STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525523	A. Building B. Wing	10/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alexian Village of Milwaukee	9255 N 76th St Milwaukee, WI 53223

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47094 Based on interview and record review the facility did not report 3 (R5, R111, R45) of 5 allegation to the State Survey Agency, Nursing Home Administrator, or local law enforcement during the required timeframe. R5 had an allegation of abuse and it was not reported to the Nursing Home Administrator until two days later, the alleged employee continued to work at the facility during those two days, and law enforcement was not contacted about R5's potential abuse allegation. R111's family members had a physical altercation in front of R111 and other resident's in the facility main dining room during meal service. Local law enforcement was notified and removed 1 of the individuals involved. The Nursing Home Administrator was not notified about the altercation until two days later at which time it was reported to the State Agency. R45's allegation of abuse was not reported timely. Findings include: The facility policy entitled Abuse Prevention revised on 8/2024 documents . Reporting/Response: A. The community will immediately, but no later than 2 (two) hours after the allegation is made, if the events that cause the allegation involve abuse of [sic] result in serious bodily injury, or not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in mistreatment, including injuries of unknown source and misappropriation of property, to the administrator and/or designee, State agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified time frames. The facility policy entitled Abuse Investigation and Reporting revised on 11/2023 documents: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment, ., and/or injuries of unknown source (abuse) shall be promptly reported to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by community management. Conclusions of investigations will also be reported, as defined by the [Facility Name] Abuse Prevention policy. Reporting: (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported to the Administrator or designee and to the following other officials or agencies: 1. The State licensing/certification agency responsible for surveying/licensing the community. 2. Other officials in accordance with State Law, including the Adult Protective Services where state law provides for jurisdiction in long term care facilities. B. Alleged violations involving abuse, neglect, exploitation, or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported: 1. Abuse or serious bodily harm- Immediately but no later than 2 hours. *If the alleged violation involves abuse or results in serious bodily injury. 2. No serious bodily injury- As soon as practical, but no later than 24 hours*. If the alleged violation involves neglect, exploitation, mistreatment, or misappropriation of resident property; does not result in serious bodily injury. 1) R5 was admitted to the facility on [DATE] and has diagnoses that include Alzheimer's disease, vascular dementia without behaviors/psych/mood, hemiplegia following cerebral infarction affecting left nondominated side, type 2 diabetes with peripheral angioplasty/diabetic neuropathy/diabetic chronic kidney disease, peripheral vascular disease, major depressive disorder, weakness, heart failure, cognitive communication deficit, dysphagia, and contracture of the left wrist/hand/and muscle. R5's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated R5 had intact cognition with a Brief Interview for Mental Status (BIMS) score of 14 and the facility assessed R5 needing extensive assist with 2 staff assistance for toileting/personal hygiene, repositioning, and transferred using a Hoyer lift. R5 is always incontinent of bowel and bladder and wore adult briefs for protection. The facility assessed R5 to not have any behavior concerns. Surveyor reviewed the facility self- report for R5. The summary report for the allegation documents an allegation of possible retaliation to R5 on 7/8/2024, at approximately 8:00 PM when certified nursing assistant (CNA)-F came out of R5's room and stated R5 scratched her. Licensed Practical Nurse (LPN)-E documented R5's left side of her face appeared to be red and swollen upon assessment. On 7/10/2024, LPN-E notified the Social Services Director (SSD) of LPN-E's concern that CNA-F possibly retaliated on R5 for scratching CNA-F during cares. SSD reported the concern to the Nursing Home Administrator (previous NHA)-D. The initial report was submitted to the State survey agency on 7/10/2024, at 5:22 PM, 2 days after the accusation of CNA-F possibly retaliating against R5 on 7/8/2024. On 10/3/2024, at 12:12 PM, Surveyor interviewed LPN-E who stated LPN-E noted CNA-F coming out of R5's room and CNA-F stated R5 scratched CNA-F on the neck and CNA-F did not want to work with R5 anymore. LPN-E directed CNA-F to report it to the charge nurse on duty, Registered Nurse (RN)-G. LPN-E stated LPN-E went into R5's room and observed R5's face to be slightly red and appeared to be a little swollen. LPN-E stated LPN-E reported it to RN-G who stated R5's face is always like that. LPN-E stated when LPN-E returned back to work on 7/10/2024, LPN-E noted CNA-F was still working and went to SSD to report concern that R5 may have been retaliated on when R5 scratched CNA-F on the neck on 7/8/2024. Surveyor asked LPN-E if LPN-E reported the concern to anyone or notified police. LPN-E stated LPN-E thought RN-G was going to take care of it. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/3/2024, at 12:23 PM, Surveyor interviewed previous NHA-D who stated, it was reported that R5's face is slightly reddened and swollen due to R5's history of having a stroke. When NHA-D interviewed R5, R5 would not respond to NHA-D. NHA-D stated CNA-F documented R5 scratched her when providing cares for R5 and that CNA-F was reassigned to another unit. NHA-D stated R5 scratched CNA-F, so police did not need to be contacted. Surveyor shared the concern with NHA-D that there was an allegation of possible retaliation made against CNA-F to R5 and it was not reported to NHA-D, to the State Agency or law enforcement agency timely. No further information was provided to Surveyor at this time. 2) R111 was admitted to the facility on [DATE] and has diagnoses that include cerebral infarction, type 2 diabetes mellitus with chronic kidney disease, cognitive communication deficit, and mild cognitive impairment. R111's admission MDS (Minimum Data Set) assessment dated [DATE] indicates R111 has moderately impaired cognition with a BIMS (Brief Interview of Mental Status) score of 8. The facility assessed R111 to not have any behavior concerns. Surveyor reviewed the facility self-report for R111. The summary of the report documents that on 6/22/2024 approximately around 5:00 PM/dinner time in the main dining room R111's wife and daughter were involved in a verbal altercation that escalated to physical altercation of hair pulling and clenched fists striking each other. Facility staff broke up the altercation, police were contacted. Local law enforcement removed one of the visitors. R111 and other residents were witness to the incident. The altercation was not reported to NHA-D until 6/24/2024, 2 days after the altercation happened. NHA-D submitted the initial report on 6/24/2024, at 5:43 PM. Surveyor noted RN (Registered Nurse)-E reported the altercation to the clinical on call staff member-Director of Quality Management (DQM)-I who did not report it any further. On 10/3/2024, at 11:55 AM, Surveyor interviewed DQM-I who stated DQM-I did not think it needed to be reported to the State Agency because the altercation did not include any resident's and no residents were harmed in the altercation. On 10/3/2024, at 12:23 PM, Surveyor interviewed NHA-D who stated NHA-D was made aware of the situation in the morning stand up meeting a couple days after the altercation and started an investigation right away. No further information was provided at this time. 38146 2) R45 admitted to the facility on [DATE] to a room on the 3rd floor and has resided in the same room since admission. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/1/24, at 9:38 AM, R45 advised Surveyor that on 6/17/24 he reported to the facility that he was held down and changed against his will. R45 reported he had a leg cramp, so he slid his leg out of bed, and the right leg went with it, so he was half on/half off the bed with his feet on the floor and his butt on the bed. R45 put his call light on and when the nurse came in and saw his position, she left to get a Certified Nursing Assistant (CNA) to help. R45 reported they lifted his legs back in bed and the nurse said he needed to be changed. R45 reported he said no, adding he has an enlarged prostate and just dribbles urine, and because in a half hour he would let the next shift change him, as he was only damp and there was no need to be changed right now. R45 reported he explained all of this to the nurse, but she kept insisting. R45 could not recall the nurses name, except that she was from Nicaragua. R45 reported he kept saying no and that the nurse told the aide to hold him down. R45 stated: I was lying flat, and the aide was pressing down on each of my shoulders, holding me down. So now I'm fighting with her, trying to get up because she's holding me down and I'm saying no so many times. In the meantime, the nurse is changing me while the aid was holding me down. R45 reported he told the nurse that he wanted to talk to someone to report what happened. On 10/3/24, at 11:06 AM, Surveyor spoke with Previous NHA (Nursing Home Administrator)-D, NHA-A and Executive Director-C regarding the abuse allegation involving R45. Surveyor asked Previous NHA-D when the abuse allegation was reported to the State Agency. Previous NHA-D stated: I'm sure I reported it right away, I usually do. Executive Director-C looked at the computer and advised Surveyor it was reported on 6/19/24 and the 5 day was submitted on 6/25/24. Previous NHA-D stated: OK, so I reported it on the 19th. Surveyor advised Previous NHA-D of concern he was made aware of the abuse allegation on 6/17/24 and it was not reported until 2 days later on 6/19/24. Previous NHA-D stated: Well, I'm not sure that abuse even happened. If you're held down by your shoulders, you would have some evidence of it, some marks or something. Review of the Facility Self Report documented Previous NHA (Nursing Home Administrator)-D was notified of the allegation of abuse on 6/17/24. The abuse was not reported to the State Agency until 6/19/24. In addition, the CNA (Certified Nursing Assistant) statement documented R45 reported the abuse allegation to her on 6/15/24. The CNA did not report the allegation of abuse because he complains about everything. On 10/7/24, at 10:49 AM, Surveyor advised NHA-A of concerns regarding the Facility not reporting of R45's abuse allegation timely to the State Agency. NHA-A reported she was present when Surveyor was interviewing Previous NHA-D and understands. No additional information was provided.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47094 Based on interview and record review, the facility did not ensure all allegations involving potential abuse, neglect, and misappropriation of resident property were thoroughly investigated for 3 (R5, R111, R45) of 5 Facility self-reports reviewed. R5's allegation of abuse reported on 7/8/2024 was not thoroughly investigated and residents were not protected from potential abuse during the abuse investigation. R111's family's verbal and physical altercation which occurred in the main dining room during meal time was reported on 6/22/2024 and was not thoroughly investigated. R45's allegation of abuse reported on 6/17/2024 was not thoroughly investigated. Findings include: The facility policy entitled Abuse Prevention revised on 8/2024 documents: . The objective of the abuse policy is to comply with the seven-step approach to abuse and neglect detection and prevention. Injury of Unknown Source is defined as an injury that meets both of the following conditions: 1. The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident. 2. The injury is suspicious because of: a. the extent of the injury. b. the location of the injury. c. generally vulnerable or trauma. TRAINING: . 3. Reporting abuse, neglect, exploitation, and misappropriation of resident property, including injuries of unknown sources, and to whom and when associate and others must report their knowledge related to any alleged violation without fear of reprisal. IDENTIFICATION: . B. Associates or person affiliated with this community who has witnessed or who believes that a resident has been a victim of mistreatment, abuse, neglect, or any other criminal offense shall immediately report suspected abuse or incidents of abuse to the administrator or designee. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy entitled Abuse Investigation and Reporting revised on 11/2023 documents: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment, ., and/or injuries of unknown source (abuse) shall be promptly reported to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by community management. Conclusions of investigations will also be reported, as defined by the [Facility Name] Abuse Prevention policy. POLICY INTERPRETATION AND IMPLEMENTATION Role of the Administrator or designee: . D. The Administrator or designee will suspend immediately any employee who has been accused of resident abuse, pending the outcome of the investigation. Role of the Investigator: A. The individual conducting the investigation will, at a minimum: . 3. Interview the person(s)reporting the incident. 4. Interview any witnesses to the incident. 5. Interview the resident (if medically appropriate). 7. Interview associates members (on all shifts) who have had contact with the resident during the period of the alleged incident. 9. Interview other residents to whom the accused employee provides cares or services. 11. Review use of community camera/video footage of incident if available. 1) R5 was admitted to the facility on [DATE] and has diagnoses that include Alzheimer's disease, vascular dementia without behaviors/psych/mood, hemiplegia following cerebral infarction affecting left nondominated side, type 2 diabetes with peripheral angioplasty/diabetic neuropathy/diabetic chronic kidney disease, peripheral vascular disease, major depressive disorder, weakness, heart failure, cognitive communication deficit, dysphagia, and contracture of the left wrist/hand/and muscle. R5's quarterly Minimum Data Set (MDS) dated [DATE] indicated R5 had intact cognition with a Brief Interview for Mental Status (BIMS) score of 14 and the facility assessed R5 needing extensive assist with 2 staff assistance for toileting/personal hygiene, repositioning, and transferred using a Hoyer lift. R5 is always incontinent of bowel and bladder and wore adult briefs for protection. The facility assessed R5 to not have any behavior concerns. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed the facility self-report for R5. The summary report for the allegation documents an allegation of possible retaliation to R5 on 7/8/2024 at approximately 8:00 PM when Certified Nursing Assistant (CNA)-F came out of R5's room and stated R5 scratched her. Licensed Practical Nurse (LPN)-E documented R5's left side of her face appeared to be red and swollen upon assessment. On 7/10/2024, LPN-E notified the Social Services Director (SSD) of LPN-E's concern that CNA-F possibly retaliated against R5 for scratching CNA-F during cares. SSD reported the concern to the Nursing Home Administrator (previous NHA)-D. The initial report was submitted to the State survey agency on 7/10/2024 at 5:22 PM, 2 days after the alleged incident occurred. Surveyor noted CNA-F continued to care for other residents including R5, law enforcement was not notified regarding the allegation of possible retaliation against R5, CNA-F was not following the care plan for R5 and was assisting R5 alone versus 2 staff members per R5's care plan, and education was not provided to all staff member in the facility. On 10/1/2024, at 3:14 PM, Surveyor observed R5 sitting in a Broda wheelchair in the dining room alone. Surveyor asked R5 if R5 felt safe and if there were any concerns with staff. R5 replied R5 was doing well and liked all the staff and the facility. Surveyor asked R5 if R5 was scared of any staff or was injured by any staff. R5 replied they had no concerns and did not recall having been injured by any staff. On 10/3/2024, at 9:18 AM Surveyor interviewed CNA-F who stated CNA-F was assisting R5 alone and did not have another staff member in the room when providing care for R5. CNA-F stated the rest of the shift CNA-F has another staff member present with R5's when care is provided. Surveyor asked CNA-F if CNA-F received education related to the incident with R5. CNA-F stated CNA-F was talked to about following the resident care cards. On 10/3/2024, at 12:12 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-E who stated LPN-E reported concerns to the Social Services Director (SSD) on 7/10/2024 when LPN-E came into work next and found out CNA-F was still on the schedule to work. Surveyor asked LPN-E if LPN-E received education regarding reporting such concerns. LPN-E stated LPN-E received education on reporting abuse. On 10/3/2024, at 12:23 PM, Surveyor interviewed previous NHA- D who stated CNA-F was taken off the schedule on 7/10/2024 when NHA-D heard about the concern that occurred with R5 on 7/8/2024. Surveyor asked NHA-D if law enforcement was contacted. NHA-D stated law enforcement was not contacted because CNA-F stated CNA-F was fine. Surveyor asked if law enforcement was contacted for the concern of possible retaliation against R5. NHA-D stated when NHA-D went to talk with R5, R5 did not talk with NHA-D and CNA-F denied retaliation against R5 and CNA-F walked out of the room after R5 scratched CNA-F. NHA-D stated there was not a need for law enforcement. Surveyor asked NHA-D if education was provided to staff regarding reporting abuse. NHA-D stated education was given to LPN-E and Registered Nurse (RN)-G regarding reporting abuse. Surveyor asked NHA-D how other staff was educated about abuse prevention and reporting and how is NHA-D aware other staff know the policy/protocols for reporting abuse. NHA-D replied NHA-D often goes onto the units and talks with staff and DON-B does monthly education with staff but not sure what DON-B covers. Surveyor requested the last time staff was educated on reporting/preventing abuse and CNA-F punch card times for the weekend of 7/8/2024 - 7/10/2024. Surveyor received CNA-F's punch cards and noted CNA-F was listed as working in the facility on: 7/8/2024: 2:29PM - 10:30 PM, 10:30 PM - 6:30 AM into 7/9/2024 (CNA-F worked a double shift) (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/10/2024: 2:37 PM - 10:32 PM Surveyor noted CNA-F worked a full shift with residents on 7/10/2024 when NHA-D was aware of the allegation of possible retaliation against R5 and during the time the investigation was in progress. Surveyor was unable to interview NHA-D further due to NHA-D's term being up at the facility and leaving. On 10/3/2024, at 3:04 PM, Surveyor shared concerns with Assistant Director of Nursing (ADON)-M, Executive Director- C, and Nursing Home Administrator (NHA)-A regarding the Facility Reported Incident not being investigated thoroughly, CNA-F was allowed to continue to work with residents when an allegation was made for possible retaliation against R5, CNA-F was not following R5's care plan and assisted R5 with cares alone instead of 2 staff members, education was not provided to staff. No further information was provided at this time. 2) R111 was admitted to the facility on [DATE] and has diagnoses that include cerebral infarction, type 2 diabetes mellitus with chronic kidney disease, cognitive communication deficit, and mild cognitive impairment. R111's admission MDS (Minimum Data Set) assessment dated [DATE] indicates R111 has moderately impaired cognition with a BIMS (Brief Interview of Mental Status) score of 8. The facility assessed R111 to not have any behavior concerns. Surveyor reviewed the facility self-report for R111. The summary of the report documents on 6/22/2024 approximately around 6:00 PM/dinner time. R111's wife and daughter were involved in a verbal altercation that escalated to a physical altercation in the main dining room with residents present. Facility staff intervened, law enforcement was contacted and did escort 1 family member out of the building. Surveyor noted all staff with knowledge of the incident were not interviewed regarding the altercation between R111's family members. On 10/3/2024, at 12:23 PM, Surveyor interviewed previous NHA-D who stated the facility obtained a staff statement regarded the whole incident, so NHA-D did not feel the need to talk to other staff members regarding the situation. Surveyor asked NHA-D how other staff were provided educating about abuse prevention and how NHA-D aware other staff know the policy/protocols for reporting abuse. NHA-D replied NHA-D often goes onto the units and talks with staff and DON-B does monthly education with staff but not sure what DON-B covers. On 10/3/2024, at 3:04 PM, surveyor shared concerns with Assistant Director of Nursing (ADON)-M, Executive Director- C, and Nursing Home Administrator (NHA)-A regarding the facility reported incident not being investigated thoroughly, staff that observed or had knowledge of the altercation did not provide statements and education was not provided to staff to ensure they were aware of abuse reporting and need for a thorough investigation. 38146 2.) R45 admitted to the facility on [DATE] to room [ROOM NUMBER] on the 3rd floor and has resided in the same room since admission. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/1/24, at 9:38 AM, R45 advised Surveyor that on 6/17/24 he reported to the facility that he was held down and changed against his will. R45 reported he had a leg cramp, so he slid his leg out of bed, and the right leg went with it, so he was half on/half off the bed with his feet on the floor and his butt on the bed. R45 reported he put his call light on and when the nurse came in and saw his position, she left to get a Certified Nursing Assistant (CNA) to help. R45 reported they lifted his legs back in bed and the nurse said he needed to be changed. R45 reported he said no (adding he has an enlarged prostate and just dribbles urine) and he told her no because in a half hour he would let the next shift change him, as he was only damp and there was no need to be changed right now. R45 reported he explained all of this to the nurse, but she kept insisting he needed to be changed. R45 reported he could not recall the nurses name, except that she was from Nicaragua. R45 reported he kept saying no and the nurse told the aide to hold him down. R45 stated: I was lying flat, and the aide was pressing down on each of my shoulders, holding me down. So now I'm fighting with her, trying to get up because she's holding me down and I'm saying no so many times. In the meantime, the nurse is changing me while the aid was holding me down. R45 reported he told the nurse he wanted to talk to someone to report what happened. R45 reported the allegation of abuse to Previous NHA (Nursing Home Administrator)-D. R45 reported he has been using Oxycodone and Bengay for shoulder pain ever since and has been going to therapy. R45 reported the therapist thinks it is a torn rotator cuff and he has an ortho appointment on 10/4/24. On 10/2/24, at 10:25 AM, Surveyor spoke with RN (Registered Nurse)-G who reported she is familiar with R45 but doesn't work with him very often. Surveyor asked RN-G to tell me about R45. RN-G stated: He once said he wants me to go back to Nigeria. He has a hard time understanding some of us sometimes and gets angry, he reports everything he gets mad about, like he don't want to be changed, even when his brief is wet, he says it's his right to not be changed. Surveyor asked if she has ever had an altercation or incident with R45. RN-G stated: No, but I heard about one time a few months ago, he was falling out of bed, and they repositioned him and changed him and he was mad because he didn't want to be changed. So now we don't change him if he don't want to. Surveyor asked RN-G if she knew what staff were involved with the alleged incident. RN-G stated: No, not really. I just heard about it, you know, with people talking. On 10/2/24, at 3:42 PM, Surveyor spoke with OTA (Occupational Therapy Assistant)-R who reported she has been seeing R45 for right should pain since 8/20/24. Surveyor confirmed OT (Occupational Therapy) Plan of Care started care on 8/20/24. Surveyor asked if she had any knowledge regarding the origin of his shoulder pain. OTA-R stated: He told me he was pinned down while they were forcibly changing him and he was fighting back, that's how he injured his shoulder. Surveyor review of R45's medical record revealed no documentation of pain or increased pain to his shoulder prior to 8/13/24 when progress notes documented: Reporting right shoulder pain with movement. NP (Nurse Practitioner) notified. Order for 2 view shoulder x-rays ordered. On 8/14/24, a 2 view x-ray shoulder: The right shoulder is normal. There is no erosion or osteophyte formation. There is no dislocation. The mineralization is normal. There are no fractures. The clavicle is normal. Impression: Normal right shoulder. On 8/28/24 NP note documents: Reports worsening pain within right shoulder and decreased movement right arm. Denies numbness or tingling. Reports thinks [sic] his rotator cuff is bad. No reported injuries or overuse, just worsening achy pain. Reportedly leans on shoulder quite a bit in bed, as it is his favorite position. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525523	A. Building B. Wing	10/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alexian Village of Milwaukee	9255 N 76th St Milwaukee, WI 53223

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/4/24 Ortho consult: Right RC (rotator cuff) tear. Very high risk, no surgical option. Offered CSI (corticosteroid injection). Aggressive therapy right shoulder. Surveyor reviewed R45's facility abuse investigation. The manilla envelope included handwritten notes on each side by Previous Nursing Home Administrator (NHA)-D. The investigation documented: On 6/17/24, at approximately 11:17 AM, received an email from (Dir Quality Mgmt/IP) that (R45) wanted to speak with the Administrator. Arrived to room at approximately 11:25 AM. (R45) reported the other evening (believed that it was the prior Saturday) sometime before 10 PM (thought but was not sure) 2 CNA's proceed to change him without his permission. NHA asked Social Service Director to speak with (R45) as a second interview to see if the two interviews were consistent. Surveyor noted the facility abuse investigation included only 5 staff statements, one of which was the Social Worker (who did not provide care). Social Worker statement dated 6/17/24, at 4:03 PM: Stated he had an issue with a 3rd shift aid, female, short and big boned, could not recall name. On Saturday, June 15 early morning, he was in bed and caught a leg cramp and was half on the bed and half off the bed as a result. Stated he turned on call light, this female aide came and helped him back in bed but insisted on wanting to change him, stating he was wet. Resident told aid no I'm not wet and I don't need to be changed. Aid said, but I have to change you now. Aid left room and came back with another aid. Stated this aid was female, could not recall a description. Stated the aid and other aid held him down, where he was unable to move his shoulders and then they changed him anyway against his will. Stated he was calling them every bad name you could think of while they were changing him. He said to writer - this aid needs to go back to Nigeria, we don't need that import here. Pool CNA interview/statement (not dated): During the weekend of 6/14, 15 and 16th did you provide any care to resident? Stated she did not remember taking care of (R45) on those dates. She had not worked the A cluster on those dates or for many months. At this point the interview ended, it was obvious that this CNA did not know (R45) nor had she provided any care to him on the dates in question. RN-G interview/statement (not dated): During the weekend of 6/14, 15 and 16th did you provide any care to resident? Stated she did not provide any care to resident on these dates. Receive any complaint from resident on these dates? NO. Surveyor noted RN-G was not on the schedule for 6/15/24. Pool CNA interview/statement (not dated): During the weekend of 6/14, 15 and 16th did you provide any care to resident? Yes, on 6/15/24 worked the 3rd floor on noc (night) shift. Did not get to floor until about 11:15 PM. Shortly after, making rounds, went into residents' room. I recall that he was extremely wet, so I changed him and his bedding. While I was working with him, he mentioned that one of the other girls from the prior shift had come in several times to do a check and change. (R45) said she kept insisting that he need to be changed and he kept telling her no that he was not wet and that it could wait. He said that she is some girl from [NAME] and can't understand her half of the time. He said that eventually this aid came back with another aid and changed him without his permission. I asked if she reported this to anyone, she stated No, because he complains about everything. Surveyor noted the CNA statement alleges the incident occurred on the previous shift, however the facility did not interview all staff on the previous shift. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Pool CNA interview/statement (not dated): During the weekend of 6/14, 15 and 16th did you provide any care to resident? Stated she did not remember taking care of resident on those dates. NHA concluded as it was very apparent that this CNA did not know (R45). On 10/3/24, at 1:22 PM, Surveyor spoke with Scheduler-S and asked to explain the schedule and how units and resident rooms are assigned. Surveyor was advised the rooms are assigned as Clusters. Nurses for A/E rooms 50-57, B 60-68, C/D 70-87B CNAs: A/E 50-57, C/E 70-78, 90, 92 and 94, B/E 60-68, 93 and 95, D/E 80-87 and 91. Surveyor noted the schedule on 6/15/24 documented 8 staff assigned to the 3rd floor on first shift. The abuse investigation included only 1 staff statement from this shift and there were no statements from the staff specifically assigned to R45's room (cluster). Surveyor noted the schedule on 6/15/24 documented 9 staff assigned to the 3rd floor on second shift. The abuse investigation included only 2 staff statements from this shift and there were no statements from staff specifically assigned to R45's room (cluster). Surveyor noted the schedule on 6/15/24 documented 6 staff assigned to the 3rd floor on third shift. The abuse investigation included only 1 staff statement from this shift. The CNA assigned to R45's room provided a statement that indicated R45 reported the incident occurred the previous shift. Surveyor notes this was not reported, and no staff were interviewed. On 10/3/24, at 10:31 AM Surveyor spoke with Dir Quality Mgmt/IP-I about R45's allegation of abuse. Dir Quality Mgmt/IP reported R45 said that he had something serious to report to someone above him. He did not ask details because he didn't want R45 to have to explain it twice and because he said it was serious, he wanted the NHA to hear it first-hand. Dir Quality Mgmt/IP reported he immediately told the Previous NHA-D that R45 had something serious to report. On 10/3/24, at 11:06 AM, Surveyor spoke with Previous NHA-D, NHA-A and Executive Director-C regarding R45's abuse allegation. Previous NHA-D stated: Let me start by saying (R45) does complain and it often has nothing to do with cares or anything, he's just prejudiced against color. He wasn't able to provide a name and we weren't able to determine which staff he was referring to in the allegation. Surveyor asked when he was notified of the allegation of abuse. Previous NHA-D reported the Social Worker was doing rounds and R45 told him about it, he immediately reported it to (Previous NHA-D) and he went to R45's room to interview him. Surveyor asked what the Social Worker reported. Previous NHA-D stated: That (R45) said he was held down and changed against his will. Surveyor advised Previous NHA-D that the investigation documents that he was advised by Dir Quality Mgmt/IP-I. Previous NHA-D stated: OK, then maybe it was (him), whoever I wrote down is the person that told me. Previous NHA-D stated: (R45)'s story changed so many times regarding the date and shift that it happened, between 2nd and 3rd shift - he kept saying something different. I reviewed the schedule for those aides assigned to him and interviewed them. They said they were in there 4-5 times to do cares, but he refused. Surveyor advised this information was not on the CNA's statements. Previous NHA-D stated: Maybe I forgot to write it down. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor advised Previous NHA-D there are only 4 interviews of staff assigned to the 3rd floor that had potential to provide care to R45, and that 1 staff interview documented R45 reported the incident occurred on the previous shift, but she did not report it. Surveyor asked why there were only 4 staff interviewed regarding R45's allegation of abuse. Previous NHA-D stated: Because I determined those were the staff that were assigned to (R45). Surveyor advised they were not the only staff assigned to the 3rd floor. Previous NHA stated: No, but I determined they were the only ones assigned to (R45). Surveyor asked if it is the expectation if call lights are on, or residents need help - would all staff to tend to all residents. Previous NHA-D stated: Of course. Surveyor advised Previous NHA-D of the fact that all staff working the floor have potential to have contact with, or provide cares, is there a reason statements were not obtained of all staff working. Previous NHA-D stated: I didn't think it was necessary adding Well, I'm not sure that abuse even happened. If you're held down by your shoulders, you would have some evidence of it, some marks or something. That was part of my investigation, I asked the DON (Director of Nursing) to do a full body assessment, and nothing was found. Surveyor advised Previous NHA-D the alleged assessment is not included in the investigation. Previous NHA-D stated: Maybe she forgot to write it down. Surveyor asked if camera footage was reviewed as part of the investigation. Previous NHA-D stated: No, I don't see how that would be relevant to the investigation. Surveyor confirmed with Previous NHA-D he only interviewed selective staff he thought were assigned and provided care to R45. Previous NHA-D stated: Yes, it wasn't necessary to get statements from everyone if they weren't assigned to him. Surveyor asked if the facility provided staff training and education on abuse and reporting related to R45's allegation of abuse. Previous NHA-D stated: Not specifically, but we're doing training all the time on abuse, staff is very aware of abuse and reporting requirements. We try to do training every month when we have a staff meeting. Surveyor asked if it is the expectation the CNA that R45 told about being changed without permission should have been reported. Previous NHA-D stated: Not really, staff says he complains about everything, and he is prejudiced against people of color. Surveyor advised Previous NHA-D of concern the facility did not complete a thorough investigation of R45's allegation of abuse. Staff working on the date alleged, who may have knowledge of the incident, were not interviewed. In addition abuse education and training was not completed with all staff. Previous NHA-D stated: I don't agree with you. I obtained statements from all staff that worked with (R45) on that date, and we do education on a monthly basis; staff are very well informed of abuse and reporting. Surveyor advised there were only 4 staff statements obtained, 1 of which was not on the schedule and 1 of which R45 reported that the abuse occurred on the previous shift (which was not reported) and no additional staff statements were obtained. Previous NHA-D stated: Again, the staff statements I obtained were the only staff that were assigned to (R45).Surveyor asked how the facility knows that no other staff provided care or have knowledge of the incident if all staff were not interviewed. Previous NHA-D stated: Well, you don't know this resident, we know him well - I sincerely doubt anything happened at all. If it happened the way he alleged, there would be some evidence, redness, bruising, something - there was nothing. Surveyor advised Previous NHA-D there is no evidence an assessment was completed to support this statement and R45 has reported right shoulder pain, has limited range of motion, is receiving therapy and has an ortho appointment for a suspected rotator cuff tear. Previous NHA-D stated: I'd be very surprised if there was any validation to that. On 10/7/24, at 10:49 AM, Surveyor advised NHA-A of concern R45's allegation of abuse was not thoroughly investigated. NHA-A reported she was present when Surveyor was interviewing Previous NHA-D and understands the concern. No additional information was provided.