STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525414	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mercy Health Services	2727 W Mitchell St Milwaukee, WI 53215

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 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. (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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(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	Based on facility policy review, record review, facility document review, and interview, the facility failed to protect the resident's right to be free from verbal and mental abuse by staff, which affected 1 (R1) of 3 residents reviewed for abuse. Specifically, Certified Nursing Assistant (CNA) C yelled at and threatened R1. Findings include:A facility policy titled, Abuse, Neglect and Exploitation, revised 07/15/2022, indicated, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. The policy revealed, Definitions included 'Mental Abuse' includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation. The policy revealed, 1. The facility will develop and implement that, which included a. Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property.An admission Record revealed the facility admitted R1 on 06/27/2018 and readmitted the resident on 08/04/2025. According to the admission Record, the resident had a medical history that included diagnoses of unspecified dementia, unspecified severity, with other behavioral disturbance; cognitive communication deficit; and generalized anxiety disorder.A skilled nursing facility (SNF) Part A discharge Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/06/2025, revealed R1 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. R1's Care Plan Report included a focus area initiated 12/27/2024, that indicated the resident had verbal/physical agitation/aggression that included throwing items, yelling at staff, cussing, hoarding items, rejection of care at times related to dementia, and social determinants. Interventions directed staff to allow the resident time to respond to directions or requests (initiated 12/27/2024); approach and allow the resident time to make their own decisions, reapproach if necessary, if the resident was noncompliant with cares/treatments (initiated 02/24/2025); and use de-escalation techniques with the resident when the resident expresses verbal and physical aggression (initiated 08/18/2025).An Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report, submitted to the state survey agency on 09/04/2025 at 10:39 PM, indicated the facility reported an allegation of abuse that occurred on 09/04/2025 at 4:30 PM. The Brief Summary of Incident revealed that at approximately 4:30 PM, R1 arrived at the nurses' station to grab a snack and was grabbing at all the snacks. Per the report, CNA C attempted to explain to R1 that she needed to assist the resident by handing the resident a snack of the resident's choice. The report indicated that CNA C proceeded to offer a snack, then set the snack tray on the other side of nurses' station. The report indicated that R1 abruptly became agitated and began to yell derogatory remarks at CNA C while throwing a sandwich. The report indicated that R1 grabbed at CNA C. The report indicated that CNA C reacted with threatening statements and was observed showing her fist at R1. Per the report, CNA C walked away from nurses' station and was then directed to leave facility, pending investigation. The report indicated that law enforcement and a case manager were notified. The report was completed by the Executive Director.A Misconduct Incident Report, dated 09/11/2025 and completed by the Executive Director, indicated that on 09/04/2025, R1 had a verbal interaction with CNA C. The report indicated that R1 became agitated and verballed aggressive toward CNA C, including threatening the CNA, and threw a sandwich at her. Per the report, CNA C reacted with a closed fist and verbally threatened [R1].During an interview on 10/13/2025 at 12:49 PM, with the assistance of a translator, R1 stated that a staff member appeared to want to hurt them (R1) when the staff member raised her arm to attempt to hit the resident. The resident stated that the staff member said something in English at the time, but they did not understand because that was not the resident's native language.During an interview on 10/13/2025 at 2:11 PM, Licensed Practical Nurse (LPN) D stated that on 09/04/2025, she heard R1 yell at CNA C and witnessed CNA C raise her fist, pointed upward in the air, and stated she was going to [expletive] [the resident] up. She stated CNA C was taken away from the incident by CNA E. She stated that she proceeded to call the Executive Director and then the Director of Nursing (DON) while she walked outside to tell CNA C to write a statement and to tell her that she was suspended, pending investigation. LPN D stated that making threats was considered abuse.During an interview on 10/13/2025 at 2:47 PM, CNA E stated that he walked up on an incident between CNA C and R1. He stated that he heard CNA C cursing at R1. He stated that he grabbed CNA C's arm and told her to go with him, and they walked away from R1. CNA E stated that he considered it abuse and intimidation because of the choice words CNA C used and her yelling at R1.During an interview on 10/14/2025 at 2:45 PM, the DON stated that it was reported to her that

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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. (continued on next page)

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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	Based on facility policy review, record review, facility document review, and interview, the facility failed to ensure allegations of abuse were reported timely, which affected 1 (R1) of 3 residents reviewed for abuse. Specifically, the facility failed to report an incident of verbal and mental abuse to the state survey agency withing two hours when Certified Nursing Assistant (CNA) C yelled at and threatened R1.Findings included:A facility policy titled, Abuse, Neglect and Exploitation, revised 07/15/2022, indicated, VII. Reporting/Response included, A. The facility will have written procedures that include, which included 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all required agencies (e.g. [exempli gratia; for example], law enforcement when applicable) within specified timeframes, which revealed, a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury.An admission Record revealed the facility admitted R1 on 06/27/2018 and readmitted the resident on 08/04/2025. According to the admission Record, the resident had a medical history that included diagnoses of unspecified dementia, unspecified severity, with other behavioral disturbance; cognitive communication deficit; and generalized anxiety disorder. A skilled nursing facility (SNF) Part A discharge Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/06/2025, revealed R1 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. R1's Care Plan Report included a focus area initiated 12/27/2024, that indicated the resident had verbal/physical agitation/aggression that included throwing items, yelling at staff, cussing, hoarding items, rejection of care at times related to dementia, and social determinants. Interventions directed staff to allow the resident time to respond to directions or requests (initiated 12/27/2024); approach and allow the resident time to make their own decisions, reapproach if necessary, if the resident was noncompliant with cares/treatments (initiated 02/24/2025); and use de-escalation techniques with the resident when the resident expresses verbal and physical aggression (initiated 08/18/2025). An Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report indicated that the facility reported an allegation of abuse that occurred on 09/04/2025 at 4:30 PM. The Brief Summary of Incident revealed that at approximately 4:30 PM, R1 arrived at the nurses' station to grab a snack and was grabbing at all the snacks. Per the report, CNA C attempted to explain to R1 that she needed to assist the resident by handing the resident a snack of the resident's choice. The report indicated that CNA C proceeded to offer a snack, then set the snack tray on the other side of nurses' station. The report indicated that R1 abruptly became agitated and began to yell derogatory remarks at CNA C while throwing a sandwich. The report indicated that R1 grabbed at CNA C. The report indicated that CNA C reacted with threatening statements and was observed showing her fist at R1. Per the report, CNA C walked away from nurses' station and was then directed to leave facility, pending investigation. The report indicated that law enforcement and a case manager were notified. The report was completed by the Executive Director and indicated that it was submitted to the state survey agency on 09/04/2025 at 10:39 PM.R1's Progress Note dated 09/05/2025 at 12:40 AM, documented by Licensed Practical Nurse (LPN) D, revealed R1 was involved in an incident with a staff member on 09/04/2025 at approximately 4:10 PM. The note indicated that the Executive Director was notified at 4:13 PM, and the Director of Nursing (DON) was notified at 4:16 PM. During an interview on 10/13/2025 at 2:11 PM, LPN D stated that on 09/04/2025, she heard R1 yell at CNA C and witnessed CNA C raise her fist, pointed upward in the air, and stated she was going to [expletive] [the resident] up. She stated CNA C was taken away from the incident by CNA E. She stated that she proceeded to call the Executive Director and then the DON while she walked outside to tell CNA C to write a statement and to tell her that she was suspended, pending investigation. LPN D stated that making threats was considered abuse. During an interview on 10/14/2025 at 2:45 PM, the DON stated that it was reported to her that CNA C told R1 I'm gonna [expletive] you up with a raised arm. The DON stated that the CNA's actions were a form of abuse and intimidation. The DON stated her expectation for the prevention of abuse included reporting anything suspicious or complicated that they might question.During an interview on 10/14/2025 at 11:21 AM, the Executive Director stated that on 09/04/2025, the two-hour time reporting timeframe for abuse to the state survey agency was not followed per the facility policy.During an interview on 10/14/2025 at 3:59 PM, the Executive Director stated that he expected reporting abuse allegations to the state survey agency to meet regulatory guidelines. He stated that anything that was abuse, or serious bodily injury was to be reported within two hours of the incident being reported to staff.