STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020719	A. BUILDING: _____ B. WING _____	C 05/01/2026

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M 000	INITIAL COMMENTS On 04/14/2026, with information obtained through 05/01/2026, the Bureau of Assisted Living, Southern Regional Office, conducted a complaint investigation at Changing Point LLC, an adult family home (AFH) located in Muskego, WI. As a result of the survey, 8 deficiencies were identified. The complaint was substantiated. Census: 3	M 000		
M 262	88.05(2)(a) DIFFICULTY WALKING If a resident is not able to walk at all or able to walk only with difficulty, or only with the assistance of crutches, a cane, or walker or is unable to easily negotiate stairs without assistance: 1. The exits from the home shall be ramped to grade with a hard surfaced pathway with handrails. 2. All entrance and exit doors and interior doors serving all common living areas and all bathrooms and bedrooms used by a resident not able to walk at all shall have a clear opening of at least 32 inches. 3. Toilet and bathing facilities used by a resident not able to walk at all shall have enough space to provide a turning radius for the resident's wheelchair and provide accessibility appropriate to the resident's needs.	M 262		

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
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M 262	Continued From page 1	M 262		

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure that the exits from the home were ramped to grade with a hard surfaced pathway with handrails for Resident 2, who walked with difficulty. Manager B acknowledged Resident 2 would not be able to easily negotiate stairs without assistance.

Findings include:

On 04/14/2026, Surveyor reviewed Department records for the provider. The provider's license indicated that ambulatory residents were to be served.

On 04/14/2026, at approximately 10:35 a.m., Surveyor observed Manager B hold Resident 2's arm as s/he walked with him/her from the dining area to the living room. Resident 2 was observed shuffling his/her feet across the floor as they walked together.

At approximately 10:45 a.m., Surveyor observed Resident 2 walking to a different area of the house. Manager B was observed to provide standby assistance to Resident 2 as s/he walked, walking closely behind him/her with his/her arms out. Resident 2 was observed to shuffle his/her feet across the floor as s/he walked.

At approximately 11:28 a.m., Surveyor interviewed Manager B. Manager B reported that Resident 2 was known to sometimes trip over his/her feet as s/he walked. Manager B reported that it wasn't required for him/her to always walk with Resident 2 when s/he ambulated, but s/he typically did it for Resident 2's safety.

As part of this interview, Manager B reported that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CHANGING POINT LLC	S68W12631 WOODS RD MUSKEGO, WI 53150

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M 262	Continued From page 2 the home had 3 exits. Surveyor observed them all with Manager B. All had at least one step to leave the home. None had ramps. Manager B reported agreement with Surveyor that it did not seem that Resident 2 demonstrated the ability to negotiate the exit steps easily or completely independently. At approximately 1:00 p.m., Surveyor interviewed Licensee A and reviewed the concern regarding the home's exits with him/her. Licensee A reported s/he did not want to make Resident 2 move out and asked Surveyor what s/he would have to do. Surveyor reviewed the accessibility regulations with Licensee A. Licensee A reported s/he knew someone that would be able to build ramps for the house. At approximately 3:41 p.m., Surveyor received an e-mail from Licensee A in which s/he reported s/he was actively obtaining quotes for the ramps.	M 262		
M 344	88.05(4)(d)2.a FIRE SAFETY EVACUATION PLAN REVIEW The licensee shall review the fire safety evacuation plan with each new resident immediately following placement and shall evaluate the resident using a form provided by the department to determine whether the resident is able to evacuate the home without any help within 2 minutes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that Resident 1 was evaluated using the Department's form to	M 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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M 344	Continued From page 3 determine whether s/he was able to evacuate the home without any help within 2 minutes. Findings include: On 04/14/2026, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 01/28/2026, where s/he resided until 03/16/2026. Surveyor observed a blank evacuation evaluation form located within Resident 1's record. There was no other evidence of an evacuation evaluation having been completed for Resident 1. At approximately 11:28 a.m., Surveyor interviewed Manager B and reviewed Resident 1's record with him/her. Manager B confirmed an evacuation evaluation for Resident 1 was not completed. At approximately 1:00 p.m., Surveyor interviewed Licensee A and reviewed Resident 1's record with him/her. Licensee A confirmed an evacuation evaluation for Resident 1 was not completed and reported that it was overlooked.	M 344		
M 380	88.06(2)(a) ADMISSION-HEALTH EXAM Except as provided in subd. 2., the licensee shall ensure that a new resident of an adult family home receives a health examination by a physician to identify health problems and is screened for communicable disease, including tuberculosis. Screening for communicable disease may be provided by a physician, a registered nurse or a physician assistant. The health examination and	M 380		

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M 380	Continued From page 4	M 380		

screening shall take place within 90 days prior to admission to the home or within 7 days after admission.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure that Resident 1 received a health examination by a physician prior to his/her admission or within 7 days after his/her admission, or that s/he was screened for communicable disease, including tuberculosis, by a physician, registered nurse, or physician assistant within that same timeframe.

Findings include:

On 04/14/2026, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 01/28/2026, where s/he resided until 03/16/2026. There was no evidence of a health examination completed for him/her, including evidence that s/he was screened for communicable disease. A form titled, "Wisconsin Tuberculosis (TB) Risk Assessment and Symptom Evaluation" within his/her record was blank.

At approximately 11:28 a.m., Surveyor interviewed Manager B and reviewed Resident 1's record with him/her. Manager B confirmed there was no evidence of a health examination completed for Resident 1 that included communicable disease screening.

At approximately 1:00 p.m., Surveyor interviewed Licensee A and reviewed Resident 1's record with him/her. Licensee A confirmed there was no evidence of a health examination completed for Resident 1 that included communicable disease

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020719	A. BUILDING: _____ B. WING _____	C 05/01/2026

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M 380	Continued From page 5 screening and reported that it was overlooked.	M 380		
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 that a statement in Resident 1's service agreement indicated that resident rights and the provider's grievance policy were explained to him/her and his/her legal representative, with copies of each provided. Findings include: On 04/14/2026, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 01/28/2026, where s/he resided until 03/16/2026. Resident 1 was documented as having a legal representative. A section in Resident 1's service agreement, titled, "Resident Rights & Grievance Procedures" contained a statement that the provider explained resident rights and the grievance policy and provided copies of each to the resident and his/her legal representative. However, that section of the service agreement, which had lines for signatures, was not signed by anyone. A resident rights document was located within Resident 1's record, with no evidence that it was reviewed with him/her and his/her legal representative. A grievance policy was located within Resident 1's	M 402		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020719	A. BUILDING: _____ B. WING _____	C 05/01/2026

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M 402	Continued From page 6 record that contained lines for the provider's representative, resident, and resident's legal representative to sign. However, there was no signature from the resident or his/her legal representative. At approximately 11:28 a.m., Surveyor interviewed Manager B and reviewed Resident 1's record with him/her. Manager B confirmed there was no evidence that resident rights and the provider's grievance policy were explained and that copies were provided of each to Resident 1 and his/her legal representative. At approximately 1:00 p.m., Surveyor interviewed Licensee A and reviewed Resident 1's record with him/her. Licensee A confirmed there was no evidence that resident rights and the provider's grievance policy were explained and that copies were provided of each to Resident 1 and his/her legal representative. Licensee A reported that it was overlooked.	M 402		
M 404	88.06(3)(a) INDIVIDUAL SERVICE PLAN & ASSESSMENT The licensee shall ensure that a written assessment and individual service plan is completed and developed for each resident within 30 days after placement. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that a written assessment and individual service plan (ISP) was developed	M 404		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020719	A. BUILDING: _____ B. WING _____	C 05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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M 404	Continued From page 7	M 404		

and completed for Resident 1 within 30 days after his/her placement. During the course of Resident 1's admission, concerns regarding his/her nutritional intake developed that warranted staff monitoring and intervention.

Findings include:

On 04/14/2026, Surveyor conducted a complaint investigation into concerns of inadequate nutritional intake monitoring by staff.

On 04/14/2026, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 01/28/2026, where s/he resided until 03/16/2026. Resident 1 was documented as having a legal representative. One assessment was located within Resident 1's record, titled "Resident Assessment," which was blank. A document titled "Individual Service Plan Review," which showed a table where staff could document the level of assistance Resident 1 required with various activities of daily living, was blank. There was no other evidence of an assessment or ISP within Resident 1's record.

At approximately 11:28 a.m., Surveyor interviewed Manager B. Regarding Resident 1's needs, Manager B stated, "We had to do everything for [him/her]." Manager B confirmed that staff assisted Resident 1 with all cares, including feeding, showering, dressing, and toileting. Manager B reported that Resident 1 required a shower chair for showering. Manager B reported that Resident 1 required staff assistance for transferring approximately 90% of the time in his/her estimation. Manager B reported that Resident 1 walked but required close staff supervision for safety. Manager B reported that Resident 1 was incontinent of both

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	0020719	A. BUILDING: _____ B. WING _____	C 05/01/2026

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M 404	Continued From page 8	M 404		

bowel and bladder and relied completely on staff to change his/her briefs. Manager B reported that staff controlled and administered Resident 1's medications. Manager B reported that Resident 1 required staff cues and encouragement on a daily basis to eat and drink during meals and snacks. Manager B reported that Resident 1 was sometimes known to not drink unless cued/encouraged by staff. Manager B reported at one point staff began giving him/her Ensure nutritional drinks 1-2 times per day due to staff noticing that s/he was eating less. Surveyor reviewed Resident 1's record with Manager B. Manager B confirmed there was no evidence of a written assessment or ISP within Resident 1's record.

At approximately 1:00 p.m., Surveyor interviewed Licensee A and reviewed Resident 1's record with him/her. Licensee A confirmed there was no evidence of a written assessment or ISP completed for Resident 1 and reported that it was overlooked.

On 04/30/2026, at approximately 3:13 p.m., Surveyor interviewed Family Member C, who was also the activated power of attorney (POA) for healthcare for Resident 1. Family Member C reported that Resident 1 could sometimes feed him/herself, but sometimes required staff assistance for feeding. Family Member C reported that Resident 1 required encouragement to eat, which was a known need even prior to his/her admission. Family Member C reported that at some point s/he met with Resident 1's case manager from his/her managed care organization and the provider's staff where it was discussed that staff would begin taking Resident 1's weights and implement use of Ensure nutritional drinks for Resident 1. Family Member

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020719	A. BUILDING: _____ B. WING _____	C 05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANGING POINT LLC	S68W12631 WOODS RD MUSKEGO, WI 53150

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M 404	Continued From page 9 C reported that s/he texted Licensee A recommendations from Resident 1's medical provider on 02/24/2026 at 2:15 p.m. that Resident 1 was to receive Ensure and have more fluid intake. On 04/30/2026, Surveyor reviewed the text message exchange, referenced by Family Member C above, but provided with records sent by Licensee A. The text, from the above date and time, from Family Member C to Licensee A showed, "Hi [Licensee A], spoke with [Resident 1's medical provider] just now. [His/her] diet needs to change...more fiber with more liquid intake. Water, juice and even smoothies or shakes...[S/he]'s going to put order in for ensure..." On 04/30/2026, Surveyor reviewed outside medical records obtained for Resident 1, which showed an emergency department admission and subsequent hospitalization from 03/15/2026 - 03/25/2026. Of note, one of Resident 1's admission diagnoses was acute kidney injury. An internal medicine progress note on 03/17/2026 documented that Resident 1's acute kidney injury was "likely due to dehydration."	M 404		
M 446	88.07(2)(b)4 RECORD OF MEDICAL VISITS AND REPORTS Keeping a current record of all medical visits, reports and recommendations for a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that a current record of all medical visits, reports, and recommendations for	M 446		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020719	A. BUILDING: _____ B. WING _____	C 05/01/2026

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M 446	Continued From page 10 Resident 1 was maintained. Findings include: On 04/14/2026, Surveyor reviewed Resident 1's record. There was no evidence of medical visits, reports, and/or recommendations for Resident 1 as part of his/her record. At approximately 11:28 a.m., Manager B confirmed that the documents provided to Surveyor as Resident 1's record was his/her entire record. On 04/30/2026, Surveyor reviewed outside medical records obtained for Resident 1. Among the records was a report from a home medical visit that occurred by his/her primary care provider on 02/16/2026. The note documented, "[Resident 1]'s appetite is variable, eating between 25-75% of [his/her] meals depending on [his/her] food preference, and [his/her] [family member] also noted possible weight loss..." Under the "Assessment/Plan" section of the note, Resident 1's medical provider directed for, "Vital signs to be done weekly to include [blood pressure], [heart rate], Temp[erature], Weight, and PulseOx." On 05/01/2026, at approximately 10:30 a.m., Surveyor interviewed Licensee A. Licensee A reported s/he believed Manager B had log-in access to Resident 1's medical records but was given limited access to the information. Licensee A reported s/he was aware of the medical provider visit but was unaware of the vitals monitoring that was directed from that report.	M 446		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020719	A. BUILDING: _____ B. WING _____	C 05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANGING POINT LLC	S68W12631 WOODS RD MUSKEGO, WI 53150

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M 448	Continued From page 11	M 448		
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: Based on record review and interview, the provider did not ensure that Resident 1's health, with observed and documented changes, was monitored in relation to the onset of various bruises s/he sustained. Resident 1 sustained a left hip-area bruise, left hand bruise, and 2 left lower leg bruises at unknown dates but first observed by Family Member C on 03/14/2026. Per report from Manager B, the left hip-area bruising was observed by staff on 03/11/2026 but an incident report that documented the bruise was not completed until 03/16/2026. Resident 1 required total assistance for all cares from staff, including bathing, toileting, and dressing. The incident report that detailed the first mention of the hip bruise, dated 03/16/2026, indicated that it was Resident 1's right hip and not left that sustained the injury. There was no documentation of Resident 1's left hand bruise or 2 left lower leg bruises. Findings include: On 04/14/2026, Surveyor conducted a complaint investigation into concerns of bruising that Resident 1 sustained. On 04/14/2026, Surveyor reviewed Resident 1's	M 448		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020719	A. BUILDING: _____ B. WING _____	C 05/01/2026

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M 448	Continued From page 12	M 448		

record. Resident 1 was admitted to the provider from 01/28/2026 through 03/16/2026. There was no assessment or individual service plan (ISP) as part of his/her record. Surveyor reviewed "Resident Daily Logs" that were maintained as part of Resident 1's record throughout his/her admission. Within the logs, there was no evidence of incidents having occurred, skin concerns, or other changes of condition documented throughout his/her admission. Within Resident 1's records, there were 2 incident reports that detailed the following:

- Incident report dated 03/09/2026, "Time: Unknown." The report documented that Manager B filled out the information but the staff on duty was Caregiver D. The location of the incident was identified as Resident 1's bedroom. A box was checked that indicated the incident was regarding "Injury/Bruising." A body diagram in the report showed hand-drawn circles at the left head with the annotation, "scalp", and at the left eyebrow with the annotation, "above eyebrow." The report documented, "...Resident is unable to provide a statement due to cognitive impairment related to dementia and inability to effectively articulated [sic] events...On 3-10-26 staff observed that [Resident 1] had a scratch to [his/her] scalp and above [his/her] eyebrow, along with broken glasses. At the time of discovery, staff believes the injuries may have been caused by [Resident 1] scratching [him/herself], as [s/he] had a history of such behaviors." The report then documented a course of monitoring actions that were to be followed by staff related to the affected areas and Resident 1's "scratching behaviors."

- Incident report dated 03/16/2026, "Time: Unknown." The report documented that Manager B filled out the information but that the staff on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020719	A. BUILDING: _____ B. WING _____	C 05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANGING POINT LLC	S68W12631 WOODS RD 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
M 448	Continued From page 13	M 448		

duty was Caregiver D. The location of the incident was identified as Resident 1's bedroom. Boxes were checked indicating that the incident was regarding "Fall" and "Injury/Bruising." A body diagram in the report showed hand-drawn circles at the left frontotemperal head area and at the right upper thigh. The report documented, "...Resident is unable to provide a statement due to inability to effectively articulate events and cognitive impairment related to dementia...On 3-16-26 staff became aware that resident [Resident 1] had experienced a fall within the home. At the time of the incident, the fall was not immediately reported to management as a fall. Staff initially believed there was no significant injuries observed...Upon later assessment and ongoing monitoring bruises was [sic] noted on [Resident 1]'s body, including left part of [his/her] forehead (ligh [sic] yellow bruise), and hip/thigh area had a bruise as well. The bruises appeared consistent with a prior fall and developed over time, which can occur as bruises may not be immediately visible following an incident. Once management was made aware, a full body assessment was completed to ensure [Resident 1]'s safety and to identify any additional concerns. Appropriate documentation was notated and all required parties were notified..."

Other than the scalp scratch (noted on 03/10/2026), left eyebrow area scratch (noted on 03/10/2026), left frontotemperal area bruising (noted on 03/16/2026), and left hip/thigh bruising (noted on 03/16/2026), no other injuries were noted.

From review of Resident 1's record, no other injuries or skin concerns were documented.

At approximately 11:28 a.m., Surveyor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020719	A. BUILDING: _____ B. WING _____	C 05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANGING POINT LLC	S68W12631 WOODS RD 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
M 448	Continued From page 14	M 448		

interviewed Manager B. Regarding Resident 1's needs, Manager B stated, "We had to do everything for [him/her]." Manager B confirmed that staff assisted Resident 1 with all cares, including feeding, showering, dressing, and toileting. Manager B reported that Resident 1 required staff assistance for transferring approximately 90% of the time in his/her estimation. Manager B reported that Resident 1 walked but required close staff supervision for safety. Manager B reported that Resident 1 was incontinent of both bowel and bladder and relied completely on staff to change his/her briefs.

As part of the same interview, Surveyor interviewed Manager B about the incident reports and courses of Resident 1's injuries. Manager B reported on the day of the first incident report, 03/10/2026, s/he arrived to work first shift and Caregiver D, who was nearing the end of his/her third shift, reported that Resident 1 cracked his/her glasses. Manager B reported s/he later observed the scratch on Resident 1's scalp and eyebrow area when doing morning cares with him/her. Manager B reported s/he was not sure what caused them and that they weren't mentioned by Caregiver D. Manager B reported that the day after this, Caregiver E was working, saw a bruise on Resident 1's left hip area, and called him/her about it. Manager B reported that body checks were typically conducted by staff daily during the course of dressing and showers. Manager B reported noticing that the affected hip-area was on the same side of Resident 1's body as his/her scratch and began wondering if Resident 1 had a fall that caused the injuries. Manager B reported s/he still couldn't confirm for sure how Resident 1 sustained the injuries but reported believing that s/he fell and transferred him/herself back up, unwitnessed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020719	A. BUILDING: _____ B. WING _____	C 05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANGING POINT LLC	S68W12631 WOODS RD 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
M 448	Continued From page 15	M 448		

As part of the same interview, Manager B clarified the incident reports. Manager B reported that s/he dated the first report 03/09/2026 as s/he believed the scratches observed then were thought to have been sustained sometime between the night of 03/09/2026 and the morning of 03/10/2026, prior to his/her arrival. Manager B reported that upon his/her shift start s/he did morning cares with Resident 1 which included showering and dressing, and did not observe any other injuries. Manager B reported that the second incident report didn't intend to detail a second, separate incident, but was an update of the original incident. Manager B reported that his/her initiation of this report was triggered by the hip-area bruising observed by Caregiver E as well as yellow facial bruising observed at Resident 1's left frontotemporal area, which s/he noted was the same area that the scratch was. Manager B reported that with the onset of hip-area bruising and left frontotemperal area bruising, s/he believed Resident 1 had fallen. Manager B reported s/he then texted Family Member C the information.

(Of note, Manager B's interview above indicated that Resident 1's left hip-area bruising was observed on 03/11/2026 but the incident report was not completed until 03/16/2026. The incident report that detailed the first mention of the hip bruise, dated 03/16/2026, indicated that it was Resident 1's right hip and not left that sustained the injury).

As part of the same interview, Surveyor reviewed text message exchanges between Manager B and Family Member C from Manager B's phone. Surveyor reviewed the entirety of text message conversations available on Manager B's phone

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020719	A. BUILDING: _____ B. WING _____	C 05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANGING POINT LLC	S68W12631 WOODS RD 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
M 448	Continued From page 16	M 448		

from 03/10/2026 - 03/16/2026. The only mention of injuries outside of the 2 scratches was in a text from Manager B to Family Member C on 03/16/2026 at 9:31 a.m. The text documented, "Good Morning [Family Member C]...I did want to mention the bruising, this morning while helping [Resident 1] get dressed I noticed some yellow bruising on [his/her] face, near where the scrape was. It looks like it's healing. I was off this weekend so I didn't notice it earlier but we believe it may have been from the fall...I just wanted to keep you informed because I only was aware of that bruise on [his/her] hip..."

On 04/16/2026, Surveyor reviewed records provided by Licensee A. The records included screenshots of a series of text message conversations between Licensee A and Family Member C. These included the following:

- Text message from Family Member C on 03/15/2026 (2:50 p.m.): "...I stopped down by [Resident 1] yesterday and was very surprised to see the multiple bruises on [Resident 1]'s body. Please tell me how and when this happened because I was not notified."

- Text message reply from Licensee A: "Multiple bruises or just 1 on the leg? If you're speaking about the leg [Manager B] seen it last week. I believe [s/he] told you this yesterday. We are not sure when it happen but we do notate every change in behavior or the body including injuries. The incident that we reported to you is all we know of which [Caregiver D] insisted [s/he] did not fall. With that being said [Caregiver D] will no longer be at that location."

- Text message reply from Family Member C: "The bruises on [his/her] shines [sic] shows signs

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020719	A. BUILDING: _____ B. WING _____	C 05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANGING POINT LLC	S68W12631 WOODS RD 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
M 448	Continued From page 17	M 448		

of them being older but the bruises on [his/her] left calf and left hip and down [his/her] thigh and bruising on left hand is most recent. They seem to be red blue and purple. Which indicates a very recent trauma."

- Text message reply from Licensee A: "I do believe [s/he] fell which is why I'm making the decisions I am. But I can only go based upon what is told to us when we are not there just like any other home."

- Text message reply from Family Member C: "[Manager B] did not inform me of any massive bruising last week but informed me of the eye and head last Tuesday morning." (Surveyor noted that Tuesday would have been 03/10/2026, consistent with the scratches observed).

On 04/30/2026, Surveyor reviewed photos of Resident 1's injuries provided by Family Member C, which included the following:

- Photo taken 03/14/2026 (5:02 p.m.): Bruising at Resident 1's left lateral and posterior hip extending distally toward his/her thigh, blue/purple in color and approximately the size of an adult hand. A person's hands were observed in the photo, appearing to hold Resident 1's skin to expose the bruise for the photo.

- Photo taken 03/14/2026 (5:21 p.m.): Bruising at Resident 1's lower leg, laterality and size unclear, blue/purple in color

- Photo taken 03/14/2026 (5:22 p.m.): Bruising at Resident 1's left shin area, approximately the size of a half-dollar. The center of the bruise appeared blue/red with the surrounding area yellow.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020719	A. BUILDING: _____ B. WING _____	C 05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANGING POINT LLC	S68W12631 WOODS RD 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
M 448	Continued From page 18	M 448		

- Photo taken 03/14/2026 (5:29 p.m.): Bruising at Resident 1's left dorsal hand at his/her entire webspace and first metacarpal area, blue/purple in color

On 04/30/2026, at approximately 3:13 p.m., Surveyor interviewed Family Member C. Family Member C reported s/he and his/her family member came to the home to visit Resident 1 on 03/14/2026. Family Member C reported Caregiver D, who was working at this time, began to change Resident 1 and it was during this that s/he (Family Member C) observed the hip-area bruise. Family Member C reported s/he asked Caregiver D what happened to Resident 1, to which Caregiver D replied, "I don't know." Family Member C reported that the hands observed by Surveyor in the photo of this bruise were those of Caregiver D. Family Member C reported after seeing the hip-area bruise s/he inspected Resident 1's skin and that was how s/he discovered the 2 lower leg bruises and hand bruise. Family Member C reported s/he asked Caregiver D about these other bruises and stated, "That's the only answer I got was, 'I don't know.'" Family Member C reported s/he assumed after this visit that Caregiver D informed Manager B of the situation because s/he then received a call from Manager B. Family Member C reported that during this phone call, Manager B confirmed being aware of the hip area bruise and thought that it occurred on Thursday (Surveyor noted this would have been 03/12/2026). Family Member C reported that s/he then reached out to Licensee A via text to inquire about the bruises. Family Member C reported that Licensee A told him/her that Manager B had already informed him/her (Family Member C) about the bruise, but Family Member C replied that s/he had not been informed of it and that the phone conversation with Manager B only happened after s/he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020719	A. BUILDING: _____ B. WING _____	C 05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANGING POINT LLC	S68W12631 WOODS RD 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
M 448	Continued From page 19	M 448		

discovered the bruises him/herself.

On 04/30/2026, Surveyor reviewed a continuation of the text message conversation on the afternoon of 03/15/2026 that occurred between Licensee A and Family Member C, provided by Family Member C. The next text message, after Family Member C's last text above, was a reply from Licensee A, documenting, "We investigate and go from there. And because [Resident 1] came with so many bruises and we were told no fall I think they were overlooked besides when [Manager B] realized the leg Thursday. That issue has been handled."

According to a publication by the American College of Emergency Physicians (ACEP), "Bruises tend to show multiple colors as they age. Red and purple tend to be fresh. They then progress to blue, then to brown, yellow, or green. Color may help determine "early" or "late" bruising...Some studies do indicate that yellow will not appear in a bruise until at least 18-24 hours after an injury," (Source: Riviello, R. (2014). Can you tell how old this bruise is based on its color?, ACEPNow: The Official Voice of Emergency Medicine, https://www.acepnow.com/article/can-tell-old-bruise-based-color/ (retrieval date - 05/01/2026).)

From all the above, Surveyor noted inconsistencies with the bruising timeline. There was no evidence of discovery or monitoring by the provider's staff of Resident 1's 2 lower leg bruises and left hand bruise, even after being discovered by Family Member C on 03/14/2026 and despite staff assisting Resident 1 with cares that had the potential to expose these areas, including toileting, bathing, and dressing. The text messages above indicated that Licensee A was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020719	A. BUILDING: _____ B. WING _____	C 05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANGING POINT LLC	S68W12631 WOODS RD 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
M 448	Continued From page 20	M 448		

made aware of the bruises on the afternoon of 03/15/2026. The left hip-area bruise was reported by Manager B to have been discovered on 03/11/2026, but the report attempting to assess its source wasn't documented until 03/16/2026 (5 days later), despite having been discovered by Family Member C on 03/14/2026, having been known by Caregiver D at least as of that date, as evidenced by his/her hands in the photo helping to expose the bruise area, and having been reported by Licensee A as being known by Manager B on 03/12/2026 from the text message exchange.

On 04/30/2026, Surveyor reviewed outside medical records obtained for Resident 1, starting when s/he was taken to the emergency department on 03/16/2026 and subsequently hospitalized. Within the records, Surveyor observed the following in relation to Resident 1's bruises:

- Emergency department assessment dated 03/16/2026: "...Blue and purple ecchymosis to the left gluteal region. Scattered ecchymosis throughout bilateral lower extremities..." The note also identified, "Multiple bruises" and "extensive bruising."

- Internal medicine history and physical note dated 03/16/2026: "...Bruising of the left hip, right calf..."

- Internal medicine progress note dated 03/17/2026: "...[S/he] has multiple bruises on [his/her] body along..."

On 05/01/2026, Surveyor interviewed Licensee A. Licensee A acknowledged Surveyor's concern at the lack of bruise monitoring conducted for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020719	A. BUILDING: _____ B. WING _____	C 05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANGING POINT LLC	S68W12631 WOODS RD 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
M 448	Continued From page 21 Resident 1.	M 448		
M 464	88.07(3)(d) MEDICATION- WRITTEN ORDER Before the licensee or service provider dispenses or administers a prescription medication to a resident, the licensee shall obtain a written order from the physician who prescribed the medication specifying who by name or position is permitted to administer the medication, under what circumstances and in what dosage the medication is to be administered. The licensee shall keep the written order in the resident's file. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that before service providers administered medication to Resident 1 a written order was obtained by his/her prescribing medical provider specifying that they were permitted to administer the medication. Findings include: On 04/14/2026, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 01/28/2026, where s/he resided until 03/16/2026. Resident 1's record contained medication administration records (MARs) throughout his/her admission period in which staff initialed off on administering his/her medications. A document within Resident 1's record, titled, "Authorization for Medication Management," contained a line for a medical provider's	M 464		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020719	A. BUILDING: _____ B. WING _____	C 05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANGING POINT LLC	S68W12631 WOODS RD 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
M 464	Continued From page 22 signature, which was blank. There was no other evidence of an authorization from Resident 1's prescribing medical provider for the provider's staff to administer his/her medication. At approximately 11:28 a.m., Surveyor interviewed Manager B and reviewed Resident 1's record with him/her. Manager B confirmed that staff administered Resident 1's medication. Manager B confirmed there was no evidence that Resident 1's prescribing medical provider authorized the provider's staff to administer his/her medication. At approximately 1:00 p.m., Surveyor interviewed Licensee A and reviewed Resident 1's record with him/her. Licensee A confirmed there was no evidence that Resident 1's prescribing medical provider authorized the provider's staff to administer his/her medication. Licensee A reported that it was overlooked.	M 464		