. Surveyor questioned why Resident 1's ISP was not	N 389			

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014200	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/05/2026
NAME OF PROVIDER OR SUPPLIER HERITAGE COURT MIDDLETON		STREET ADDRESS, CITY, STATE, ZIP CODE 6234 MAYWOOD AVE MIDDLETON, WI 53562		
(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 389	Continued From page 6 updated with skin integrity interventions. DON B reported Resident 1's ISP included the standard language that staff would perform skin checks with weekly showers but acknowledged his/her ISP should have been updated. DON B stated staff should be doing a quick check during cares, but not sure if this was consistently completed as staff got comfortable with Resident 1's private caregiver completing showers. On 08/05/2026 at 12:35 PM, Surveyor interviewed DON B. DON B reported nursing was going to implement weekly skin checks on Mondays as a new intervention. On 08/05/2026 at 1:15 PM, Surveyor conducted an exit conference and shared findings with Executive Director A, DON B, Regional Nurse C, and Regional Operations D. The management team stated they were unaware of Resident 1's bruising on 05/04, 05/25, 05/28, and today. The management team stated Private Caregiver E or staff had not reported when new bruises were found. The management team acknowledged the above concerns and did not provide further comment.	N 389		