STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525108	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allis Care Center	9047 W Greenfield Ave West Allis, WI 53214

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 20483 Based on interview and record review the facility did not ensure 1 (R4) of 1 Residents reviewed for grievances has the right to voice grievances in writing, in a manner they prefer, and receive written grievance decisions. On 4/29/24 the facility issued a letter to residents and/or their representatives informing them they would not accept grievances emailed to the facility. Resident's grievances do not include whether their issues were confirmed or not confirmed and the date written decisions were issued to the individual with the grievance/concern Findings include: The facility's policy titled, Grievance/Concern Process and not dated under procedure documents: 1. The facility must notify the residents individually or through posting in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance officer with whom a grievance can be filed, that is his or her name, business address and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information on independent entities with whom grievances can be filed, that is, the pertinent Stage agency, Quality Improvement Organization, State Survey Agency and State Long Term Care Ombudsman program or protection and advocacy system. 7. The Grievance Officer will ensure that all written grievance decisions include the date the grievance was received, a summary statement of the grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the residents concern(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued. R4's diagnoses include quadriplegia and anxiety. The quarterly MDS (minimum data set) with an assessment reference date of 8/12/24 has a BIMS (brief interview mental status) score of 15 which indicates cognitively intact. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/27/24, at 12:16 p.m., Surveyor interviewed R4. R4 informed Surveyor at the end of April he received a letter from the facility that grievances can't be emailed anymore. R4 informed Surveyor the facility said there are certain issues that need to be resolved in a timely manner and email causes delay. Surveyor asked R4 if he still has this letter. R4 explained he had the paper copy but it got wet. R4 informed Surveyor he thought he had a copy on his IPad and would look for it. On 8/27/24, at 1:23 p.m., Surveyor reviewed the facility's June to August 2024 grievance log. Surveyor noted there are no grievances for R4 during June 2024, there is one grievance dated 7/14/24 on the July 2024 log, and one grievance dated 8/20/24. On 8/27/24, at 2:14 p.m., Surveyor asked R4 after he received the April 2024 letter indicating grievances can't be emailed did he receive another letter indicating that grievances via email are now accepted. R4 replied no if they changed it I don't know. On 8/27/24, at 3:36 p.m., Surveyor received R4's grievances dated 7/14/24 & 8/26/24. Surveyor noted the 7/14/24 grievance does not include whether the grievance was confirmed or not confirmed and the date the written decision was issued to R4. Surveyor noted the 8/26/24 grievance does not include whether the grievance was confirmed or not confirmed, the date the written decision was issued to R4 and on the back of this grievance is a handwritten notation which documents Resident not satisfied with receiving/not sending grievances via email. On 8/27/24, at 6:08 p.m., Surveyor reviewed an email from R4 with the April 29, 2024 letter attached. Prior NHA (Nursing Home Administrator)-F's 4/29/24 letter includes in part We write to inform you that there will be an upcoming adherence to our policy as it related to the grievances effective immediately. Per requirements and our facility policy, a resident or resident representative who wishes to complete a grievance/concern form may do so by filling out the form in writing or by relaying the concern verbally to a staff member. This grievance form is then submitted immediately to a supervisor in the facility for appropriate investigation and follow up. We take each and every concern very seriously, and your feedback is important to us. This is why it is so vital we maintain consistency in the submission of your concerns. Per State and Federal requirements, grievances of a certain nature require immediate investigation and reporting. Emailing concern forms could result in a potential delay in response and lead to non-compliance, therefore will no longer be accepted On 8/29/24, at 9:45 a.m., Surveyor asked NHA (Nursing Home Administrator)-A if she is the grievance officer. NHA-A replied yes. Surveyor asked NHA-A to explain how a resident or their representative would file a grievance. NHA-A explained they have a couple ways to report. There are paper forms at the nurses station if the resident is mobile can fill out or they can ask nursing staff including a CNA (Certified Nursing Assistant) to fill out the grievance form. Surveyor asked if a grievance can be emailed. NHA-A replied I believe they changed it awhile ago and explained they let residents know they are not to email. NHA-A explained if an email is sent on Friday, the email isn't picked up until Monday then they are pass the time to report. NHA-A stated we don't want the email, due to the potential, to lag. NHA-A informed Surveyor she thinks they changed it because this happened once. NHA-A informed Surveyor Assistant NHA-C handles grievances. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/29/24, at 10:23 a.m., Surveyor met with R4 to discuss the facility's grievance process. R4 informed Surveyor SSD (Social Service Director)-H informed him they don't have to put exactly what he says on the grievance form and they can just paraphrase it. R4 informed Surveyor he was told by ADON (Assistant Director of Nursing)-I he can't get a copy of the grievance because that's their policy. Surveyor informed R4 Surveyor had reviewed his grievance dated 7/14/24 and asked how this grievance was filed. R4 explained Scheduler-G was the MOD (manager on duty) and she stopped in my room to see if I had any concerns. R4 informed Surveyor he spoke with her about the bugs and Scheduler-G said she would write up a grievance. Surveyor inquired how the 8/26/24 grievance was written up. R4 informed Surveyor this grievance was with RN (Registered Nurse) Supervisor-D. R4 explained his call light was not answered, he didn't get his supper tray when they were being passed, and told RN Supervisor-D he wanted her to file a grievance. Surveyor asked R4 what are his concerns with not being able to email his grievances to the facility. R4 informed Surveyor it's discriminatory, violates his right to write a grievance stating I can't physically write because of my hands. R4 also explained not being to email doesn't allow him to keep track of grievances as the facility won't provide him with a copy of the grievance and by not being allowed to write the grievance in his own words the facility can downplay his concerns especially when waiting for someone to respond to his requests. R4 also informed Surveyor if someone is disrespectful he can put in his own words what occurred and if the facility writes the grievance it allows for misinterpretation or downplaying. Surveyor asked if anyone from the facility has spoken to him about being able to email his grievances. R4 replied no, no one told me I can send emails only said they are working on it. On 8/29/24, at 11:47 a.m., Surveyor asked Assistant NHA-C about the facility's grievance process. Assistant NHA-C informed Surveyor they are posted in the nurses station; on the first floor the grievance forms are across from the nurses station where they are accessible. Once they are filled out they are given to a staff member who places the grievance form in the mailbox. Surveyor inquired what mailbox. Assistant NHA-C explained either his, DON (Director of Nursing)-B, SSD-H or NHA-A. Surveyor asked what if the resident can't fill out the grievance form. Assistant NHA-C informed Surveyor a staff member will fill it out. Surveyor asked Assistant NHA-C if Surveyor was a family member could Surveyor email a grievance. Assistant NHA-C replied no. Surveyor asked if I was a resident could I email a grievance. Assistant NHA-C replied no and explained the facility gave out letters to stop emailing grievances. Assistant NHA-C informed Surveyor if he doesn't come in for three days the email is just sitting there. Assistant NHA-C informed Surveyor they are in the process of changing the process. Assistant NHA-C explained they are going to have a grievance email address which will go to NHA-A, himself, DON-B, ADON-I, and believes SSD-H is on there. Assistant NHA-C informed Surveyor they will be educating those residents who want to email grievances and have them sign an acknowledgment. Surveyor asked how many residents want to email their grievances. Assistant NHA-C informed Surveyor he believes two or three. On 8/29/24, at 2:21 p.m., Surveyor asked Assistant NHA-C after the facility has completed the investigation for a resident's grievance do they provide the resident with a written grievance decision. Assistant NHA-C replied no.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 20483 Based on interview and record review the facility did not report 1 (R6) of 3 incidents to the State survey agency and/or Nursing Home Administrator during the required timeframe. An allegation of verbal abuse and possible neglect on 7/10/24 was not reported to NHA (Nursing Home Administrator)-A or the State agency until 7/16/24 which was 6 days after the incident occurred. Findings include: The facility's policy titled, Freedom from Abuse and Neglect not dated under Reporting and Response documents: 1. Allegations will be reported to the Executive Director immediately. 2. The facility will report all alleged violations and substantiated incidents to the state agency and to all other agencies as required and will take all necessary corrective actions depending on the results of the investigation. R6's diagnoses includes epilepsy, anoxic brain injury, and depression. The quarterly MDS (minimum data set) with an assessment reference date of 8/8/24 has a BIMS (brief interview mental status score of 14 which indicates cognitively intact. The Facility's investigation for Resident Name documents [R6's name] and allegation/incident (brief description) documents Verbal Abuse Allegation. Date of allegation/incident documents 7/10/24 and date allegation/incident reported documents 7/16/24. Under allegation/incident reported summary includes documentation of Writer received a call that a staff member engaged in verbal abuse with a resident one week prior. Investigation was initiated immediately. Upon receiving the complaint, the caregiver was immediately sent home. ADON (Assistant Director of Nursing) proceeded to ensure resident felt safe in the building while Unit Manager reported it to the ED (Executive Director). Resident was asked if he felt safe in the building, he stated yes. Resident was asked if he recalled anyone yelling at him within the last 2 weeks or recently, he stated no. Resident was asked if he had any concerns with caregiver [CNA-J's first name], resident stated no. Resident was asked if he is scared of anyone in the facility, resident stated he is not. Resident continued on throughout the day with visiting resident and staff like he does at baseline. All parties were notified regarding the allegation. Resident was referred to psych services for evaluation to determine if this incident had any ill effect on his mood or psychosocial well being. ADON interviewed the Med Tech [E's initials] who reported the allegation. [Med Tech-E's initials] stated that she was on her med cart when she heard the accused caregiver say that's why I am not going to change you now. [Med Tech-E's initials] states she then proceeded to go intervene and separate the resident and staff member and also assist with the cares. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/28/24, at 9:51 a.m., Surveyor interviewed Med Tech-E on the telephone regarding an incident of R2's medication cards being removed from the medication cart on 7/10/24. (Cross-reference F755). Med Tech-E informed Surveyor she left her medication cart on 7/10/24 as she witnessed abuse. Med Tech-E indicated she ran to the resident as a staff member was screaming at him. Med Tech-E informed Surveyor she reported the abuse to RN (Registered Nurse) Supervisor-D. Surveyor asked Med Tech-E who was the resident & staff and what happened. Med Tech-E explained CNA-J was standing over R6 stating that's why I'm not going to change him. CNA-J was screaming at R6. Med Tech-E informed Surveyor R6 was soiled up to his stomach. Med Tech-E informed Surveyor DON (Director of Nursing)-B asked her why she didn't call the Administrator. Med Tech-E informed Surveyor she honestly didn't know she was suppose to notify the Administrator as she told the supervisor who is a RN. Med Tech-E stated it was abuse. On 8/28/24, at 2:27 p.m., Surveyor met with RN Supervisor-D. Surveyor asked on 7/10/24 when Med Tech-E left the medication cart unlocked did Med Tech-E say why she left the medication cart. RN Supervisor-D informed Surveyor she can't recall at this moment. Surveyor asked RN Supervisor-D if Med Tech-E told her a staff member was yelling at R6. RN Supervisor-D asked Surveyor do you have what I wrote and informed Surveyor she can't remember. On 8/29/24, at 11:26 a.m., DON (Director of Nursing)-B informed Surveyor she has RN Supervisor-D on the telephone. DON-B asked RN Supervisor-D if she wants to explain the night of the 10th (July 10, 2024) with R6. RN Supervisor-D explained she got off the elevator, looked down south hall, looked to left and saw a medication cart was opened with no nurse at the cart. RN Supervisor-D indicated the narcotics drawer was open, she counted the number of cards and took 2 cards out. RN Supervisor-D indicated she flagged Med Tech-E down. Med Tech-E came to the cart and Med Tech-E minimally acknowledged what she was saying to her about the cart being unlocked. Surveyor asked RN Supervisor-D what Med Tech-E told her as to why she left the medication cart. RN Supervisor-D informed Surveyor at first she didn't give a reason. RN Supervisor-D then explained LPN (Licensed Practical Nurse)-K came over, could hear what she was saying to Med Tech-E and told Med Tech-E yes she's right but couldn't remember exactly what he said. RN Supervisor-D informed Surveyor Med Tech-E stated I have a resident being abused. DON-B asked RN Supervisor-D abused or yelling. RN Supervisor-D then stated yelling. On 8/29/24, at 2:56 p.m. NHA-A, Assistant NHA-C, DON -B, ADON-I, and Monitor-L were informed Med Tech-E was aware of an allegation of verbal abuse and possible neglect on 7/10/24 and NHA-A & the State agency was not notified until 7/16/24.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 20483 Based on interview and record review the facility did not ensure 1 (R2) of 2 Residents received prescribed medication as ordered by the physician. On 7/10/24 the medication cart and narcotics drawer were observed open & unlocked. RN (Registered Nurse) Supervisor-D removed 2 medication cards from the narcotics drawer of the unlocked medication cart for R2. R2 did not receive her Tramadol HCL 50 mg (milligrams) and Lorazepam 0.25 mg as ordered by the physician during the evening medication pass. Findings include: The facility's policy titled, Medication Administration -General Guidelines and dated March 2021 under procedures for B. Administration #2 documents Medications are administered in accordance with written orders of the prescriber. #16 documents During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by. In addition, privacy is maintained always for all resident information (e.g., MAR (medication administration record)) by closing the MAR book/covering the MAR sheet or computer screen when not in use. R2's diagnoses includes dementia, major depressive disorder, and anxiety disorder. The quarterly MDS (minimum data set) with an assessment reference date of 6/24/24 has a BIMS (brief interview mental status) score of 7 which indicates severe cognitive impairment. R2's physician orders include with an order date of 9/29/23 Lorazepam Tablet 0.5 mg (milligrams) Give 0.5 tablet by mouth two times a day for anxiety, Give Lorazepam 0.25 mg twice daily and with an order date of 2/14/24 Tramadol HCL Tablet 50 mg Give 1 tablet by mouth three times a day for pain. Surveyor reviewed R2's July MAR (medication administration record) and noted on 7/10/24 for Lorazepam at 1600 (4:00 p.m.) documents 9 with Med Tech-E's initials. Code 9 is other/see nurses note. On 7/10/24 for Tramadol pain level is 0 and 1900 (7:00 p.m.) documents 9 with Med Tech-E's initials. The order note dated 7/10/24, at 2045 (8:45 p.m.), by Med Tech-E documents Lorazepam Tablet 0.5 mg Give 0.5 tablet by mouth two ties a day for Anxiety. Give Lorazepam 0.25 mg twice daily. Med (medication) not available. The order note dated 7/10/24, at 2046 (8:46 p.m.), by Med Tech-E documents Tramadol HCL Tablet 50 mg. Give 1 tablet by mouth three times a day for pain. Med not available. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed R2's Lorazepam 0.5 mg tab Half tab (0.25 mg) by mouth twice daily Controlled Drug Receipt Record/Disposition form for time period 6/18/24 to 7/18/24. Surveyor noted the last dose of Lorazepam R2 received on 7/10/24 was at 0730 (7:30 a.m.) with the next dose being administered on 7/11/24 at 0745 (7:45 a.m.). R2 did not receive the 2nd dose of Lorazepam with a scheduled time of 1600 (4:00 p.m.). Surveyor reviewed R2's Tramadol HCL 50 mg tablet Controlled Drug Receipt Record/Disposition form for time period 7/6/24 to 7/17/24. Surveyor noted the last dose of Tramadol R2 received on 7/10/24 was at 1200 (12:00 p.m.) with the next dose being administered on 7/11/24 at 0745 (7:45 a.m.). R2 did not receive the 3rd dose of Tramadol on 7/10/24 with a scheduled time at 1900 (7:00 p.m.). On 8/28/24, at 9:51 a.m., Surveyor interviewed Med Tech-E on the telephone. Surveyor informed Med Tech-E Surveyor had spoken to a CNA (Certified Nursing Assistant) who informed Surveyor she had observed RN Supervisor-D remove two medication cards from her medication cart. Surveyor asked Med Tech-E if on 7/10/24 R2's medication cards were removed from the medication cart. Med Tech-E informed Surveyor she left her medication cart unlocked on 7/10/24 as she witnessed abuse. Med Tech-E informed Surveyor after the incident she came back to her cart and started passing medication. Med Tech-E informed Surveyor she counted the narcotic cards when she got there and knew two cards were missing for R2. Med Tech-E informed Surveyor she called pharmacy and was told they sent her supply. Med Tech-E informed RN Supervisor-D R2's medication is missing. Med Tech-E indicated RN Supervisor-D gave her the two narcotic medication cards telling her here you go I was teaching you a lesson. Med Tech-E informed Surveyor she didn't think it was funny and asked RN Supervisor-D why did you do that to me. Med Tech-E informed Surveyor RN Supervisor-D stated I was trying to teach you a lesson. Med Tech-E indicated RN Supervisor-D stated she would strike out what she documented and to give R2 the medication. On 8/29/24, at 8:11 a.m., Surveyor reviewed Med Tech-E's statement dated 8/2/24. This statement documents On July 10, 2024 during my PM shift I was in the middle of my med pass when I witness an incident occur between a resident and staff. As I walked off from my med cart to go to see what was going on between staff and resident, the RN Supervisor [RN Supervisor-D's name] took two narc cards out of my narcotic drawer for resident in room [number]. Once everything calm (sic) down with the situation I was dealing with, is when I noticed my cart didn't have any of her narcs in it. I told [name of RN Supervisor-D] that I needed her medication and could she get me a dose out of the pyxis. Once [name of RN Supervisor-D] saw that I had checked off that the med wasn't available and had begin (sic) to call pharmacy she pulled the two cards out and said she was teaching me a lesson. She told me she would strike out what I charted and told me to give the resident the medication which was a hour later after I had put that it wasn't available . On 8/29/24, at 2:56 p.m., NHA-A, Assistant NHA-C, DON -B, ADON-I, and Monitor-L were informed R2 did not receive on 7/10/24 Lorazepam 0.25 mg at 4:00 p.m. and Tramadol 50 mg at 7:00 p.m.