STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525504	A. Building B. Wing	12/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Greenfield	5790 S 27th St Milwaukee, WI 53221

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 - Immediate jeopardy to resident health or safety 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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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and policy review, the facility failed to ensure residents were free from sexual abuse for 1 resident (R) of 3 residents reviewed for abuse (R2), R1 had a previous documented incident of trying to kiss another resident and there was a reported incident of R1 attempting to fondle the breasts of R2, a cognitively impaired resident. The facility failed to implement effective preventive measures after these incidents. R1 was later found by staff with his hand down R2's pants. Following this incident, not all caregivers were aware of the need to monitor the whereabouts of R1 or to keep R1 and R2 separated.The facility's failure to keep R2 free from sexual abuse created a finding of immediate jeopardy that began on 11/20/25. The Administrator, Director of Nursing (DON), and the Assistant Director of Nursing (ADON) were informed on the immediate jeopardy on 12/11/25 at 11:50 AM. The immediate jeopardy was removed on 12/13/25, however, the deficient practice continues at a scope/severity level of D (potential for more than minimal harm/isolated) as the facility continues to implement its action plan. Findings include:Review of the facility's policy Abuse, Neglect and Exploitation, dated 03/25/25, indicated, .An immediate investigation is warranted when suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect or exploitation occur . The facility will make efforts to ensure all residents are protected from physical and psychosocial harm as well as additional abuse. Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator. Revision of the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs change as a result of an incident of abuse.1. Review of R1's undated Face Sheet located under the Profile tab in the electronic medical record (EMR) indicated R1 was originally admitted to the facility on [DATE] with diagnoses of metabolic encephalopathy and dementia.Review of R1's Psych Progress Note, dated 06/18/25, indicated, Chief Complaint: Staff requested follow up psych visit for inappropriately attempting to kiss another resident. Plan Staff educated to redirect patient to keep him away from other vulnerable patients.Review of R1's quarterly Minimum Data Set (MDS), located under the MDS tab in the EMR, with an Assessment Reference Date (ARD) of 09/19/25, indicated R1 had a Brief Interview for Mental Status (BIMS) score of eight out of 15 which indicated R1 was moderately cognitively impaired. There was no documentation that R1 exhibited any behaviors during the seven day look back period. R1 self-propelled in a high back wheelchair.Review of R1's Care Plan, located under the Care Plan tab in the EMR, indicated R1 had not been care planned for behaviors until 11/20/25 when a Focus was initiated, [R1] requires frequent checks r/t [related to] physical inappropriateness with other resident. Interventions included: Encourage use of prescribed devices. Perform safety risk evaluation[s] on admission, as needed and upon changes in condition. Safety measures - including strategies to reduce the risk of infection, falls, injury initiated as appropriate. Place in common area visible to staff. Frequent check of [R1's] whereabouts. Keep [R1] separated from other female residents .2. Review of R2's undated Face Sheet located under the Profile tab in the EMR indicated R2 was admitted to the facility on [DATE] with diagnoses of [NAME]-[NAME] Syndrome, epilepsy, and developmental disorder.Review of R2's quarterly MDS, located under the MDS tab in the EMR with an ARD of 09/13/25, indicated R2 was severely cognitively impaired. R2 was dependent on staff for wheelchair mobility.Review of R2's Care Plan located under the Care Plan tab in the EMR indicated a Focus dated 09/21/22 for behavior problem r/t [related to] calling out/yelling out/screaming out/crying both during cares and at other times Interventions were to: Approach within view smiling and say 'Hello [R2]' to set positive tone of interaction. Caregivers to provide opportunity for positive interaction attention, stop and talk with her as passing by. If not calm during cares, withdraw and approach later. Review of R2's Care Plan did not indicate the care plan had been developed or revised after an incident with R1 on 11/20/25.R1 and R2 resided on the same hall of the facility in November 2025.Review of the facility's investigation revealed that on 11/20/25 at 12:30 PM in the East Lounge, R1 was witnessed with his hand down R2's pants. Certified Nursing Assistant (CNA) 1 immediately stopped the interaction and asked R2 what he was doing. CNA1 stated R1 said to R2, I told you we can't do this. CNA1 separated the residents. R1 was taken to his room. R2 remained in the East Lounge. The Administrator was notified, and R1 and R2 were assessed by the ADON. R2 was sent to the emergency room (ER) for a Sexual Assault Nursing Examiner (SANE) exam, a specialized medical exam for sexual assault survivors, with no injury or trauma noted. On 11/21/25, a nurse practitioner ordered sertraline (an antidepressant medication) 25 milligrams (mg) once a day for R1.During an interview on 12/09/25 at 12:07 PM, Certified Medication Aide (CMA) 1 was asked if R1 had inappropriate

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and policy review, the facility failed to report allegations of abuse to the state agency for two of four residents (Resident (R) 1 and R2) reviewed for allegations of abuse out of 17 sampled residents. As a result of this deficient practice, the facility failed to investigate these incidents and implement interventions to prevent further occurrence, and R1 continued to touch R2 inappropriately. Cross Reference: F600 Freedom from Abuse. Findings include:1. Review of R1's undated Face Sheet located under the Profile tab in the electronic medical record (EMR) indicated R1 was originally admitted to the facility on [DATE] with diagnoses of dementia and metabolic encephalopathy.Review of R1's Psych Progress Note, dated 06/18/25, indicated, Chief Complaint: Staff requested follow up psych visit for inappropriately attempting to kiss another resident . Plan . Staff educated to redirect patient . to keep him . away from other vulnerable patients . Review of R1's quarterly Minimum Data Set (MDS), located under the MDS tab in the EMR with an Assessment Reference Date (ARD) of 09/19/25, indicated R1 had a Brief Interview for Mental Status (BIMS) score of eight out of 15, which indicated R1 was moderately cognitively impaired. There was no documentation that R1 exhibited any behaviors in the seven day look back period. R1 propelled independently in a wheelchair.Review of R1's Care Plan located under the Care Plan tab in the EMR indicated there was no care plan for sexual inappropriateness prior to 11/20/25.2. Review of R2's undated Face Sheet located under the Profile tab in the EMR indicated R2 was admitted to the facility on [DATE] with diagnoses of [NAME]-[NAME] syndrome, epilepsy, and developmental disorder.Review of R2's quarterly MDS, located under the MDS tab in the EMR with an ARD of 09/13/25, indicated R2 was coded as severely cognitively impaired.Review of R2's Care Plan, located under the Care Plan tab in the EMR and dated 02/14/17, indicated R2 had behaviors of screaming and swinging her arms if she did not want to do something or was upset or afraid. R2 was dependent on staff for wheelchair mobility.During an interview on 12/09/25 at 1:30 PM, Unit Manager (UM) 1 stated, A couple of months ago, I was told by another resident's family member that R1 and R2 should not be in the same area. The person told me that R1 likes to put his hands up R2's shirt and fondle her breasts . UM1 stated she did not report the allegation. During interviews on 12/09/25 at 12:07 PM and 12/10/25 at 11:00 AM, Certified Medication Aide (CMA) 1 stated, I was told by another resident's family member that R1 was holding R2's hand and would touch her breasts while they were in the east lounge area. CMA1 stated she had reported this to the social worker. During an interview on 12/10/25 at 11:08 AM, the Social Services Director (SSD) reported she had no knowledge of the family member's report or the incident the 06/18/25 Psych Progress Note referred to.During an interview on 12/10/25 at 11:26 AM, the Director of Nursing (DON) reported she had no knowledge of the family member's report or the incident the 06/18/25 Psych Progress Note referred to.During an interview on 12/10/25 at 11:28 AM, the Assistant Director of Nursing (ADON) reported he had no knowledge of the family member's report or the incident the 06/18/25 Psych Progress Note referred to.During an interview on 12/10/25 at 11:32 AM, the Administrator stated, If these had been reported to me, then I would have reported these to the State and done an investigation.Review of the facility's policy titled Abuse, Neglect and Exploitation, dated 03/25/25, revealed, . Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies [e.g., law enforcement when applicable] within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, interviews, and policy review, the facility failed to maintain the cleanliness of a nebulizer mask for one of one resident (Resident (R) 7) reviewed for nebulizer use out of 17 sampled residents. This deficient practice increased the risk of infection for residents requiring nebulizer therapy. Findings include:Review of R7's undated Face Sheet located under the Profile tab in the electronic medical record (EMR) indicated R7 was originally admitted to the facility on [DATE] with a diagnosis of chronic obstructive pulmonary disease.Review of R7's Physician Orders located under the Orders tab in the EMR indicated an order dated 09/10/24 for Budesonide Inhalation Suspension [an inhaled steroid] 0.5 mg [milligram]/ 2 ml [milliliter] inhalation . 2 ml inhale orally two times a day for SOB [shortness of breath] related to chronic obstructive pulmonary disease.Review of R7's annual Minimum Data Set (MDS) located under the MDS tab in the EMR with an Assessment Reference Date (ARD) of 10/27/25 indicated R7 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated R7 was cognitively intact. Review of R7's Care Plan located under the Care Plan tab in the EMR indicated R7 had a Focus, dated 01/10/22, [R7] has COPD [chronic obstructive pulmonary disease]/asthma/sleep apnea. Interventions included, . Give aerosol or bronchodilators as ordered . Observations conducted on 12/08/25 at 2:29 PM and on 12/12/25 at 9:00 AM revealed R7's nebulizer mask was sitting out on the bedside table, uncovered, and not in use. During an interview on 12/12/25 at 9:00 AM, Licensed Practical Nurse (LPN) 2 confirmed the nebulizer was on the bedside table and stated, The mask [nebulizer] should be in a plastic bag when not in use.During an interview on 12/13/25 at 1:00 PM, the Director of Nursing (DON) stated, The nebulizer mask is to be stored in a plastic bag when not in use.Review of the facility's policy Oxygen Administration, dated 02/01/25, indicated, . Keep delivery devices covered in plastic bag when not in use .

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and policy review, the facility failed to provide a fish-free meal to one resident (Resident (R) 13) with a documented fish allergy out of three residents reviewed for food allergies from a sample of 17 residents. This failure had the potential for R13 to experience a severe anaphylactic reaction. Findings include:Review of R13's undated Face Sheet located under the Profile tab in the electronic medical record (EMR) indicated R13 was admitted to the facility on [DATE] with diagnoses of osteoarthritis and diabetes mellitus. R13's Face Sheet also included documentation of R13 having an allergy to . Fish Allergy, fish products . Review of R13's admission Minimum Data Set (MDS) located under the MDS tab in the EMR with an Assessment Reference Date (ARD) of 10/09/25 indicated R13 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated R13 was cognitively intact.Review of R13's Nursing Progress Notes located under the Progress Note tab in the EMR indicated a note dated 11/11/25 at 3:34 AM, Called to room resident states they had served Fish [sic] with supper, she [R13] did not eat any but just having it in her room made her itch all over, wants benadryl [sic] 50mg [milligram] prn [as needed] and hydrocortisone ointment to be kept at bedside so she can apply as needed to arms/hands/face/back and thighs. [Name of on call company] contacted.Review of Physician Orders located under the Orders tab in the EMR indicated an order dated 11/11/25 for Benadryl 50 mg by mouth every eight hours as needed for allergic reaction/ itching for 10 days and hydrocortisone 1% (percent) apply a thin layer to the affected skin twice a day for 10 days. Review of R13's Medication Administration Record, dated November 2025, indicated R13 received Benadryl 50 mg for itching on 11/11/25 at 4:21 AM, 11/16/25 at 9:35 AM, and 11/18/25 at 1:30 AM. It was documented that R13 received relief from itching after the administration of Benadryl on those dates and times. It was also documented that R13 was administrated hydrocortisone ointment on 11/15/25 at 2:44 AM and 11/18/25 at 1:32 AM. It was documented that R13 received relief from the use of the hydrocortisone ointment.During an interview on 12/13/25 at 12:30 PM, R13 stated, I got fish one day on my tray. I am allergic to fish and didn't eat it. I told them [staff] to never bring me fish again. R13 confirmed that she did not eat the fish that was brought to her on her tray.During an interview on 12/13/25 at 3:21 PM, Dietary Manager (DM) 1 stated, The line aide that served the fish that day was talked to, and I let her go home early that day. I explained to staff to look at the food allergies and highlight these so everyone can see the allergies of the residents so the residents will not get the food by mistake like what happened in this case. DM1 confirmed Fish allergy was on R13's tray card.During an interview on 12/13/25 at 3:30 PM, the Administrator stated, I expect the dietary staff to pay attention to the food allergies of each resident and not give the residents what they are allergic to. Review of the facility's policy titled Menus and Adequate Nutrition, dated 02/16/25, indicated, . Resident preferences, including likes and dislikes will be documented in the resident's chart, and shall be reviewed . It did not reflect documentation of the residents' food allergies.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and policy review, the facility failed to maintain a complete and accurate medical record for one of 17 sampled residents (Resident (R) 5). This failure resulted in the medical record not accurately showing whether R5's medication was administered.Findings include:Review of R5's undated Face Sheet located under the Profile tab in the electronic medical record (EMR) indicated R5 was admitted to the facility on [DATE] with diagnoses of fracture of the left femur and malignant neoplasm of the prostate with secondary neoplasm of the bone.Review of R5's Physician Orders located under the Orders tab in the EMR indicated an order dated 10/30/25 for apalutamide (a hormone blocker used to treat prostate cancer) 240 milligrams by mouth one time a day.Review of R5's Medication Administration Record (MAR), dated November 2025 and located under the Orders tab in the EMR, revealed that on 11/08/25 at 12:00 PM, the nurse documented code 9, which indicated that additional details should be referenced in the Progress Notes. Review of R5's Nursing Progress Notes located under the Progress Note tab in the EMR revealed there was no documentation regarding the administration of the apalutamide on 11/08/25.During an interview on 12/12/25 at 1:12 PM, Licensed Practical Nurse (LPN) 4 stated, I remember that day because I couldn't find it [cancer medication], and his family member told me where it was in the med [medication] cart, and I was able to go back and give it to him [R5]. When asked if she documented it as being given, LPN4 stated, I don't remember if I went back and charted that or not. LPN4 stated she should have documented it as given in the nurses' notes with an explanation of what happened since she documented a 9 on the MAR. During an interview on 12/13/25 at 1:10 PM, the Director of Nursing stated, The nurse should have clicked the medication as given or went to the nurses' note and explained this.Review of the facility's policy titled, Person-Centered Medication Administration, dated 02/02/25, indicated, . will document administration or refusal of medications as per facility policy .