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	03/13/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35426 Based on interview, record review, and policy review, the facility failed to notify the representative of a hospital transfer for one of two residents (Resident (R) reviewed for hospital transfer out of a total sample of 17. Findings include: Review of the facility's policy titled, Determining Decision-Making Capacity, revised 09/2017, revealed, . Physicians and staff shall collaborate to define each resident/patient's decision-making capacity . Residents/patients who lack decision-making capacity will have decisions made by an appropriately authorized substitute decision-maker. 3. The facility's care will be consistent with related clinical standards of practice and will comply with applicable laws and regulations related to determining decision-making capacity . Procedures 4. Based on these assessments and related discussions, and consistent with applicable laws and regulations, the physician and staff will define an individual's decision-making capacity and will document the basis for such conclusions in the medical record . Review of the facility's undated policy titled, Notice of Transfer or Discharge revealed, . To specify the timing and content of the notice of transfer or discharge to the resident, resident's representative, and state agencies . Review of R10's Admission Record, located in the electronic medical record (EMR) under the Profile tab, revealed R10 was admitted to the facility on [DATE] with multiple diagnoses which included major depressive disorder recurrent, muscle weakness, polyneuropathy, Bacteremia, unspecified abnormalities of gait and mobility, Type 2 diabetes with diabetic proliferative diabetic retinopathy, polyneuropathy, palmar fascial fibromatosis, acquired absence of left great toe, acquired absence of other left toes. Review of R10's Activation for Power of Attorney for Healthcare (POA), provided by the facility, revealed the resident's family member was selected by the resident has the resident's Healthcare Power of Attorney on 12/02/16, and the Activation for Power of Attorney for Healthcare was invoked by the resident's Healthcare Provider on 01/28/25 and the psychologist on 02/06/25. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R10's clinical record revealed the resident was transferred to the hospital on 02/27/25. There was no documented evidence that the family representative and POA was notified of the transfer. During the interview with the Administrator on 03/13/25 at 4:15 PM she confirmed that R10 had been transferred to the hospital on 02/27/25 and that the family representative and POA had not been notified of the transfer.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35426 Based on review of facility policy, record review, and interviews, the facility failed to protect the resident's right to be free of staff to resident abuse for two of 17 residents (Resident (R) 2 and R7) reviewed for abuse out of a total sample of 17. This failure created the potential for these and other residents to experience further abuse. Findings include: Review of the facility's undated Freedom from Abuse and Neglect Policy read, in pertinent part, Purpose: To prohibit abuse, neglect, exploitation of residents and misappropriation of property; and Definition: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. 1. Review of R2's Admission Record, dated 03/13/25 and found in the electronic medical record (EMR) under the Profile tab, revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included quadriplegia. Review of R2's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/10/25 and found in the EMR under the MDS tab, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. Review of the Misconduct Incident Report and Facility Investigation related to an allegation of verbal abuse by R2 and dated 01/19/25, revealed, resident alleging that nurse [Registered Nurse (RN3)] made statements to another employee outside his room and heard her say she refuses to care for him and had another nurse provide him his medications. He stated it caused him emotional anguish and (he) doesn't feel safe with her as the supervisor over his care. Executive Director (Administrator) received a report at this time and investigation was initiated immediately. Review of the investigation related to the alleged potential verbal/emotional abuse revealed a thorough investigation. The Investigation Conclusion revealed . the facility has determined the complaint is substantiated. The alleged RN (RN3) has been terminated. During an interview with R2 on 03/12/25 at 2:10 PM, R2 confirmed the above incident of alleged abuse, stated he reported the abuse to the Administrator via email (as per his usual method of communication with the Administrator), and confirmed he felt emotional anguish and unsafe when the event occurred. R2 stated the allegation had been resolved to his satisfaction and he currently felt safe in the facility. 2. Review of R7's Admission Record, dated 03/13/25 and found in the EMR under the Profile tab, revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included type 2 diabetes and chronic obstructive pulmonary disease (COPD). Review of R7's quarterly MDS, with an ARD of 02/14/25 and found in the EMR under the MDS tab, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Misconduct Incident Report and Facility Investigation, dated 02/23/25, related to an allegation of staff to resident physical abuse perpetrated upon R7 by a staff member (Certified Nursing Assistant (CNA1), revealed, Staff member reported to Supervisor that she witnessed another CNA [CNA1] swat a resident on the hand when resident accidentally grabbed her arm and nails went into staff when repositioning resident. In addition, she stated that she heard alleged CNA using vulgar language with the resident while they were assisting to change her [R7]. Review of the investigation related to the alleged physical abuse revealed a thorough investigation. The Investigation Conclusion revealed: Due to physical contact [by CNA1] with resident we are substantiating physical abuse. The document indicated verbal abuse was not able to be substantiated for this incident. R7 was not able to be interviewed since she had been discharged from the facility. During an interview with the Administrator and Director of Nursing (DON) on 03/12/25 at 4:06 PM, the Administrator confirmed abuse had been substantiated for both R2 and R7 and that employees involved in both incidents were terminated. The Administrator and DON stated their expectation was residents would not be abused.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947 Based on review of facility policy, record review, and interviews, the facility failed to ensure timely reporting of potential abuse for one out of 17 residents (Resident (R) R7) reviewed for abuse out of a total sample of 17. This failure created the potential for this and other residents to experience further abuse. Findings include: The facility's undated Freedom from Abuse and Neglect Policy read, in pertinent part, Staff will immediately report any suspicious event or injury that may constitute abuse, neglect, exploitation or misappropriation to the Executive Director (Administrator.) Review of R7's Admission Record, dated 03/13/25 and found in the EMR under the Profile tab, revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included type 2 diabetes and chronic obstructive pulmonary disease (COPD). Review of R7's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/14/25 and found in the EMR under the MDS tab, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. Review of the Misconduct Incident Report and Facility Investigation, dated 02/23/25, related to an allegation of staff to resident physical abuse perpetrated upon R7 by a staff member (Certified Nursing Assistant (CNA1revealed, Staff member reported to Supervisor that she witnessed another CNA [CNA1] swat a resident on the hand when resident accidently grabbed her arm and nails went into staff when repositioning resident. In addition, she stated that she heard alleged CNA using vulgar language with the resident while they were assisting to change her [R7]. Review of the investigation related to the alleged abuse revealed the incident occurred on 02/23/25 at 5:30 AM; however, the potential abuse was not reported to facility administration until 02/23/25 at 7:30 PM, 14 hours after the incident occurred. During an interview with Registered Nurse Manager (RN4) on 03/13/25 at 3:39 PM, she stated the incident of potential physical abuse by CNA1 to R7 was reported to her by CNA 8 on the evening of 02/23/25 when CNA8 arrived for her night shift duties. RN4 confirmed she was the acting manager on that date and time and stated CNA4 reported the incident to her when CNA4 arrived at work and saw that CNA1 was on the schedule for that night. CNA8 reported another RN Manager (RN5) had actually been present in R7's room when the alleged abuse took place, so CNA8 thought RN5 had reported the abuse since he was in charge on that shift. RN4 indicated she had received any information about the alleged incident when she began her shift that day, and she called the Administrator right away to report the incident and was told at that time the incident had never been reported to administration. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Administrator and Director of Nursing (DON) on 03/12/25 at 4:06 PM, the Administrator confirmed she did not receive a report of the alleged abuse until RN4 reported it to her on the evening of 02/23/25. The Administrator stated the alleged abuse was then immediately reported to the State Agency (SA) and local Law Enforcement. The Administrator confirmed the allegation of abuse against R7 was not reported timely to administration by staff. She stated RN5 and CNA1 had been terminated related to the incident and stated her expectation was that any suspected abuse was to be reported to administration immediately and alleged abuse was to be reported to the SA and Local Law Enforcement within two hours of the alleged occurrence.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947 Based on review of facility policy, record review, and interviews, the facility failed to ensure one out of 17 residents (Resident (R) R2 reviewed in the sample received his medication routinely as ordered by his physician. This failure caused multiple medication errors during the resident's medication administration, which created the potential for this resident to experience significant negative physical effects related to the errors. Findings include: The facility's Medication Administration - General Guidelines Policy, dated 12/2019, read, in pertinent part, FIVE Rights - Right resident, right drug, right dose, right route and right time, are applied for each medication being administered. Review of R2's Admission Record, dated 03/13/25 and found in the electronic medical record (EMR) under the Profile tab, revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included quadriplegia and orthostatic hypotension. Review of R2's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/10/25 and found in the EMR under the MDS tab, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. Review of R2's physician's orders, dated 09/08/24 and found in the EMR under the Orders Tab, revealed an order for the resident to receive Midodrine (an anti-hypotensive medication) 10 milligrams (MG) by mouth three times daily for hypotension (low blood pressure). The order indicated the midodrine was to be held (not given) if the resident's systolic blood pressure was above 110. Review of R2's Medication Administration Recor (MAR), dated 02/01/25 through 03/13/25 revealed the resident's Midodrine was administered on the following dates even though the resident's systolic blood pressure was above 110: On 02/02/24 at 7:00 AM, the medication was given even though R2's BP reading was 125/80; On 02/02/25 at 5:00 PM, the medication was given even though R2's BP reading was 125/80; On 02/14/25 at 12:00 PM, the medication was given even though R2's BP reading was 123/87; On 02/20/25 at 12:00 PM, the medication was given even though R2's BP reading was 152/76; and On 03/01/25 at 7:00 AM, the medication was given even though R2's BP reading was 151/89. During an interview with R2 on 03/12/25 at 2:10 PM, he confirmed his Midodrine had been administered to him even when his blood pressure was above the ordered parameter to receive the medication. He stated he could not remember specific dates but stated he was concerned that the errors could have a negative effect on his health by causing his blood pressure to get too high. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on 03/13/25 at 11:21 AM, she confirmed the above indicated medication errors had been made and stated her expectation was medication would be administered to all residents as ordered.