STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020768	A. BUILDING: _____ B. WING _____	C 09/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE ON HAMPTON ASSISTED LIVING F/	4615 W HAMPTON AVE MILWAUKEE, WI 53218

(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 09/09/2026, Surveyor completed a complaint investigation at Heritage on Hampton Assisted Living Facility. As a result, 4 deficiencies were identified. The complaint was substantiated. Census: 25	N 000		
N 205	83.14(2)(j) Not permit a condition of substantial risk. The licensee may not permit the existence or continuation of any condition which is or may create a substantial risk to the health, safety or welfare of any resident. This Rule is not met as evidenced by: Based on interview and record review, the provider did not prohibit the existence of a condition which may create substantial risk to the welfare of 1 of 1 resident (Resident 1). Resident 1 alleged Resident 2 sexually harassed her/him. Findings include: Interviews On 09/09/2026, at 11:10 AM, Surveyor interviewed Resident 1. Resident 1 reported shortly after s/he moved into the facility; Resident 2 came into her/his bedroom while s/he was in bed. Resident 1 reported Resident 2 began to self-pleasure herself/himself while sitting on the bed. Resident 1 reported s/he was unable to lock her/his door. Resident 1 reported s/he spoke with Registered Nurse (RN) D and "it felt like it was brushed off." Resident 1 reported the police were not contacted. Resident 1 reported s/he was	N 205		

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

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N 205	Continued From page 1 afraid to say anything more as s/he was afraid of becoming homeless. On 09/09/2026, at 1:30 PM, Surveyor interviewed Licensee A and Manager B. Licensee A and Manager B reported RN D conducted the investigation and were unaware if the police were contacted. Observation On 09/09/2026, at approximately 11:20 AM, Surveyor observed Resident 1's door. The door handle was a lever handle style, with a keyed entry. The inside of the door handle contained a turn lock. Surveyor attempted to turn the lock and was unable to engage the door lock. Record Review On 09/09/2026, at 12:50 PM, Surveyor reviewed facility investigations and identified the following: - "Member Concern Investigation 11/24/25 Received verbal report 11/24/25 at [3:00 PM] from manager, [Floor Manager C] that [Resident 1] told her/him that resident [Resident 2] came into her/his room and asked her/him to see her/his [private area]. [Resident 1]. also told [Floor Manager C] that [Resident 2] sat on her/his bed and began to pleasure herself/himself .... Immediate Interventions: Teaching done with resident one to notify care staff if any person entered her/his room without permission. Resident asked if s/he would like her/his room locked at bedtime every night. S/He replied yes. Care plan updated. Resident asked if s/he would like her/his room moved to the opposite end of the hallway and s/he declined. Resident instructed that s/he should not go into resident	N 205		

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N 205	Continued From page 2 one's room period resident verbalized understanding." - 01/20/2026, Resident 1 reported Resident 2 came into her/his room, sat on her/his bed and attempted to fondle Resident 1's private areas. Resident 1 asked Resident 2 to leave her/his room and Resident 2 refused. A custodial worker arrived to mop Resident 1's floor, Resident 1 asked custodial worker to get a caregiver. Resident 2 was redirected from Resident 1's room. On 09/09/2026 at 12:00 PM, Surveyor reviewed resident records and identified the following: Resident 1 was admitted on 08/22/2025 with diagnoses including Guillain-Barre Syndrome and depression. Resident 1 was her/his own person. Resident 1's individual service plan (ISP), dated 11/16/2025, under interpersonal relationships indicated Resident 1 had many interpersonal relationships, was social and developed close bonds with care staff. Resident 1 would often invite other residents to her/his room to socialize and watch television (TV). Resident 2 was admitted on 07/07/2025 with diagnoses including hypertension, atrial fibrillation, and anemia. Resident 2's care plan, undated, indicated Resident 2 had behaviors in verbally abusive and was orientated to person, place and time. Resident 2's ISP, undated, did not indicate any behaviors for Resident 2 and social participation was blank.	N 205		
N 362	83.33(1)(d) Grievance procedure: written summary	N 362		

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N 362	Continued From page 3 The CBRF shall provide a written summary of the grievance, the findings and the conclusions and any action taken to the resident or the resident ' s legal representative and the resident ' s case manager. The CBRF shall maintain a copy of the investigation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide in 8 of 8 grievances, the findings, and the conclusions and any action taken to the resident, resident's legal representative, and case managers. Findings include: On 09/09/2026 at 1:05 PM, Surveyor reviewed the facility's record of grievances. The following was identified: -Resident 6's grievance, dated 05/27/2026, indicated s/he woke up in the afternoon and s/he was missing money from her/his wallet. There was no resolution indicated on the form. -Resident 4's grievance, dated 06/15/2026, identified Resident 4 complained s/he received a package, and staff put the box near the manager's office. When Resident 4 went to retrieve the package, the package was missing. There was no resolution indicated on the form. -Resident 4's grievance, dated 06/15/2026, identified staff asked Resident 4 at 8:30 AM if s/he wanted a shower. Resident 4 requested a shower and was unable to receive one until 5:32 PM due to the staff member reporting s/he was	N 362		

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N 362	Continued From page 4	N 362		

unable to find help from another staff member. Resident 4 had 3 accidents during the time span. There was no resolution indicated on the form.

- Resident 5's grievance, dated 08/14/2026, indicated overnight no one came in to assist with repositioning. Resident 5 pushed her/his pendant between 11:00 PM - 1:00 AM. Resident 5 called Licensee A. Caregiver G came in and told Resident 5 s/he was hitting the bell like s/he was going crazy and slammed the door. Another staff came in to assist with repositioning of Resident 5.

- Resident 5's grievance, dated 08/14/2026, indicated Caregiver G came in and inquired if Resident 5 needed assistance, Resident 5 reported yes but Caregiver G left. Resident 5 hit her/his pendant at 1:00 AM. Another staff came in at 1:45 AM and reported Caregiver G left to go to the store. Caregiver G came in to assist with repositioning at 4:00 AM.

- Resident 4's grievance, dated 08/17/2026, indicated Resident 4 had not received a shower for 2 weeks due to the shower sling was sent down to laundry and was never returned. There was no resolution on the form.

-Resident 5's grievance, dated 08/18/2026, identified Resident 5 complained on 08/17/2026, staff did not check on Resident 5 from 6:00 AM until 3:15 PM. Resident 5 hits the pendant to go to the bathroom and does not get assistance and needs to be reposition. There was no resolution indicated on the form.

- Resident 7's grievance, undated, identified Resident 7 requested an alternative meal for lunch, Caregiver E took the meal and did not come back with an alternative meal. Resident 7

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N 362	Continued From page 5 pushed her/his pendant and an hour later Caregiver F came. There was no resolution on the form. On 09/09/2026, Surveyor reviewed the facility's grievance policy. The policy was dated 03/05/2025, indicated the following: "...4. CBRF (community based residential facility) shall provide a written summary of the grievance, the findings and the conclusions, and any action taken by the resident or the resident's legal representative and the resident's case manager. The CBRF shall maintain a copy of the investigation... 9. Investigation Process Upon receiving grievance, the Grievance Officer will conduct a thorough and timely investigation ...the investigation will be completed within 10 business days of receipt of the grievance...10. Responses to Grievances the Grievance Officer will provide a written response to the complainant within 15 business days of completing the investigation. This response will include a summary of the investigation findings [sic] resolution or actions taken ..." On 09/09/2026, at 1:30 PM, Surveyor interviewed Licensee A and Manager B. Licensee A and Manager B confirmed the code requirement. Licensee A reported they would ensure the grievances were investigated and filled out as indicated by the policy.	N 362		
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 6 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 interview and record review, the provider did not ensure each resident's individual service plan (ISP) was updated when there was a change in resident's needs, abilities or physical or mental condition for 1 of 1 resident (Resident 2). Findings include: On 09/09/2026, at 12:50 PM, Surveyor reviewed facility investigations and identified the following: - "Member Concern Investigation 11/24/25 Received verbal report 11/24/25 at [3:00 PM] from manager, [Floor Manager C] that [Resident 1] told her/him that resident [Resident 2] came into her/his room and asked her/him to see her/his [private area]. [Resident 1]. also told [Floor Manager C] that [Resident 2] sat on her/his bed and began to pleasure herself/himself .... Immediate Interventions: Teaching done with resident one to notify care staff if any person entered her/his room without permission. Resident asked if s/he would like her/his room locked at bedtime every night. S/He replied yes. Care plan updated. Resident asked if s/he would like her/his room moved to the opposite end of	N 389		

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N 389	Continued From page 7 the hallway and s/he declined. Resident instructed that s/he should not go into resident one's room period resident verbalized understanding. - 01/20/2026, Resident 1 reported Resident 2 came into her/his room, sat on her/his bed and attempted to fondle Resident 1's private areas. Resident 1 asked Resident 2 to leave her/his room and Resident 2 refused. A custodial worker arrived to mop Resident 1's floor, Resident 1 asked custodial worker to get a caregiver. Resident 2 was redirected from Resident 1's room. Resident 2 was admitted on 07/07/2025 with diagnoses including hypertension, atrial fibrillation, and anemia. Resident 2's care plan, undated, indicated Resident 2 had behaviors in verbally abusive and was orientated to person, place and time. Resident 2's ISP, undated, did not indicate any behaviors for Resident 2 and social participation was blank. On 09/09/2026, at 1:30 PM, Surveyor interviewed Licensee A and Manager B. Licensee A and Manager B confirmed the code requirement. Manager B acknowledged Surveyor's concerns regarding updating the ISPs to ensure the ISPs reported accurate needs and abilities for residents.	N 389		
Y3235	50.09(1)(f) Privacy (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to:	Y3235		

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Y3235	Continued From page 8 (f) Physical and emotional privacy in treatment, living arrangements and in caring for personal needs, including, but not limited to: This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all residents had the right to privacy. This had the potential to affect 25 of 25 residents. Resident 1's bedroom lock was unable to be engaged. Floor Manager C was wearing a type of artificial intelligence (AI) smart glasses. Findings include: Example 1 On 09/09/2026, at 11:10 AM, Surveyor interviewed Resident 1. Resident 1 reported shortly after s/he moved into the facility; Resident 2 came into her/his bedroom while s/he was in bed. Resident 1 reported Resident 2 began to self-pleasure herself/himself while sitting on the bed. Resident 1 reported s/he was unable to lock her/his door. Resident 1 reported the police were not called. Resident 1 reported s/he spoke with Registered Nurse (RN) D and "it felt like it was	Y3235		

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Y3235	Continued From page 9 brushed off." Surveyor observed Resident 1's door. The door handle was a lever handle style, with a keyed entry. The inside of the door handle contained a turn lock. Surveyor attempted to turn the lock and was unable to engage the door lock. On 09/09/2026, at 12:50 PM, Surveyor reviewed facility investigations and identified the following: - "Member Concern Investigation 11/24/25 Received verbal report 11/24/25 at [3:00 PM] from manager, [Floor Manager C] that [Resident 1] told her/him that resident [Resident 2] came into her/his room and asked her/him to see her/his [private area]. [Resident 1] also told [Floor Manager C] that [Resident 2] sat on her/his bed and began to pleasure herself/himself .... Immediate Interventions: Teaching done with resident one to notify care staff if any person entered her/his room without permission. Resident asked if s/he would like her/his room locked at bedtime every night. S/He replied yes. Care plan updated. Resident asked if s/he would like her/his room moved to the opposite end of the hallway and s/he declined. Resident instructed that s/he should not go into resident one's room period resident verbalized understanding. - 01/20/2026, Resident 1 reported Resident 2 came into her/his room, sat on her/his bed and attempted to fondle Resident 1's private areas. Resident 1 asked Resident 2 to leave her/his room and Resident 2 refused. A custodial worker arrived to mop Resident 1's floor, Resident 1 asked custodial worker to get a caregiver. Resident 2 was redirected from Resident 1's room.	Y3235		

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Y3235	Continued From page 10 On 09/09/2026, at 1:30 PM, Surveyor interviewed Licensee A and Manager B. Licensee A confirmed the code requirement. Licensee A reported s/he was unaware of Resident 1's bedroom door not being able to lock. Manager B reported they would replace the door lock. Licensee A reported s/he could probably get the door locked. Surveyor reported s/he nor Resident 1 were able to lock the door, and Resident 1 should be able to lock her/his door. Licensee A acknowledged Surveyor's concerns. Example 2 On 09/09/2026, at 9:55 AM, Surveyor entered the facility. Surveyor observed Floor Manager C behind the nurse's station. Floor Manager C answered a call from a cell phone and stated, "Hold on, let me connect my glasses." Surveyor observed Floor Manager C wearing a pair of black plastic rimmed glasses with a little camera lens located on the right-side end piece on the front of the frame on the outer edges. Floor Manager C walked away from the nurse's station. During the survey, Surveyor observed Floor Manager C walk around the facility, and into resident rooms while wearing the glasses. Surveyor was unable to determine if Floor Manager C's glasses were recording audio and/or visual. On 09/09/2026, at 10:20 AM, Surveyor interviewed Resident 3. Resident 3 reported s/he did not know Floor Manager C's glasses were capable of recording. Resident 3 reported Floor Manager C was not always in her/his room. Resident 3 stated, "I didn't know, I don't think I would like that."	Y3235		

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Y3235	Continued From page 11 On 09/09/2026, at 10:45 AM, Surveyor interviewed Resident 4. Resident 4 reported s/he had seen Floor Manager C's glasses. Resident 4 reported s/he did not know if Floor Manager C was recording or not. Resident 4 reported s/he would not feel comfortable if Floor Manager C was recording personal cares. "Many smart glasses feature built-in cameras for a variety of uses. The most obvious and direct purpose is to take photos and videos without having to touch your phone. This is handy for sharing what you're doing on social media, but it's a double-edged sword: Some people have been using camera-equipped smart glasses to creep on [people] and record them without their consent. Cameras also expand the functionality of any AI assistant built into smart glasses. They can use machine vision to analyze whatever you're looking at to help you identify a flower or translate a menu. Of course, as with surreptitious snapshots, using AI to scan everything around you can raise privacy concerns. (Source: PC Mag, What Smart Glasses Can (and Can't) Do: I Wore the Top Models So You Don't Have To, July 11, 2026, https://www.pcmag.com/explainers/what-smart-glasses-can-and-cant-do-i-wore-top-models-so-you-dont-have-to (retrieval date - September 17, 2026).) On 09/09/2026, at 1:30 PM, Surveyor interviewed Licensee A and Manager B. Licensee A reported s/he was unaware of Floor Manager C was wearing AI smart glasses. Surveyor inquired about how licensee would know if Floor Manager C was recording during personal cares. Licensee A acknowledged Surveyor's concerns and reported s/he would take care of it immediately.	Y3235		