STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525417	A. Building B. Wing	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milwaukee Health and Rehab	3216 W Highland Blvd Milwaukee, WI 53208

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 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)

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility did not ensure allegations of verbal abuse were immediately reported to the Administrator. This was observed with 1 (R1) of 1 resident reviewed for allegations of verbal abuse.On 6/29/2025 staff and R1 heard Registered Nurse (RN)-D call R1 a dizzy bitch around 9:30pm. The verbal abuse was observed by other staff but not reported to Nursing Home Administrator (NHA)-A until the following morning on 6/30/2025. RN-D continued to finish RN-D's shift which ended at 11:00pm. Findings include:The facility policy titled ABUSE POLICY no initiation or revision date documents: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This facility therefore prohibits abuse, neglect, exploitation misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property and mistreatment of residents. IV. Internal Reporting Requirements and Identification of Allegations. Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately, to an immediate supervisor who must then immediately report it to the administrator or to a compliance hotline or compliance officer. Upon learning of the report, the administrator or a designee shall initiate an incident investigation. Any allegation of abuse or any incident that results in serious bodily injury will be reported to the required regulatory agencies immediately, but not more than two hours of the allegation of abuse. Any incident that does not involve abuse and does not result in serious bodily injury shall be reported within 24 hours. V. Protection of Residents . Employees of this facility who have been accused of abuse, neglect, exploitation, mistreatment or misappropriation of resident property will be removed from resident contact immediately. The employee shall not be permitted to return to work until the results of the investigation have been reviewed by the administrator and it is determined that any allegation of abuse, neglect, exploitation mistreatment or misappropriation of resident property is unsubstantiated.R1 was admitted to the facility on [DATE] and has diagnoses that include anxiety disorder, and paraplegia. R1's admission minimum data set (MDS) dated [DATE] indicates R1 had moderately impaired cognition with a Brief Interview for Mental Status (BIMS) score of 11 and the facility assessed R1 to require total assist with 2 staff members for dressing, transferring, and repositioning. R1's MDS documents at the time of assessment R1 did not have mood or behavior symptoms. R1 has a urostomy and is always incontinent of bowel. R1 was their own person and did not have an activated power of attorney (POA). Surveyor reviewed the facility self-report that was initially submitted to the State Agency on 6/30/2025, at 9:57 AM. A brief summary of incident documents R1 reported yesterday evening (6/29/25) RN-D called R1 a bitch at the nurse's station. RN-D is not on duty at the time of report. Facility initiated an investigation. R1 states feels safe in building. The final submission of the facility self-report was submitted to the State Agency on 7/3/2025, at 7:10 PM, which documents on 6/29/2025, at 9:30 PM, RN-D was overheard saying loudly enough for R1 to hear (R1's name) is such a dizzy bitch. The staff members present heard RN-D make this statement and R1 acknowledged hearing RN-D.Surveyor notes the shift ends at 11:00 PM. Staff members were aware of the verbal abuse by RN-D towards R1 but did not report the allegation immediately to NHA-A. RN-D remained in the facility until 11:00 PM, allowing RN-D to have contact with R1 and other residents in the facility. RN-D was not immediately removed from the resident care areas pending further investigation of the situation.On 7/10/2025, at 10:00 AM, Surveyor interviewed licensed practical nurse (LPN)-C who stated LPN-C was sitting next to RN-D at the nurse's station on 6/29/2025 and heard RN-D call R1 a name when R1 came off the elevator. Surveyor asked why they thought RN-D called R1 a name. LPN-C stated they just think RN-D had had it with R1 being rude to the staff that day. Surveyor asked if R1 was RN-D's patient on 6/29/2025. LPN-C stated R1 was LPN-C's patient that day. Surveyor asked if LPN-C reported RN-D calling R1 a name. LPN-C stated LPN-C did not tell anyone and stated LPN-C is aware that it should have been reported right away. LPN-C stated someone reported it because LPN-C was questioned the next day, and a statement was taken. Surveyor asked if RN-D continued to work the rest of the shift the night of 6/29/25. LPN-C stated LPN-C and RN-D both finished their shifts around 11:00 PM on 6/29/2025. On 7/10/2025, at 11:15 AM, Surveyor interviewed NHA-A who stated NHA-A found out about the verbal abuse towards R1

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure the safety and supervision of 1 (R1) of 1 resident reviewed for supervision and accidents. On 6/28/2025 while sitting outside R1 asked another resident to push them to the store. The other resident began to push R1's wheelchair to the store. The facility did not re access R1 for elopement risk, ability to leave the facility unsupervised, or initiate a care plan to prevent future incidents from happening. Findings include:The facility policy titled Elopements and Wandering Residents reviewed/revised 5/8/2025 documents: This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. Policy Explanation and Compliance Guidelines: . 3. The facility shall establish and utilize a systemic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. 4. Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering. a. Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team (IDT). b. IDT will evaluate the unique factors contributing to risk in order to develop a person-centered care plan. R1 was admitted to the facility on [DATE] and has diagnoses that include type 2 diabetes with foot ulcer, peripheral vascular disease, anxiety disorder, and paraplegia. R1's admission minimum data set (MDS) dated [DATE] indicated R1 had moderately impaired cognition with a Brief Interview for Mental Status (BIMS) score of 11 and the facility assessed R1 needing total assist with 2 staff members for dressing, transferring, and repositioning. R1's MDS documents at time of assessment that R1 did not have mood or behavior symptoms. R1's admission elopement risk assessment dated [DATE] indicated R1 was not at risk for elopement. R1 was their own person and did not have an activated power of attorney (POA). On 6/28/2025, at 2302 (11:01 PM) in the progress notes nursing documented (R1) was outside today and asked another resident to push (R1) to the store. Facility staff were able to catch up to R1 and the other resident and bring back to the facility.Surveyor reviewed R1's medical record and noted that there was not an elopement assessment done on R1 to indicate if R1 was an elopement risk after R1 was brought back to the facility.Surveyor reviewed R1's comprehensive care plan and noted there was not a care plan initiated to indicate a risk/concern R1 would ask another resident to assist R1 away from the facility or interventions in place to prevent further incidences from re-occurring.On 7/10/2025, at 2:20 PM, Surveyor shared concern with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B that R1 was not reassessed for elopement risk after R1 left the facility without staff knowledge on 6/28/2025 and that there was not a care plan initiated to indicate R1's risk/potential to ask peers for assistance with leaving the facility without staff knowledge. DON-B stated that R1 is R1's own person and that R1 is not an elopement risk and that R1 can leave the facility. NHA-A stated staff interfered because they thought R1 was going to get alcohol. Surveyor shared concern there are no interventions or concerns in R1's care plan related to alcohol seeking behaviors. Surveyor asked if R1 signed out from the facility on 6/28/2025 when R1 left the facility. DON-B stated R1 had not signed out and would agree maybe a community safety/awareness assessment should have been completed but did not think an elopement assessment should have been completed. Surveyor shared that a concern remained as R1's ability to leave the facility unknown and unassisted by staff was not assessed by the facility and a care plan was not initiated with interventions so staff are made aware and can act if R1 leaves the facility again without signing out.