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	02/03/2026

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

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 3 (R1, R5, & R3) of 4 residents had the right to participate in the development and implementation of their person-centered plan of care. R1, R5, & R3 did not have evidence of quarterly care plan meetings and facility staff did not know when their last quarterly care conference meetings occurred. Findings include: The facility's policy dated 1/5/25 and titled, Care Plan Conference Meeting documents: The facility will conduct a care plan review/conference at least quarterly, and as needed, that is interdisciplinary, provides an in-depth review of the resident's plan of care, and provides an opportunity for resident and family discussions/input. R1 was admitted to the facility on [DATE] with diagnoses which include radiculopathy cervical region (nerve roots in the cervical spine are compressed or irritated causing neck pain, weakness, numbness, and radiating pain in the arms or hands), adult failure to thrive (state of decline that is multifactorial and may be caused by chronic concurrent diseases and functional impairments), pulmonary hypertension (chronic condition characterized by high blood pressure in the arteries of the lungs) and depression (serious mood disorder that causes a persistent feeling of sadness and a loss of interest in activities, interfering with daily life). R1's quarterly MDS (minimum data set) with an assessment reference date of 10/31/25 documents a BIMS (brief interview mental status) score of 15, which indicates R1is cognitively intact. On 2/3/26, at 9:18 a.m., Surveyor spoke with R1 who was in bed with the head of the bed up high eating a piece of bacon. During this conversation, R1 stated to Surveyor he's supposed to have care conferences. R1 explained he had a care conference scheduled for April 15th and in July, but no one showed up. Surveyor noted that R1 does not get out of bed. Surveyor asked R1 if he had a quarterly care conference meeting in September 2025. R1 informed Surveyor nothing has been scheduled since July 2025. Surveyor reviewed R1's medical record including progress notes from 6/17/25 to present (2/3/26) and was unable to locate the date when R1 had a quarterly care conference. On 2/3/26, at 9:24 a.m., Surveyor asked Social Services Designee (SSD)-L which residents he is responsible for. SSD-L explained he does resident's admission initial assessments and care conferences (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for admissions. Surveyor asked SSD-L who conducts resident's quarterly care conferences. SSD-L replied I usually do those and then explained he has been splitting these up with Director of Social Services (DSS)-E as she has been here a long time. On 2/3/26, at 10:06 a.m., Surveyor asked DSS-E when R1's last quarterly care conference was held. DSS-E explained she came from activities in August 2025 to social service and was on her own in the beginning. DSS-E stated I'm playing catch up explaining they are buried with the number of admissions and discharges. DSS-E informed Surveyor they are playing catch up with quarterly care conferences. Surveyor asked DSS-E when was the last time R1 had a quarterly care conference. DSS-E informed Surveyor from her recollection they have not had a care conference with R1. DSS-E informed Surveyor they have not had quarterly care conferences with therapy and nursing. On 2/3/26, at 12:35 p.m., Surveyor asked SSD-L if he knew the last time R1 had a quarterly care conference. SSD-L replied it's been a while honestly. Surveyor asked SSD-L if he could look at R1's electronic record for the last quarterly care conference. SSD-L reviewed R1's medical record and then stated to Surveyor I do not see anything for a care conference. On 2/3/26, at 1:27 p.m., Surveyor asked Nursing Home Administrator (NHA)-A who attends resident's quarterly care conferences. NHA-A informed Surveyor social service, nursing, therapy if they are on, resident, POA (power of attorney)/family, and any care team such as case manager. Surveyor asked how often care conferences are held. NHA-A informed Surveyor upon admission and quarterly for long term residents. Surveyor informed NHA-A Surveyor was unable to locate when R1 last had a quarterly care conference meeting and facility staff is unable to provide dates of R1's quarterly care conferences. No additional information was provided. 2.) R5 was admitted to the facility on [DATE] with diagnoses that include encounter for palliative care (care focused on reducing pain and stress through a variety of medical, emotional, and spiritual means alongside care of a serious illness), chronic lymphocytic leukemia of B cell type not having remission (a slow growing blood cancer that does not respond to treatment), heart failure (the heart does not pump efficiently and can cause fluid to build In the lungs or legs), and chronic obstructive pulmonary disease (a progressive irreversible lung disease that restricts airflow). R5's Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) of 7, which indicates R5 has severe cognitive impairment. The MDS documents that R5 has a lower extremity impairment on one side; R5 ususes a cane and wheelchair for mobility; R5 can walk with supervision, requires set up assistance with hygiene and eating, and requires partial to moderate assistance with showering, bed mobility, changing positions, and transferring. On 2/3/26, at 10:30AM, Surveyor reviewed R5's progress notes and medical record and was unable to locate any documentation of care conferences for R5. On 2/3/26, at 11:16 AM, Surveyor interviewed Social Worker (SW)-L. SW-L informed Surveyor that SW-L is responsible for care conferences and admissions. SW-L stated no care conferences have been completed for R5 to SW-L's knowledge. SW-L stated SW-L has not completed any care conferences for R5. SW-L was unable to provide Surveyor with any emails or notes about care conferences for R5. On 2/3/26, at 1:06 PM, Surveyor interviewed R5 regarding care conferences. R5 did not recall any care conferences being completed since R5's admission. R5 stated R5's family takes care of R5's care and they update R5. R5 has not heard anything from family recently regarding any care conferences. R5 (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated R5 keeps in touch with family frequently throughout the week. On 2/3/26, at 2:15 PM, Surveyor shared concern that R5 has had no documented care conferences to discuss R5's ongoing plan of care with Director of Nursing (DON)- B, Nursing Home Administrator (NHA)- A, and Director of Operations (DOO)-C. No additional information was provided regarding R5's lack of care conferences at this time. 3.) R3 was readmitted to the facility on [DATE] with diagnoses that include Alzheimer's Disease, Diabetes Mellitus Type II, Dementia and Anxiety Disorder. Per staff, R3 speaks only [NAME] and is confused. Surveyor reviewed R3's medical record and was unable to locate any evidence that R3 had a care conference meeting in the last twelve months. On 2/3/26, at 11:20 AM, Surveyor interviewed Social Worker (SW)-L. SW-L informed Surveyor that SW-L is responsible for care conferences and admissions. SW-L stated no care conferences have been completed for R3 to SW-L's knowledge. SW-L stated SW-L has not completed any care conferences for R3. SW-L was unable to provide Surveyor with any emails or notes about care conferences for R3. On 2/3/26, at 2:15 PM, Surveyor Director of Nursing (DON)- B, Nursing Home Administrator (NHA)- A, and Director of Operations (DOO)-C of the above findings. No additional information was provided why R3 did not have a care conference in the last twelve months while residing full time at the facility.

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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. Based on interview and record review, the facility did not report 1 (R1) of 1 incident reviewed to the State survey agency and Nursing Home Administrator during the required timeframe.On 1/1/26, Registered Nurse (RN)-G's nurses note documents R1 had complaints regarding the two-night Certified Nursing Assistants (CNAs) who performed ADL (activities daily living) cares for him. RN-G attempted to resolve it but R1 said he wanted it reported. On 2/2/26, R1 informed Surveyor he didn't want to be changed but staff said they had to and R1 alleged his wrists were held down when the staff members provided cares. R1's allegation of potential abuse was not reported to the State agency and Nursing Home Administrator.Findings include:The facility's policy titled, Abuse, Neglect and Exploitation and last reviewed/revised 11/5/25 under section VII. Reporting/Response documents A. The facility will have written procedures that include: 1. Reporting 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 or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. R1's diagnoses include radiculopathy cervical region (nerve roots in the cervical spine are compressed or irritated causing neck pain, weakness, numbness, and radiating pain in the arms or hands), benign prostatic hyperplasia (non-cancerous enlargement of the prostate gland), adult failure to thrive (state of decline that is multifactorial and may be caused by chronic concurrent diseases and functional impairments), pulmonary hypertension (chronic condition characterized by high blood pressure in the arteries of the lungs) and depression (serious mood disorder that causes a persistent feeling of sadness and a loss of interest in activities, interfering with daily life).R1's Quarterly MDS (minimum data set) with an assessment reference date of 10/31/25, documents a BIMS (brief interview mental status) score of 15, which indicates R1 is cognitively intact. The MDS documents: R1 is dependent on staff for toileting hygiene & chair/bed to chair transfer; requires substantial/maximal assistance for rolling left and right; R1 is always incontinent of urine and has a colostomy.On 2/2/26, at 11:42 a.m., Surveyor asked Nursing Home Administrator (NHA)-A for facility reported incidents in the last six months.On 2/2/26, at 12:49 p.m., Surveyor was provided with a list of residents and dates the facility reported incidents to the state agency. Surveyor noted R1 is not included in this list.On 2/2/26, at 1:20 p.m., Surveyor observed R1 in bed with the head of the bed up high. During the conversation with R1, R1 informed Surveyor on New Years Day he had an incident with staff. R1 explained he has an enlarged prostate, so he dribbles. R1 informed Surveyor he can feel when he is wet. R1 explained two girls came in and told him they were going to change him. R1 informed Surveyor he told them he's not wet and they said no we have to do it. R1 stated one of the girls held my wrists, she pulled me, hurt my shoulder again, and one took the brief off. R1 stated he told them I don't need this, I don't have dementia. R1 informed Surveyor they changed him. R1 informed Surveyor he told them I hope I don't see you again tonight and they stated you probably will. Surveyor asked R1 if he reported this to anyone. R1 replied oh ya the nurse. Surveyor asked R1 what he told the nurse. R1 informed Surveyor he told him they roughed him up; something has to be done. Surveyor asked R1 if he told the nurse they held his wrists down. R1 replied yes. Surveyor asked what the nurse said to him. R1 informed Surveyor he said nothing. Surveyor asked R1 what time this occurred. R1 replied 2:00 a.m. Surveyor asked how he knew it was at 2:00 a.m. R1 informed Surveyor there's a clock on the wall.R1's nurses note dated 1/1/26 at 06:12 (6:12 a.m.) and written by Registered Nurse (RN)-G documents: Writer was notified that resident wants to (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	see the nurse during the noc (night) shift, writer went in, resident said he had complaints concerning the 2 noc CNA's (Certified Nursing Assistant) that performed ADL (activities daily living) on him, writer attempted to resolve the issues with resident, but resident mentioned that he wants to report it. Writer updated DON (Director of Nursing) [first name], authorizing that the CNA's [first name] and [first name] write statements about the incident, and placed it under her door. CNAs agreed to do that.On 2/2/26, at 2:21 p.m., Surveyor spoke with RN-G on the telephone regarding R1. Surveyor asked if R1 reported any incident regarding staff treatment. RN-G informed Surveyor there was an incident sometime early last month which was reported to the DON (Director of Nursing). R1 was complaining about how staff were trying to change him. R1 said he wanted to make a report. Surveyor asked RN-G if he called DON-B in the middle of the night. RN-G replied yes about the two CNAs, and she would take care of it in the morning.On 2/3/26, at 11:25 a.m., Surveyor asked NHA-A if there has been any facility reported incidents to the State agency for R1 in the last 6 months. NHA-A replied to no.On 2/3/26, at 2:46 p.m., Surveyor asked NHA-A if she was notified of the allegation on 1/1/26 regarding staff mistreatment with R1. NHA-A replied to no. NHA-A was informed of the above.No additional information was provided as to why R1's allegation of potential abuse was not reported to the State agency and Nursing Home Administrator.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, the facility did not have evidence that all alleged violations of mistreatment were thoroughly investigated for 1 (R1) of 1 resident.On 1/1/26, Registered Nurse (RN)-G's nurses note documents R1 had complaints regarding the two-night Certified Nursing Assistants (CNAs) who performed ADL (activities daily living) cares for him. RN-G attempted to resolve it but R1 said he wanted it reported. On 2/2/26, R1 informed Surveyor he didn't want to be changed but staff said they had to and R1 alleges his wrists were held down. The facility did not thoroughly investigate R1's allegation as R1 was not interviewed, CNA-K & CNA-D were not interviewed, and a statement was not received from RN-G. The facility did not interview any residents to see if there were any concerns regarding care provided to them.Findings include:The facility's policy titled, Abuse, Neglect and Exploitation and last reviewed/revised 11/5/25 under section V. Investigation of Alleged Abuse, Neglect, and Exploitation documents A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigations include: 1. Identifying staff responsible for the investigation; 2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence); 3. Investigating different types of alleged violations; 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation.R1's diagnoses include radiculopathy cervical region (nerve roots in the cervical spine are compressed or irritated causing neck pain, weakness, numbness, and radiating pain in the arms or hands), benign prostatic hyperplasia (non-cancerous enlargement of the prostate gland), adult failure to thrive (state of decline that is multifactorial and may be caused by chronic concurrent diseases and functional impairments), pulmonary hypertension (chronic condition characterized by high blood pressure in the arteries of the lungs) and depression (serious mood disorder that causes a persistent feeling of sadness and a loss of interest in activities, interfering with daily life).R1's Quarterly MDS (minimum data set) with an assessment reference date of 10/31/25 documents a BIMS (brief interview mental status) score of 15, which indicates R1 is cognitively intact. R1 is assessed as being dependent on toileting hygiene & chair/bed to chair transfer, and requiring substantial/maximal assistance for rolling left and right. The MDS documents that R1 is always incontinent of urine and has a colostomy.On 2/2/26, at 1:20 p.m., Surveyor observed R1 in bed with the head of the bed up high. During the conversation with R1, R1 informed Surveyor on New Years Day he had an incident with staff. R1 explained he has an enlarged prostate, so he dribbles. R1 informed Surveyor he can feel when he is wet. R1 explained two girls came in and told him they were going to change him. R1 informed Surveyor he told them he's not wet and they said no we have to do it. R1 stated one of the girls held my wrists, she pulled me, hurt my shoulder again, and one took the brief off. R1 stated he told them I don't need this, I don't have dementia. R1 informed Surveyor they changed him. R1 informed Surveyor he told them I hope I don't see you again tonight and they stated you probably will. Surveyor asked R1 if he reported this to anyone. R1 replied oh ya the nurse. Surveyor asked R1 what he told the nurse. R1 informed Surveyor he told him they roughed him up; something has to be done. Surveyor asked R1 if he told the nurse they held his wrists down. R1 replied yes. Surveyor asked what the nurse said to him. R1 informed Surveyor he said nothing. Surveyor asked R1 what time this occurred. R1 replied 2:00 a.m. Surveyor asked how he knew it was at 2:00 a.m. R1 informed Surveyor there's a clock on the wall.R1's nurses note dated 1/1/26 at 06:12 (6:12 a.m.) and written by Registered Nurse (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(RN)-G documents: Writer was notified that resident wants to see the nurse during the noc (night) shift, writer went in, resident said he had complaints concerning the 2 noc CNA's (Certified Nursing Assistant) that performed ADL (activities daily living) on him, writer attempted to resolve the issues with resident, but resident mentioned that he wants to report it. Writer updated DON (Director of Nursing) [first name], authorizing that the CNA's [first name] and [first name] write statements about the incident, and placed it under her door. CNAs agreed to do that.On 2/2/26, at 2:21 p.m., Surveyor spoke with RN-G on the telephone regarding R1. Surveyor asked if R1 reported any incident regarding staff treatment. RN-G informed Surveyor there was an incident sometime early last month which was reported to the DON (Director of Nursing). R1 was complaining about how staff were trying to change him. R1 said he wanted to make a report. Surveyor asked RN-G if he called DON-B in the middle of the night. RN-G replied yes about the two CNAs, and she would take care of it in the morning.On 2/3/26, at 11:26 a.m., Surveyor met with Director of Nursing (DON)-B to discuss R1. Surveyor asked DON-B if in the last month or month in a half has, she had to conduct any investigations regarding R1. DON-B informed Surveyor she has not had to do any investigations but receives updates regarding R1 refusing cares. Surveyor inquired if DON-B received a call from the night nurse regarding R1 complaints about the two CNA's who provided care. DON-B informed Surveyor R1 didn't want to be changed, she was notified and has those statements. DON-B informed Surveyor it was R1 becoming belligerent, striking out at staff and refusing cares. Surveyor asked DON-B if she spoke with R1. DON-B replied I did not talk to him. Surveyor asked DON-B if she did any investigation. DON-B replied I did not. Surveyor asked DON-B if she received a statement from the night nurse (RN-G). DON-B replied I did not, he's the one that reported.On 2/3/26, at 1:17 p.m., Surveyor informed DON-B Surveyor was provided with statements from CNA-K and CNA-D. Surveyor asked DON-B if she interviewed CNA-K & CNA-D regarding what occurred with R1 on 1/1/26. DON-B replied I don't think so, no. Surveyor asked DON-B if she read RN-G's note dated 1/1/26. DON-B replied I would have. I don't remember verbatim. Surveyor asked DON-B after she read RN-G's nurses note, did she interview RN-G. DON-B replied to no. Surveyor asked why she didn't interview RN-G. DON-B replied I don't know explaining she got the two statements from the CNAs.On 2/3/26, at 1:29 p.m., Surveyor asked Nursing Home Administrator (NHA)-A what the process is if a resident voices a concern regarding staff treatment to a nurse. NHA-A if it's a specific person, time they do a grievance. If something more specific like harsh touching rough touching, they call her right away. NHA-A explained she would talk to the resident to hear what occurred. If she's not sure if an allegation should be self-reported, she could speak with name of Director of Operations (DOO)-C. If it's an allegation of abuse they do a self-report. Surveyor asked NHA-A if she had done any investigation regarding R1. NHA-A replied I have not. Surveyor informed NHA-A of R1 informing Surveyor he did not want to be changed, staff changed him and R1 alleges he was held down by his wrists. Surveyor informed NHA-A that the night nurse wrote a note on 1/1/26 regarding complaint R1 had regarding two CNAs with ADL care and wanted it reported. The night nurse called DON-B. Surveyor informed NHA-A there are two CNA statements but there was not a thorough investigation as no one interviewed R1, the night nurse who contacted DON-B did not write a statement and the CNA's were not interviewed.No additional information was provided.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure a person-centered baseline care plan was developed and implemented containing the minimum of required healthcare necessary to care for a resident within a resident's admission for 1 (R4) of 1 Resident reviewed for new admissions.*A person-centered baseline care plan was not developed with interventions necessary to care for R4 upon admission to the facility on 1/6/26.Findings include:The facility's Baseline Care Plan implemented 1/5/25 documents:Policy: The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.Policy Explanation and Compliance Guidelines:1. The baseline care plan will:a. Be developed within 48 hours of a resident's admission.b. Include the minimum healthcare information necessary to properly care for a resident including, but not limited to:i. Initial goals based on admission ordersii. Physician ordersiii. Dietary ordersiv. Therapy servicesv. Social servicesvi. PASARR recommendation, if applicable2. The admitting nurse, or supervising nurse on duty, shall gather information from the admission physical assessment, hospital transfer information, physician orders, and discussion with the resident and resident representative, if applicable.a. Once gathered, initial goals shall be established that reflect the resident's stated goals and objectives.b. Interventions shall be initiated that address the residents' current needs including:i. Any health and safety concerns to prevent decline or injury, such as elopement, fall, or pressure injury risk.ii. Any identified needs for supervision, behavioral interventions, and assistance with activities of daily living.iii. Any special needs such as for IV therapy, dialysis, or wound care.c. Once established, goals and interventions shall be documented in the designated format.3. A supervising nurse shall verify within 48 hours that a baseline care plan has been developed.R4 was admitted to the facility on [DATE] with diagnoses of Wedge Compression Fracture of Second Thoracic Vertebra, Subsequent Encounter for Fracture with Routine Healing, Unspecified Fall, Pneumonia(a lung infection that causes air sacs to fill with fluid or pus), Type 2 Diabetes Mellitus(adult onset of trouble controlling blood sugar), Essential Hypertension(chronic condition of persistently high blood pressure), Chronic Heart Failure(long term condition where the heart cannot pump enough blood to meet the body's oxygen needs), Alzheimer's(progressive disease that destroys memory and other important mental functions), and Dementia(loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life). R4 discharged to the hospital on 1/8/26 and did not return.R4's 5-day admission Minimum Data Set(MDS) completed 1/8/26 documents a Brief Interview For Mental Status(BIMS) score of 4, indicating R4 demonstrated severely impaired skills for daily decision making. The MDS documents: No depressive symptoms or behaviors are documented; R4 had no range of motion impairment; R4 required set-up for eating. R4 required partial/moderate assistance for showering, lower dressing, and mobility; R4's MDS documented R4 required supervision for upper dressing and substantial/maximum assistance for transfers; R4 was always incontinent of bowel and bladder, was at risk for pressure injuries. R4 was on a mechanically altered diet.R4's hospital Discharge summary dated [DATE] documents:Discharge Diagnoses:Fall, Bilateral Pneumonia, Closed Wedge Compression Fracture of T2 VertebraWill need TLSO(Thoracolumbar Sacral Orthosis) BracePuree/thin, no straws, small sips, upright positioning, 1-1 supervisionMedications crushed in pureeR4's hospital referral dated 1/6/26 documents:Therapy discharge recommendations:1/5/26- R4 is unable to complete self care and functional mobility that would allow return to previous living situation.Patient Safety-In bed/Alarm onSkilled intervention focused on gait training to/from the bathroom [ROOM NUMBER] feet with 2 staff with 2 (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wheeled walker and minimum/moderate cues to stay closer to walker. No carryover.1/6/26 - R4 requires moderate assist for functional mobility, demonstrating deficits in activities of daily living, functional mobility, activity tolerance, strength, cognition, insight to safety, and sequencing for functional tasks. R4 would benefit from skilled occupational therapy(OT) services to achieve maximum level of function and safety prior to discharge. Patient Safety-Up in chair/Alarm on.R4's Fall Risk Assessment completed 1/6/26 documents a score of 12.0 indicating R4 was high risk for falls.R4's facility physical(PT) and occupational(OT) therapy notes document:1/7/26- R4 presents with balance deficits, decreased functional capacity, decreased safety awareness, deficits in judgement, gross motor coordination deficits and strength impairments and in consideration of history, personal factors, and functional limitations documented in this evaluation summary, R4 requires skilled PT services to facilitate discharge planning and facilitate independence with all functional mobility. Barriers likely to impact discharge to next level equals exacerbation of cognitive impairment. Lacks insight into condition and risk factors, lacks capacity for chronic disease management, multiple medical conditions, and unstable psychiatric history.1/7/26-R4 presents with impairments in balance, mobility, self-modification, self monitoring, problem solving, planning, follow through, attention and strength resulting in limitations and/or participation restrictions in the areas of self-care, mobility, general tasks and demands, which requires OT services to maximize rehab potential, maximize independence with activities of daily living, increase safety awareness, increase independence with activities of daily living and increase functional activity tolerance in order to return to prior level of skill performed.Due to the documented physical impairments and associated functional deficits, without skilled therapeutic interventions, R4 is at risk for: falls, further declined in function, immobility, increased agitation, increased dependency on caregivers, limited out-of-bed activity, compromised general health, decreased ability to return to prior living environment, decrease in level of mobility, decreased leisure task participation and decreased participation with functional tasks.Surveyor reviewed R4's 'baseline care plan' and the following targeted focused problems all initiated 1/6/26 are documented:-R4 has diabetes mellitus-R4 uses oxygen therapy due to respiratory illnessIntervention not person-centered: Oxygen via(specify: nasal prongs) per MD (medical doctor) orders.-R4 has pain and/or receiving pain medication(specify: scheduled/as needed)-not person-c Intervention not person-centered: R4 prefers to have pain controlled by(specify medication, treatment)-R4 has an active order for psychotropic medication(s) use(name of medication is not listed)-R4 is at risk for falls due to history of falls, weaknessInterventions not person-centered:Be sure R4's call light is within reach and encourage R4 to use it for assistance as neededEducate R4/family/caregivers about safety reminders and what to do if a fall occursEnsure R4 is wearing appropriate footwearFollow facility fall protocol-R4 has potential/actual impairment to skin integrity due to impaired mobility, diabetes mellitusInterventions not person-centered: provide pressure relieving device(s): (specify)-R4 has bowel incontinence and only 1 intervention is listed to provide pericare after each incontinent episode-R4 has bladder incontinence due to(not filled in) and 2 interventions listed to provide pericare after each incontinence episode and to encourage fluids during the day to promote prompted voiding responses.-R4 has ADL(activities of daily living) self-care performance deficit due to weakness, impaired mobilityInterventions not person-centered:Provide adaptive equipment necessary during transferBED MOBILITY: R4 requires (specify what assistance) by (X) staff to turn and reposition in bed (specify frequency) and as necessaryEATING: R4 requires (specify what assistance) by (X) staff to eatTOILET USE: R4 requires (specify assistance) by (X) staff for toiletingTRANSFER: R4 requires (specify what assistance) by (X0 staff to move between surfaces (specify frequency) and as necessaryEncourage R4 to (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	use bell to call for assistancePraise all efforts at self carePT/OT evaluation and treatment as per MD orders.-R4 has limited physical mobility due to weaknessInterventions not person-centered:R4 is non-weight bearingR4 is weight-bearingAMBULATION: R4 requires(specify: assistance) by (X) staff to walk (specify frequency) and as necessaryProvide supportive care, assistance with mobility as needed. Document assistance as needed.PT/OT referrals as ordered, as needed-R4 would like to discharge home or communitySurveyor noted there are multiple interventions for R4 that do not give specific instructions on how to care for R4. Surveyor noted that R4 had a history of falls prior to admission, was high risk for falls, was closely monitored in the hospital for falls with a chair and bed alarm and the facility did not develop person-centered interventions on admission and did not revise interventions after R4 fell two times. R4 was to have 1:1 supervision, pureed diet, and no straws which were not documented on R4's care plan.R4's Kardex which instructs certified nursing assistants(CNAs) on the care that needs to be provided is documents the same interventions as R4's 'baseline care plan'. Bed mobility, mobility, transferring, eating, monitoring, and toileting are all not complete or addressed. The Kardex instructs CNAs to follow facility fall policy and did not have any interventions to prevent falls similar to when R4 was in the hospital Surveyor noted the facility fall policy is not documented on the Kardex, and fall interventions are not person-centered. Surveyor noted that CNAs provide care based on R4's Kardex and would not have known how to care for R4 to minimize risks of falls and injury and aspiration.On 2/3/26, at 1:21 PM, Surveyor interviewed Director of Nursing (DON)-B in regard to baseline care plans. DON-B explained that the baseline care plan is created based on the resident admission assessment. The MDS nurse reviews and tweaks the care plan. The next day, the interdisciplinary team(IDT) will review and MDS nurse will add targeted concerns based on IDT input. DON-B stated that the basic fall interventions would be in place for R4 like offering toileting, etc. Surveyor shared the concern with DON-B that R4's baseline care plan was not completed with person-centered interventions. Surveyor also shared the concern that the CNA Kardex which is generated off the baseline care plan to instruct the CNAs on how to care for R4 was not specific. Surveyor shared that CNAs would not have known how to provide cares and keep R4 safe. DON-B acknowledged the concern that staff did not know how to care for R4 and provide person-centered cares and interventions to keep R4 safe and meet R4's highest level of independence.On 2/3/26, at 2:46 PM, Nursing Home Administrator (NHA)-A informed Surveyor that Minimum Data Set (MDS)-N is responsible for pulling resident information from the admission assessment and completing the baseline care plan. NHA-A stated that MDS-N is not available to be interviewed at this time. Surveyor shared with NHA-A that R4's baseline care plan was not completed with person-centered interventions to best take care of R4 and maintain safety.No additional information was provided as to why R4's baseline care plan was not person-centered with interventions to care for R4.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility did not complete neurological checks in accordance with policy and procedure for 1 (R4) of 3 residents reviewed for unwitnessed falls.*R4 sustained two unwitnessed falls on 1/7/26. Facility staff did not complete neurological checks in accordance with the facility's policy and procedure.Findings include:The facility's Neurological Assessment policy and procedure effective 5/19/22 documents:Policy: Residents will have a neurological assessment completed when they experience a head injury or a change in condition that deems it necessary or per physician order.Procedure:1.Neurological assessments will be completed upon a physician's order, when indicated for a change of resident's condition, after all head injuries and when nursing judgment deems necessary.Exception: If a resident is sent to the hospital and a head injury is ruled out using diagnostic testing consider discontinuing neuro check monitoring.2.Observe, assess and document the resident's level of consciousness, speech, pupils, hand grasps and vital signs.3.Unless otherwise ordered by the physician, neuro checks will be completed along the following schedule: Q 15 minutes times X 1 hours, Q 1 hours X 4 hours, and then Q shift X 72 hours or as ordered by attending physician.4. Notify physician immediately regarding any changes in the neurological assessment or other signs of possible increased intracranial pressure.5. If a resident is on an anticoagulant and sustains a head injury, notify physician.R4 was admitted to the facility on [DATE] with diagnoses of Wedge Compression Fracture of Second Thoracic Vertebra, Subsequent Encounter for Fracture with Routine Healing, Unspecified Fall, Pneumonia(a lung infection that causes air sacs to fill with fluid or pus), Type 2 Diabetes Mellitus(adult onset of trouble controlling blood sugar), Essential Hypertension(chronic condition of persistently high blood pressure), Chronic Heart Failure(long term condition where the heart cannot pump enough blood to meet the body's oxygen needs), Alzheimer's(progressive disease that destroys memory and other important mental functions), and Dementia(loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life). R4 discharged to the hospital on 1/8/26 and did not return.R4's 5-day admission Minimum Data Set(MDS) completed 1/8/26 documents a Brief Interview For Mental Status(BIMS) score of 4, indicating R4 demonstrated severely impaired skills for daily decision making. The MDS documents: No depressive symptoms or behaviors; R4 had no range of motion impairment; R4 required set-up for eating; R4 required partial/moderate assistance for showering, lower dressing, and mobility; R4 required supervision for upper dressing and substantial/maximum assistance for transfers; R4 was always incontinent of bowel and bladder, was at risk for pressure injuries; R4 was on a mechanically altered diet.R4 had two unwitnessed falls at the facility on 1/7/26.On 1/7/26, at 4:33 PM, R4 had an unwitnessed fall with no injuries. The facility 24 hour report indicates that neuro-checks were initiated.Surveyor notes that neuro-checks were initiated by nursing staff. Surveyor reviewed the facility neuro-checks completed for R4's fall on 1/7/26 at 4:33 PM.4 15 minute neuro-checks was completed2 30-minute neuro-checks was completed2 1 hour neuro-checks was completedSurveyor noted that no other neuro-checks were completed per facility policy and procedure.On 1/7/26, at 8:35 PM, R4 had an unwitnessed fall with no injuries. The facility 24 hour report indicates that neuro-checks were initiated.Surveyor notes that neuro-checks were initiated by nursing staff. Surveyor reviewed the facility neuro-checks completed for R4's fall on 1/7/26 at 4:33 PM.4 15 minute neuro-checks was completed1 30 minute neuro-check was completedSurveyor noted that no other neuro-checks were completed per facility policy and procedure.On 2/3/26 at 1:21 PM, Director of Nursing, (DON)-B informed Surveyor that the facility policy for neuro-checks is completed for resident unwitnessed falls. If a resident is sent to the emergency room, neuro-checks would not be completed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON-B stated that 4 15 minute checks, 4 1 hour checks, 4 8 hour checks is to be completed and documented in the resident electronic medical record. Surveyor shared the concern with DON-B that neuro-checks were not completed per facility policy and procedure for R4's 2 unwitnessed falls on 1/7/26. DON-B acknowledged the concern and stated the expectation is that nursing staff should complete the neuro-checks per facility policy and document in the resident electronic medical record.No additional information was provided as to why R4's neurological-checks were not completed per facility policy and procedure.

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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 observation, interview and record review, the facility did not ensure each resident received adequate supervision and assistance to prevent accidents for 2 (R4 and R2) of 3 residents reviewed for falls. *On 1/7/26, R4 had two unwitnessed falls on 1/7/26 and one witnessed fall on 1/8/26. The facility did not thoroughly investigate the falls and did not establish a root/cause analysis. *On 1/27/26, R2 had an unwitnessed fall, and the facility did not thoroughly investigate the falls and did not establish a root/cause analysis. Findings include: The facility's Fall Policy last reviewed 1/2/26 documents: Policy: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Policy Explanation and Compliance Guidelines: 1.The facility utilizes a risk assessment tool for determining a resident's fall risk. 2.A risk assessment will be completed upon admission, quarterly, or when a significant change is identified. 3.An individualized care plan will be implemented according to the risk factors identified on the fall assessment tool. 4. Interventions will be monitored for effectiveness and reviewed/ revised following a fall event, quarterly, annually, and with significant change or as needed. 5. When any resident experiences a fall, the following will result: a.Nursing emergency care will be provided. Neurological(neuro) observations will be conducted following any observation of a resident hitting their head during a fall/incident/accident or if it is unknown/not observed whether a resident actually hit their head or not during the fall/incident/accident. b. Complete a post-fall investigation which may include witness statements as applicable. c. Complete an incident report. d. Notify physician and family and/or resident representative. e. Document all assessments and actions. f. Complete a Root Cause Analysis with Interdisplinary Team(IDT) and update the plan of care based (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on RCA. 1.) R4 was admitted to the facility on [DATE] with diagnoses of Wedge Compression Fracture of Second Thoracic Vertebra, Subsequent Encounter for Fracture with Routine Healing, Unspecified Fall, Pneumonia(a lung infection that causes air sacs to fill with fluid or pus), Type 2 Diabetes Mellitus(adult onset of trouble controlling blood sugar), Essential Hypertension(chronic condition of persistently high blood pressure), Chronic Heart Failure(long term condition where the heart cannot pump enough blood to meet the body's oxygen needs), Alzheimer's(progressive disease that destroys memory and other important mental functions), and Dementia(loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life). R4 discharged to the hospital on 1/8/26 and did not return. R4's 5-day admission Minimum Data Set(MDS) completed 1/8/26 documents a Brief Interview For Mental Status(BIMS) score of 4, indicating R4 demonstrated severely impaired skills for daily decision making. The MDS documents: No depressive symptoms or behaviors; R4 had no range of motion impairment; R4 required set-up for eating; R4 required partial/moderate assistance for showering, lower dressing, and mobility; R4 required supervision for upper dressing and substantial/maximum assistance for transfers; R4 was always incontinent of bowel and bladder, and was at risk for pressure injuries; R4 was on a mechanically altered diet. R4's hospital referral dated 1/6/26 documents: Therapy discharge recommendations: 1/5/26- R4 is unable to complete self-care and functional mobility that would allow return to previous living situation. Patient Safety-In bed/Alarm on Skilled intervention focused on gait training to/from the bathroom [ROOM NUMBER] feet with 2 staff with 2 wheeled walker and minimum/moderate cues to stay closer to walker. No carryover. 1/6/26- R4 requires moderate assistance for functional mobility, demonstrating deficits in activities of daily living, functional mobility, activity tolerance, strength, cognition, insight to safety, and sequencing for functional tasks. R4 would benefit from skilled occupational therapy(OT) services to achieve maximum level of function and safety prior to discharge. Patient Safety-Up in chair/Alarm on R4's facility Fall Risk Assessment completed 1/6/26 documents a score of 12.0 indicating R4 is high risk for falls. R4's facility physical(PT) and occupational(OT) therapy notes document: 1/7/26- R4 presents with balance deficits, decreased functional capacity, decreased safety awareness, deficits in judgement, gross motor coordination deficits and strength impairments and in consideration of history, personal factors, and functional limitations documented in this evaluation summary, R4 requires skilled PT services to facilitate discharge planning and facilitate independence with all functional mobility. Barriers likely to impact discharge to next level equals exacerbation of (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cognitive impairment. Lacks insight into condition and risk factors, lacks capacity for chronic disease management, multiple medical conditions, and unstable psychiatric history. 1/7/26-R4 presents with impairments in balance, mobility, self-modification, self-monitoring, problem solving, planning, follow through, attention and strength resulting in limitations and/or participation restrictions in the areas of self-care, mobility, general tasks and demands, which requires OT services to maximize rehab potential, maximize independence with activities of daily living, increase safety awareness, increase independence with activities of daily living and increase functional activity tolerance in order to return to prior level of skill performed. Due to the documented physical impairments and associated functional deficits, without skilled therapeutic interventions, R4 is at risk for: falls, further declined in function, immobility, increased agitation, increased dependency on caregivers, limited out-of-bed activity, compromised general health, decreased ability to return to prior living environment, decrease in level of mobility, decreased leisure task participation and decreased participation with functional tasks. Surveyor reviewed R4's baseline care plan which documents: -R4 is at risk for falls due to history of falls, weakness Interventions not person-centered: Be sure R4's call light is within reach and encourage R4 to use it for assistance as needed Educate R4/family/caregivers about safety reminders and what to do if a fall occurs Ensure R4 is wearing appropriate footwear Follow facility fall protocol -R4 has ADL(activities of daily living) self-care performance deficit due to weakness, impaired mobility Interventions not person-centered: Provide adaptive equipment necessary during transfer BED MOBILITY: R4 requires (specify what assistance) by (X) staff to turn and reposition in bed (specify frequency) and as necessary EATING: R4 requires (specify what assistance) by (X) staff to eat TOILET USE: R4 requires (specify assistance) by (X) staff for toileting TRANSFER: R4 requires (specify what assistance) by (X0 staff to move between surfaces (specify frequency) and as necessary Encourage R4 to use bell to call for assistance (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Praise all efforts at self-care PT/OT evaluation and treatment as per MD orders. -R4 has limited physical mobility due to weakness Interventions not person-centered: R4 is non-weight bearing R4 is weight-bearing AMBULATION: R4 requires(specify:assistance) by (X) staff to walk (specify frequency) and as necessary Provide supportive care, assistance with mobility as needed. Document assistance as needed. PT/OT referrals as ordered, as needed Surveyor notes there are multiple interventions for R4 that do not give specific instructions on how to care for R4. Surveyor's concern is that R4 had a history of falls prior to admission, was high risk for falls, was closely monitored in the hospital for falls as evidenced by documentation of R4 having a chair and bed alarm and the facility did not develop person-centered interventions on admission and did not revise interventions after R4 fell two times on 1/7/26. R4's Kardex which instructs certified nursing assistants(CNAs) on the needed care provided is exactly the same as the 'baseline care plan'. Bed mobility, mobility, transferring, eating, monitoring, and toileting are all not complete. For safety it instructs CNAs to follow facility fall policy. Surveyor notes the facility fall policy is not documented on the Kardex, and fall interventions are not person-centered. Surveyor's noted that CNAs whom provide care based on the Kardex would not have known how to care for R4 to minimize risks of falls and injury. On 1/7/26 at 4:33 PM, Licensed Practical Nurse (LPN)-F documented: Writer noted resident on floor sitting on her buttocks, next to bed, denies hitting head. Resident head to toe assessment completed by writer noted resident alert and oriented times one(A&Ox1), neuro check negative, no injuries noted, vital signs stable(VSS), denies pain, and hitting head. Resident assisted back in wheelchair by writer, and staff member. Intervention in place by sitting resident in dining room with staff for supervision. Writer contacted nurse practitioner(NP) present at facility and updated regarding resident unwitnessed fall, no new orders(NNO) at this time. On 1/7/26, at 4:55 PM, LPN-F documented: Resident head to toe assessment complete by writer noted resident A&O x 1, neuro check negative, no injuries noted, VSS, denies pain, and hitting head. Resident assisted back in wheelchair by writer and staff member. Intervention in place by sitting resident in dining room with staff for supervision. Writer contact NP present at facility updated regarding resident unwitnessed fall, NNO at this time. Writer contacted resident power of attorney(POA) several attempts, left message regarding fall, no injuries, and to contact facility. On 2/3/26, at 9:50 AM, Surveyor requested R4's fall investigation for this first fall at 4:33 PM. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility was not able to provide a fall investigation with a root/cause analysis. There are no statements from staff who last observed R4 and details of where R4 was found in R4's room, was R4 continent at the time, etc. On 1/7/26, at 9:09 PM, LPN-F documented: Resident head to toe assessment complete by RN assisted by writer, noted resident A&O x 1, neuro check negative , small bump to rt side of head, no c/o pain, VSS. Resident assisted back in wheelchair by writer and staff member. Intervention in place by sitting resident at nurses' station with staff for supervision. NP contacted by supervisor updated regarding unwitnessed fall, and bump to side of head, NNO at this time. Resident POA updated regarding resident fall and bump to right side of head. A fall investigation provided by the facility documents R4's unwitnessed fall occurred at 8:30 PM, and R4 was last seen sleeping at 8:25 PM by a CNA. It is documented R4 .states 'opening the door'. R4 had gripper socks on. The picture drawn indicates R4 was found under a chair. Surveyor notes it is unclear if the chair is a room chair, or the wheelchair. If R4 was last seen sleeping, was this in bed or in a chair? If R4 was last seen in bed, how far is it to where R4 was found on the floor. How did R4 sustain a small bump to right side of head? There are no statements from staff included in the fall investigation. The immediate intervention was to place R4 at the nurses' station for supervision. There is no root/cause analysis or a thorough investigation for R4's second fall. On 2/3/26, at 10:43 AM, Surveyor attempted to reach Certified Nursing Assistant (CNA)-I by phone who was assigned to R4 at the time of the two falls and was not able to speak with CNA-I. On 2/3/26, at 10:45 AM, Surveyor attempted to reach LPN-F who was the assigned nurse to R4 at the time of the two falls, and was not able to speak with LPN-F. Surveyor notes there is no documentation of a registered nurse (RN) assessment completed after R4's first fall. On 1/8/26, at 7:32 AM, Registered Nurse (RN)-H documented:Resident had a witnessed fall at 0425 with laceration to the back of her head. Resident alert and responsive with confusion related to Dementia. Resident was with staff in the nursing station all night, she kept refusing to sit, fighting and scratching staff, cursed staff by telling go to hell stating that she has the right to fall. Resident was politely reminded that staff are trying to prevent her from falling for good and safety, and she said if I fall and break my head/neck, it's my head and neck not yours. Pulling oxygen(O2) tubing out. Finally took a fast one on nurse by standing quickly and before writer could catch her, she fell hitting her head on the floor, with bleeding which was stopped before 911 arrived. Resident was taken to emergency room via ambulance for evaluation and treatment. Daughter updated. On 2/3/26, at 9:50 AM, Surveyor requested R4's fall investigation for the 1/8/26 fall. The facility was not able to provide a fall investigation with a root/cause analysis. There are no statements from staff who observed R4 at the nurses' station or details of what interventions were attempted to reduce R4's anxiety and keep R4 safe. On 2/3/26, at 1:49 PM, Surveyor spoke with RN-H via telephone. RN-H stated that when RN-H started RN-H's shift at 10:00 PM, R4 was already at the nurse's station. RN-H had been informed from the previous shift that R4 had fallen a couple of times and was not following directions. RN-H stated that the staff tried very hard to watch R4. RN-H stated there was always someone at the nurses' station watching R4. RN-H stated that RN-H was too scared to leave R4 alone. RN-H stated it happened so fast (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when R4 fell. RN-H was able to stop the bleeding before 911 arrived. RN-H informed Surveyor that R4 required 1:1 supervision at all times. 2/3/26, at 1:21 PM, Surveyor interviewed Director of Nursing (DON)-B in regard to R4's three falls. Surveyor shared that for the first fall and the last fall there are no facility fall investigations. DON-B stated DON-B does not believe that R4 fell two times on 1/7/26, but that actually R4 fell only once. DON-B then stated DON-B thinks R4 was sent out to the hospital after the second fall. Surveyor shared the concern that there is no documentation of R4 being sent out to the hospital, and no transfer form completed in R4's electronic medical record(EMR). Surveyor shared the concern that R4's baseline care plan and Kardex do not document person-centered interventions to prevent R4 from falling and prevent injuries. Surveyor shared that prior to admission to the facility, hospital documentation indicates R4 was at risk for falling and lacked judgement for R4's own safety. Surveyor also shared that R4 triggered as high risk for falls by the facility fall risk assessment. DON-B understands the concern that person-centered fall interventions were not in place resulting in R4 falling three times in 48 hours. On 2/3/26, at 2:46 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A that R4 did not have person-centered fall interventions in place resulting in R4 falling three times in 48 hours. NHA-A understands the concern and no additional information has been provided by the facility at this time. On 2/3/26, at 3:28 PM, Surveyor reviewed R4's emergency room documentation provided by the facility. Documentation states there was evidence of a superior occipital hematoma with associated approximately 1.5 cm abrasion that is currently hemostatic. A CT head without contrast was completed on R4. The result is no intracranial hemorrhage nor acute calvarial fracture. No additional information was provided. 2.) R2 was admitted to the facility on [DATE] with diagnoses that included Syncope and Collapse, Repeated Falls, Dementia, Hypertension and General Anxiety Disorder. R2's Quarterly MDS (Minimum Data Set) dated 11/26/25 documents a BIMS (Brief Interview for Mental Status) of 10, indicating that R2 is moderately cognitively impaired. R2's MDS documents that R2 requires moderate to partial assistance with transfers from the bed to a chair. R2's Falls Risk assessment dated [DATE] documents a score of 10, indicating that R2 is at high risk for falls. R2's Falls plan of care documents the following interventions for R2: Call light within reach, appropriate footwear, follow facility protocol. R2's Fall Investigation form dated 1/27/26 documents: R2 fell on 1/27/26 at 8:30 PM; Statement from witness: fond on the floor laying down; What was the resident doing at the time of the fall: Getting out of bed; Call light within reach; Fall witness statement: I didn't see anything. Surveyor noted that R2's fall investigation dated 1/27/26 did not include any other staff statements about when R2 was last seen prior to R2's fall at 8:30 PM or when R2 was last toileted. On 2/3/26 at 1:19 PM, Surveyor asked Director of Nursing (DON)-B if the facility had additional (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	02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avina 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff statements or information of when R2 was last seen or toileted prior to R2's fall on 1/27/26. DON-B informed Surveyor that the facility did not have any additional information and understood that the facility did not have information of when R2 was last seen or toileted prior to R2's fall on 1/27/26.