STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019086	A. BUILDING: _____ B. WING _____	C 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NELSON HOME HEALTH CARE NO 4 LLC	10015 W TERRA AVE MILWAUKEE, WI 53224

(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
M 000	INITIAL COMMENTS On 07/14/2025 with information gathered through 07/23/2025, Surveyor conducted a standard survey and complaint investigation, at Nelson Home Health Care NO 4 LLC, an Adult Family Home (AFH) in Milwaukee, WI. Eight deficiencies were identified. Complaint substantiated. Census: 4	M 000		
M 114	88.03(3)(b) CRIMINAL RECORDS CHECK Criminal records check. Prior to an initial license the licensing agency shall ask the Wisconsin department of justice to conduct a criminal records check on the license applicant and on any other adult household member. The licensee shall arrange for a criminal records check of all service providers. At least every second year following issuance of an initial license the licensing agency shall request a criminal records check on the licensee and all other adult household members and the licensee shall arrange for a criminal records check on any service provider. In addition, during the period of the licensure, the licensee shall arrange for a criminal records check on any new service provider. If any of these persons has a conviction record or a pending criminal charge which substantially relates to the care of a dependent population, the funds or property of adults or minors or	M 114		

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
	0019086	A. BUILDING: _____ B. WING _____	C 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NELSON HOME HEALTH CARE NO 4 LLC	10015 W TERRA AVE MILWAUKEE, WI 53224

(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
M 114	Continued From page 1 activities of the adult family home, the licensing agency may deny, revoke, refuse to renew or suspend a license, initiate other enforcement action provided in this chapter or in ch. 50, Stats., or place conditions on the license. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 employees' (Caregiver B and Caregiver C) reviewed had a background check. Caregiver B and Caregiver C did not have a background check. At a minimum, a complete caregiver background check completed for a caregiver consists of the following three documents: - A completed DHS form F-82064, Background Information Disclosure (BID). - A response from the Department of Justice (DOJ), either - A "no record found" response or - A criminal record transcript. - A Governmental Findings Report (previously "IBIS letter") from DHS that reports the person' s status, including administrative finding or licensing restrictions. Findings include: On 07/14/2024, Surveyor reviewed Caregiver B's record and identified the following:	M 114		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019086	A. BUILDING: _____ B. WING _____	C 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NELSON HOME HEALTH CARE NO 4 LLC	10015 W TERRA AVE MILWAUKEE, WI 53224

(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
M 114	Continued From page 2 -Caregiver B was hired on 06/29/2022. -Caregiver B's record included a BID, dated 06/23/2022. -Caregiver B's record did not contain evidence of a DOJ. -Caregiver B's record did not contain a Governmental Findings Report. On 07/14/2024, Surveyor reviewed Caregiver C's record and identified the following: -Caregiver C was hired on 10/18/2022. -Caregiver C's record included a BID, dated 10/17/2022. -Caregiver C's record included a DOJ, dated 12/22/2022. -Caregiver C's record did not contain a Governmental Findings Report. On 07/14/2025, at approximately 4:13 PM, Surveyor interviewed Registered Nurse A. Registered Nurse A confirmed Caregiver B's and Caregiver C's records did not contain evidence of a complete background check.	M 114		
M 244	88.04(5)(a) TRAINING-15 HOURS WITHIN 6 MONTHS The licensee and each service provider shall complete 15 hours of training approved by the licensing agency related to health, safety and welfare of residents, resident rights and	M 244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019086	A. BUILDING: _____ B. WING _____	C 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NELSON HOME HEALTH CARE NO 4 LLC	10015 W TERRA AVE MILWAUKEE, WI 53224

(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
M 244	Continued From page 3 treatment appropriate to residents served prior to or within 6 months after starting to provide care. This training shall include training in fire safety and first aid. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 service providers (Caregiver B and Caregiver C) received training within 6 months after starting to provide care related to resident rights and first aid. Findings include: On 07/14/2025, Surveyor reviewed records and identified the following: -Caregiver B was hired on 06/29/2022. Caregiver B's employee record did not contain evidence of training related to resident rights and first aid. -Caregiver C was hired on 10/18/2022. Caregiver C's employee record did not contain evidence of training related to resident rights and first aid. On 07/14/2025 at approximately 4:13 PM, Surveyor interviewed Registered Nurse A. Registered Nurse A confirmed Caregiver B's and Caregiver C's records did not contain evidence of the above training. Registered Nurse A stated s/he was not aware of this requirement.	M 244		
M 332	88.05(4)(a) FIRE SAFETY-FIRE EXTINGUISHERS Fire extinguishers. Every adult family home shall be equipped with one	M 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019086	A. BUILDING: _____ B. WING _____	C 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NELSON HOME HEALTH CARE NO 4 LLC	10015 W TERRA AVE MILWAUKEE, WI 53224

(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
M 332	Continued From page 4 or more fire extinguishers on each floor. Each required fire extinguisher shall have a minimum 2A, 10-B-C rating. All required fire extinguishers shall be mounted. A fire extinguisher is required at the head of each stairway and in or near the kitchen except that a single fire extinguisher located in close proximity to the kitchen and the head of a stairway may be used to meet the requirement for an extinguisher at each location. Each required fire extinguisher shall be maintained in readily usable condition and shall be inspected annually by the authorized dealer or the local fire department and have an attached tag showing the date of the last dealer or fire department inspection. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 4 of 4 fire extinguishers were inspected annually by an authorized dealer and had an attached tag showing the date of inspection. The fire extinguishers, located near the kitchen, two at the head of basement stairway and one in the basement did not have an attached tag showing the date of the last inspection. Findings include: The provider is licensed to care for up to 4 residents within the following client group: advanced aged. On 07/14/2025, at approximately 10:22 AM,	M 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019086	A. BUILDING: _____ B. WING _____	C 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NELSON HOME HEALTH CARE NO 4 LLC	10015 W TERRA AVE MILWAUKEE, WI 53224

(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
M 332	Continued From page 5 Surveyor conducted a tour of the facility with Caregiver C and observed the following: -Fire extinguishers located near the kitchen, two at the head of basement stairway and one in the basement did not have an attached tag showing the date of the last inspection. On 07/14/2025, at approximately 4:13 PM, Surveyor interviewed Registered Nurse A. Registered Nurse A confirmed the above fire extinguishers did not have an attached tag showing the date of the last inspection. Registered Nurse A stated s/he was not aware of this requirement.	M 332		
M 402	88.06(2)(c)8 RESIDENT RIGHTS AND GRIEVANCE A statement indicating that the resident rights and grievance procedures have been explained and copies provided to the resident and the resident's guardian or designated representative, if any. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 residents (Resident 1 and Resident 2) admitted to the home had a statement indicating resident rights and grievance procedures had been explained and copies provided to the residents and residents' healthcare power of attorney (POA). Findings include: On 07/14/2025, Surveyor reviewed resident records and identified the following:	M 402		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019086	A. BUILDING: _____ B. WING _____	C 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NELSON HOME HEALTH CARE NO 4 LLC	10015 W TERRA AVE MILWAUKEE, WI 53224

(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
M 402	Continued From page 6 Resident 1 was admitted to the facility on 02/02/2024. Resident 1's record did not contain evidence of resident rights and grievance procedures explained with him/her. Resident 2 was admitted to the facility on 09/14/2024. Resident 2's record did not contain evidence of resident rights and grievance procedures explained with his/her activated POA. On 07/14/2025, at approximately 4:13 PM, Surveyor interviewed Registered Nurse A about reviewing resident rights and grievance procedures. Registered Nurse A stated s/he was not aware this was a requirement.	M 402		
M 420	88.06(3)(d)5 SIGNED STATEMENT OF AGREEMENT A statement of agreement with the plan, dated and signed by all persons involved in developing the plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 residents' (Resident 1 and Resident 2) individual service plans (ISP) reviewed included a statement of agreement with the plan, dated and signed by all persons involved with developing the plan. Resident 1's and Resident 2's ISPs did not include a signed statement of agreement with all parties involved. Findings include:	M 420		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019086	A. BUILDING: _____ B. WING _____	C 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NELSON HOME HEALTH CARE NO 4 LLC	10015 W TERRA AVE MILWAUKEE, WI 53224

(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
M 420	Continued From page 7 On 07/14/2025, Surveyor reviewed residents' records and identified the following: -Resident 1 was admitted to the provider's home on 02/02/2024. -Resident 1 was his/her own person. -Resident 1's ISP, dated 04/08/2025, was not signed by him/her. -Resident 2 was admitted to the provider's home on 09/14/2024. -Resident 2 had an activated Power of Attorney (POA). -Resident 2's ISP, dated 09/14/2024, was not signed by his/her POA. On 07/14/2025, at approximately 4:13 PM, Surveyor interviewed Registered Nurse A. Registered Nurse A confirmed Resident 1 did not sign his/her ISP and Resident 2's POA did not sign his/her ISP. Registered Nurse A stated s/he was not aware of this requirement.	M 420		
M 424	88.06(3)(f) REVIEW OF ISP The individual service plan shall be reviewed at least once every 6 months by the licensee, the resident or the resident's guardian, the service coordinator, if any, the designated representative, if any, the placing agency with the resident participating in a manner appropriate for the resident's level of understanding and method of communication. This review is to determine continued appropriateness of the plan and to update the plan as necessary. A plan shall be updated, in writing, whenever	M 424		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019086	A. BUILDING: _____ B. WING _____	C 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NELSON HOME HEALTH CARE NO 4 LLC	10015 W TERRA AVE MILWAUKEE, WI 53224

(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
M 424	Continued From page 8 the resident's needs or preferences change substantially or when requested by the resident or the resident's guardian. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 residents (Resident 1 and Resident 2) reviewed had his/her individual service plan (ISP) reviewed every 6 months to determine continued appropriateness of the plan and to update the plan as necessary. Findings include: On 07/14/2025, Surveyor reviewed resident records and identified the following: Resident 1 -Resident 1 was admitted to the provider's home on 02/02/2024. -Resident 1's managed care organization Member Centered Plan, dated 01/01/2025, stated the following: "[This facility] provides assistance with grooming, bathing, dressing, toileting, transferring, transportation, meal prep, medication management/administration, ostomy care, repositioning, emptying urinary catheter, and some wound care. [Resident 1] has stage 3 or 4 pressure ulcer and needs assistance with wound cares." -Resident 1's ISP was dated 04/08/2025. Resident 1's current ISP did not include a plan for maintaining skin integrity and a plan to monitor wounds.	M 424		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019086	A. BUILDING: _____ B. WING _____	C 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NELSON HOME HEALTH CARE NO 4 LLC	10015 W TERRA AVE MILWAUKEE, WI 53224

(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
M 424	Continued From page 9 Resident 2 -Resident 2 was admitted to the provider's home on 09/14/2024. -Resident 2 had an activated healthcare power of attorney. -There was no evidence Resident 2's ISP was reviewed and updated after 09/14/2024. At minimum, Resident 2's ISP should have been reviewed and updated in March 2025. On 07/14/2025, at approximately 4:13 PM, Surveyor interviewed Registered Nurse A. Registered Nurse A confirmed Resident 1's ISP, dated 04/08/2025, was the most recent and did not include a plan for maintaining skin integrity and a plan to monitor wounds. Registered Nurse A stated s/he was aware Resident 2's ISP should have been reviewed at least once every 6 months to determine continued appropriateness of the plan and to update the plan as necessary. Registered Nurse A stated s/he was the one who completed the ISP updates. Registered Nurse A stated s/he did not complete Resident 2's ISP update due to being out of town.	M 424		
M 448	88.07(2)(b)5 MONITORING HEALTH Monitoring resident health by observing and documenting changes in each resident's health and referring a resident to health care providers when necessary. This Rule is not met as evidenced by:	M 448		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019086	A. BUILDING: _____ B. WING _____	C 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NELSON HOME HEALTH CARE NO 4 LLC	10015 W TERRA AVE MILWAUKEE, WI 53224

(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
M 448	Continued From page 10 Based on record review and interview, the provider did not ensure 1 of 1 residents' (Resident 1) health was monitored in relation to wounds. Resident 1 had a pressure ulcer when s/he was admitted on 02/02/2024. Resident 1 received wound care services from a home health agency 3 days per week. The provider did not monitor Resident 1's skin integrity to monitor the sacral wound or monitor for additional skin integrity concerns. Findings include: On 04/11/2025, the Department received a complaint alleging the provider did not monitor wounds. On 07/14/2025, Surveyor reviewed Resident 1's record and identified the following: -Resident 1 was admitted to the provider's home on 02/02/2024, with diagnosis of a sacral pressure ulcer. -Resident 1's Wound Care Clinic After Visit Summary (AVS), dated 04/08/2025, stated the following: "The following issues were addressed: Pressure injury of sacral region, stage 4, Chronic osteomyelitis of sacrum, Chronic osteomyelitis of left pelvis, Pressure injury of right ischium, stage 4, Bleeding from wound, Palliative care encounter, Pressure ulcer of right leg, unstageable, Pressure injury of left ischium, stage 4, Pressure injury of toe of right foot, stage 3 and Pressure injury of left lower leg, stage 3... Ambulatory Social Services referral was placed for concern of neglect." -Resident 1's Individual Service Plan, dated 04/08/2025, stated the following: "Registered	M 448		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019086	A. BUILDING: _____ B. WING _____	C 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NELSON HOME HEALTH CARE NO 4 LLC	10015 W TERRA AVE MILWAUKEE, WI 53224

(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
M 448	Continued From page 11 Nurse (RN) from [Home Health Agency] to treat wounds M W F (Monday, Wednesday, and Friday). [Resident 1] requires a 2 person assist with hoyer [sic] to power wheelchair. [Resident 1] requires 2 person assist with shower and bath. Skin care: Provided by RN. Chronic wound coccyx, new lower limb wound and right lower extremity, and wound right toe." -Resident 1's Wound Care Clinic After Visit Summary (AVS), dated 04/23/2025, stated the following: "The following issues were addressed: Palliative care encounter, Green-colored discharge from wound, Pressure injury of sacral region stage 4, Pressure injury of right ischium stage 4, Pressure injury of left ischium stage 4, Incomplete quadriplegia at C5-6 level, Chronic osteomyelitis of sacrum, Chronic osteomyelitis of pelvis left and Bleeding from wound."The following instructions were provided: "Wound care instructions for all posterior wounds and legs: -Wash hands. -Carefully remove old dressing and discard. -Wash entire leg and foot with mild soap and warm water. Rinse and dry well. -Spray the hypochlorous acid wound therapy (Puracyn Plus) to the wound bed and allow it to dry. -Apply Acetic Acid to roll gauze and apply it to the wound bed. -Cover with foam border dressing (Mepilex, Tielle). -Secure with wrap gauze and tape as needed. -Wash hands again. -Change dressing daily." "Wound care instructions for toe: -Follow steps 1-4 above. -Apply Iodoflex/Iodosorb to the wound bed first.	M 448		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019086	A. BUILDING: _____ B. WING _____	C 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NELSON HOME HEALTH CARE NO 4 LLC	10015 W TERRA AVE MILWAUKEE, WI 53224

(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
M 448	Continued From page 12 -Cover with foam border dressing (Mepilex, Tielle). -Secure with wrap gauze and tape. -Wash hands again. -Change dressing daily." On 07/14/2025, at approximately 4:13 PM, Surveyor interviewed Registered Nurse A regarding Resident 1 receiving wound care. Registered Nurse A stated Resident 1 had not received wound care from facility staff. Registered Nurse A stated the Registered Nurse from a home health agency came to facility on Monday, Wednesday, and Friday to provide wound care. Registered Nurse A reported s/he was unaware Resident 1 had additional wounds develop until Resident 1 was seen by the wound care doctor in April 2025 for his/her check up. Registered Nurse A reported s/he was unaware of the physician's instructions from 04/23/2025 to change dressings daily and confirmed staff of the adult family home did not change the dressings. CROSS REFERENCE M 424 88.06(3)(f) - Review Of Isp	M 448		
M 466	88.07(3)(e)1 MEDICATION- RECORD KEEPING The licensee shall keep a record of all prescription medications controlled, dispensed or administered by the licensee which show the name of the resident, the name of the particular medication, the date and time the resident took the medication and errors and omissions. The medication controlled by the licensee shall be kept in a locked place.	M 466		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019086	A. BUILDING: _____ B. WING _____	C 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NELSON HOME HEALTH CARE NO 4 LLC	10015 W TERRA AVE MILWAUKEE, WI 53224

(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
M 466	Continued From page 13	M 466		

This Rule is not met as evidenced by:
Based on observation, record review and interview, the provider did not ensure medications administered were recorded for 1 of 1 resident (Resident 2). Resident 2 did not have a record of their medication administration.

Findings include:

On 07/14/2025, at approximately 11:55 AM, Surveyor observed several medication bottles in the medication closet.
The medication closet contained Resident 2's medication bottles which were in a clear container. The medication bottles identified Resident 2's name and the following medications: aspirin 81 milligrams (mg), atorvastatin calcium 40 mg, and warfarin (Golden State) 2 mg.

On 07/14/2025, Surveyor reviewed Resident 2's record and identified the following:

-Resident 2 was admitted to the provider's home on 09/14/2024.
-Resident 2 had an activated healthcare power of attorney.
-Resident 2's record did not include medication administration records (MARs).

On 07/14/2025, at approximately 4:13 PM, Surveyor interviewed Registered Nurse A regarding medication administration. Registered Nurse A reported staff controlled, dispensed, and administered Resident 2's medications. Registered Nurse A confirmed Resident 2's record did not include MARs. Registered Nurse A stated Resident 2's receives his/her medications from the Veterans Affairs (VA). Registered Nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019086	A. BUILDING: _____ B. WING _____	C 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NELSON HOME HEALTH CARE NO 4 LLC	10015 W TERRA AVE MILWAUKEE, WI 53224

(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
M 466	Continued From page 14 A stated the VA did not provide MARs for Resident 2.	M 466		