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	04/14/2026

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure the accurate and safe administration of medication for 1 (R68) of 7 residents reviewed for medication administration.*Surveyor observed Medication Technician (MT)-J deliver R68 an afternoon medication. MT-J left the medication on R68's bedside table and exited R68's room. R68 did not have a self-administration of medication assessment completed, did not have a physician's order to self-administer medication and did not have a care plan regarding self-administration of medication.Findings include:The facility's policy dated 1/1/26 and titled, Medication Administration, documents: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state as ordered by the physician and in accordance with professional standards of practice. Review [Medication Administration Record (MAR)] to identify medications to be administered. Remove medication from source. Administer medication as ordered in accordance with manufacturer specifications. Crush medications as ordered. Observe resident consumption of medication unless otherwise specified in order.R68 was admitted to the facility on [DATE] with diagnosis that includes Diabetes, Autoimmune thyroiditis (Chronic condition where the immune system attacks the thyroid gland), Hypertension (high blood pressure), Chronic kidney disease, Dementia, and Depression.R68's admission Minimum Data Set (MDS) assessment dated [DATE] documents R68 is cognitively intact.R68's physician order with a start date of 2/14/26 documents: Cholecalciferol Tablet 1000 UNIT. Give 1 tablet by mouth in the evening for [chronic kidney disease] supplement.On 4/13/26 at 2:38 PM, Surveyor observed MT-J administering medications. MT-J started to prepare R68's medication. MT-J put R68's Cholecalciferol tablet in a medication cup. MT-J informed Surveyor that R68 prefers medications crushed and in applesauce. MT-J crushed R68's medication, put applesauce in a small medication cup and mixed in R68's Cholecalciferol.On 4/13/26 at 2:42 PM, MT-J entered R68's room. MT-J informed R68 that MT-J had R68's medication. MT-J placed a glass of water and the small medication cup with applesauce and Cholecalciferol on R68's bedside table. MT-J then exited R68's room. Surveyor asked MT-J if it is ok to leave R68's medication on the bedside table. MT-J stated that R68 can take it by R68's self. MT-J stated if you stay until the medication is gone, residents will start talking and you will not be able to leave. If a resident is not with it, MT-J will stay until the medication is gone, but MT-J stated again that R68 can do it themselves.On 4/13/26 t 2:54 PM and at 3:01 PM, Surveyor observed R68's applesauce and Cholecalciferol still sitting on R68's bedside table and not consumed.On 4/13/26 at 11:40 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-O. Surveyor asked if facility staff leave medications on resident's bedside table. LPN-O stated that there are residents who have been assessed to self-administer medications. LPN-O stated that they have permission from the physician to self-administer, and if it is in the resident's care plan. LPN-O stated that other than that, staff should not leave medications on bedside table. LPN-O indicated that it is the facility policy to be in the resident's room and watch until the medication is consumed.Surveyor reviewed R68's medical record and did not find a physician order, an assessment or a care plan regarding self-administration of medication.On 4/14/26 at 11:55 AM, Surveyor interviewed Director of Nursing (DON)-B. Surveyor (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	asked if R68 can self-administer medication. DON-B stated that DON-B would check. Surveyor asked what facility staff need to complete for residents to self-administer medications. DON-B stated that the residents need a self-administration assessment and care plan that would document what medications can be self-administered. Surveyor asked if facility staff are allowed to leave medications on resident's bedside table. DON-B stated if they have a physician order for that, staff can leave it, but if there is no physician order they should not leave it on the bedside table. DON-B informed Surveyor that DON-B did not see an order or documentation that R68 can self-administer medications. Surveyor informed DON-B of the concern that MT-J was observed leaving R68's applesauce and crushed Cholecalciferol on R68's bedside table during MT-J's medication pass. In addition, MT-J informed Surveyor that R68 can take it by R68's self. On 4/14/26 at 3:17 PM, Surveyor informed Nursing Home Administrator (NHA)-A, DON-B, Director of Operations-C and Regional Nurse-D of the above concern. No additional information was provided.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 2 (R102 and R109) of 4 residents reviewed for grievances had their grievances resolved.*A grievance filed for R102 on 11/13/25 documents R102 was not provided incontinence cares on day shift of 11/12/25. There is no documentation that the grievance was investigated and that steps were taken to investigate the grievance, a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued and/or communicated to the resident and/or representative filing the grievance.* A grievance filed for R109 on 3/31/26 documents R109 was served a lunch tray with a fly on it and was not receiving a salad with lunch. There is no documentation that the grievance was investigated and the steps were taken to investigate the grievance, a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued and/or communicated to the resident and/or representative filing the grievance.Findings Include:The facility's Grievance Policy implemented 10/1/25 documents: Policy: It is the policy of the facility to provide a system whereby residents, and/or their significant others or representatives, can voice concerns about the quality of services received at the facility.The facility will designate a Grievance Officer who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusion; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances; taking immediate action, as necessary, to prevent further potential violations of any resident right while the alleged violation is being investigated; immediate reporting of all alleged violations involving neglect, abuse, injuries of unknown source, misappropriation of resident property and/or exploitation; and taking appropriate corrective action in accordance with State law when indicated.Procedure:The Grievance Officer will route the grievance to the appropriate department head related to the grievance filed, and an investigation of the grievance will be conducted. Based on the nature of grievance, the Grievance Officer will initiate any additional interventions that are indicated at that time. The resident and/or resident's representative may be interviewed for additional information as needed. The Department Head or Grievance Officer may also question other members of the healthcare team that have been involved in the care of the residents. After thorough research has been conducted, the Department Head and/or Grievance Officer will work in tandem with staff identified as key individuals critical to problem resolution for the specific identified concern. All efforts will be made to effectively and expeditiously resolve the grievance.All grievances receive immediate priority and must be investigated with efforts made toward resolution within 7 days by either the facility Administrator or Director of Nursing (DON).The resident will be provided with a verbal or written print out of the concern from facility metrics Grievance log showing the follow up to their grievance including the following information:The name of the Department head who conducted the follow up/investigationThe steps taken to investigate and resolve the grievanceThe outcome of the grievance.1.) R102 was admitted to the facility on [DATE] with diagnoses of Unspecified Protein-Calorie Malnutrition, Severe (deficiency of both protein and energy), Hypoglycemia (blood sugar drops below normal levels), Adult Failure to Thrive(decline in overall health in older adults), Hypothyroidism (underactive thyroid), Thrombocytopenia(low number of platelets in the blood), Gastro-Esophageal Reflux Disease(stomach contents leak backward from stomach into the esophagus(food pipe), Chronic Kidney Disease(progressive damage and loss of function in the kidneys), and Dementia(loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life).R102 discharged from the facility on 3/23/26. R102's significant change Minimum Data Set (MDS) completed 2/6/26 documents a Brief Interview for Mental Status (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(BIMS) score to be 15, indicating R102 is cognitively intact daily decision-making skills. The MDS documents that R102 was assessed for: R102 had no range of motion impairment; R102 was independent with eating, required set-up for showers and dressing, and required supervision for mobility and transfers.Surveyor reviewed all facility grievances from October 2025 to present. Surveyor noted that R102's representative filed a grievance on 11/13/25 documenting that R102 received no incontinence cares on day shift of 11/12/25. Documentation states that DON-B went and observed R102 and documented R102 was dry. There is no other documentation that the grievance was investigated including interviewing R102 and staff assigned to R102 on day shift of 11/12/25. Surveyor noted that the documented grievance states the grievance was reported on 11/13/25, but the resolved date is 11/12/25, one day prior to the grievance being reported. DON-B document that R102 was dry and comfortable on 1/5/26. Surveyor noted there is conflicting dates documented on the grievance form. There is no documentation of R102 and representative being informed of resolution and actions taken to prevent further concerns or grievances. On 04/14/26, at 11:55 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A regarding the grievance process. NHA-A confirmed that NHA-A is the grievance officer. NHA-A explained that grievances are reviewed as an interdisciplinary team (IDT). NHA-A stated that if the department manager states the grievance was addressed and everything is good, then NHA-A will not complete any further review. Surveyor shared the concern that R102's grievances have no documentation that an investigation was completed, resolution was achieved, and steps taken to prevent further occurrences. Surveyor also shared that R102 and R102's representative were not notified of any resolution.No additional information was provided. 2.) R109 was admitted to the facility on [DATE] with diagnoses of Unspecified Protein-Calorie Malnutrition(deficiency of both protein and energy), Type 2 Diabetes Mellitus(adult onset of trouble controlling blood sugar), Hemiplegia and Hemiparesis Following Cerebral Infarction(complete paralysis on one side of body and partial/incomplete weakness on one side following stroke), Parkinson's Disease(disorder of the central nervous system that affects movement, often including tremors), Peripheral Vascular Disease(circulatory condition in which narrowed blood vessels reduce blood flow to limbs), and Atherosclerotic Heart Disease of the Native Coronary Artery(plaque buildup narrows the arteries that supply blood to the heart). R109 discharged from the facility on 4/8/26.R109's admission MDS completed 4/2/26 documents R109's BIMS (Brief Interview for Mental Status) score to be a 14, indicating R109 is cognitively intact for daily decision making. R109 had no range of motion impairment. R109's MDS also documents that R109 was independent for eating and required partial/moderate assistance for mobility and transfers.Surveyor reviewed all facility grievances from October 2025 to present. Surveyor noted there was grievance filed on 3/31/26 by R109 documenting that R109 received a lunch tray with a fly on it and not receiving a salad at lunch. The grievance documents that Dietary Manager (DM)-K discussed with R109 the concern and will receive a salad at lunch. There is no documentation that DM-K addressed the concern of the fly. On 4/13/26, at 2:43 PM, Surveyor interviewed DM-K regarding fly grievances. DM-K stated that DM-K was unable to speak with R109 because R109 was discharged the next day. DM-K stated that DM-K has not seen a fly herself but stated there may be flies because the steam table on the second floor is located right next to a door.DM-K provided documentation that stated: Received a concern from Social Worker (SW)-P that R109 had a fly in R109's food. The following day when DM-K was going to visit R109, R109 was discharged . I did, however, talk to my staff and informed them of the situation and told them to be more observant as we prepare food, especially because our location is in very close proximity to an outside entrance.Surveyor noted that R109 filed the grievance on 3/31/26, but was not discharged the next day on 4/1/26, but rather R109 was discharged on 4/8/26.On 4/14/26, at 11:19 AM, Surveyor interviewed Maintenance Director (MD)- N. MD-N stated that no one had informed the maintenance department that there was a fly issue. MD-N stated that pest control comes in monthly and when notified, will also address specific concerns.On 11/14/26, at 11:55 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A regarding the (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	grievance process. NHA-A confirmed that NHA-A is the grievance officer. NHA-A explained that grievances are reviewed as an interdisciplinary team (IDT). NHA-A stated that if the department manager states the grievance was addressed and everything is good, then NHA-A will not complete any further review. Surveyor shared the concern that R109's grievances have no documentation that an investigation was completed, resolution was achieved, and steps taken to prevent further occurrences. Surveyor also shared that R109 was not notified of any resolution.No additional information was provided.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to protect the resident's right to be free from neglect, including the failure to provide timely incontinence care by staff, resulted in the deprivation of necessary services, prolonged exposure to urine, compromised dignity, and caused mental anguish and emotional distress for 1 (R105) of 2 residents reviewed. *R105 informed Surveyor that 2 or 3 months ago, an unknown facility Certified Nursing Assistant (CNA), CNA-Q, left R105 in urine-soaked bed linens and incontinence brief. R105 went the entire day shift without incontinence cares despite R105 asking CNA-Q to change and clean R105. R105 tearfully informed Surveyor that this made R105 feel like garbage and useless and R105 felt like R105 had been physically abused. CNA-G informed Surveyor that when CNA-G went into R105's room on second shift that same day, CNA-G noted that R105's bed linens and incontinence brief were soaked with urine. CNA-G helped get R105 clean and dry. R105 informed CNA-G that R105 had not been changed since 3rd shift. CNA-G informed Surveyor that R105 was in tears and upset. CNA-G reported this incident to Assistant Director of Nursing (ADON)-E and Social Worker (SW)-R. ADON-E informed Surveyor that R105 was crying and needed consoling when talking about this allegation of neglect. ADON-E initiated a grievance and gave the grievance to the facility Social Workers (SW). Neither SW-R nor SW-P had documentation of the allegation of neglect. Nursing Home Administrator (NHA)-A informed Surveyor that NHA-A was not aware of this allegation of neglect. This allegation of neglect was known by multiple facility staff members and was not immediately reported to NHA-A.Approximately 2 months after the incident, R105 continued to have persistent mental anguish and emotional distress, vividly describing the incidentand becoming tearful and emotional when being interviewed about the incident. Findings include:The facility policy with a last reviewed date of 2/25/26 and titled, Abuse, Neglect and Exploitation, documents: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The facility will have written procedures to assist staff in identifying the different types of abuse- mental/verbal abuse, sexual abuse, physical abuse, and deprivation by an individual of goods and services. Possible indicators of abuse include, but are not limited to: Resident, staff or family report of abuse.Verbal abuse of a resident overheard, Physical abuse of a resident observed, Psychological abuse of a resident observed, Failure to provide care needs such as comfort, safety, feeding, bathing, dressing, turning and positioning. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. The facility will have written procedures that include: Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes. Taking all necessary actions as a result if the investigation, which may include, but are not limited to, the following: Analyzing the occurrence (s) to determine why abuse, neglect, misappropriation of resident property or exploitation occurred, and what changes are needed to prevent further occurrences. Defining how care provision will be changed and/or improved to protect residents receiving services. Training of staff. Identification of staff responsible (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	for implementation of corrective actions. The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies.1.) R105 was admitted to the facility on [DATE] with diagnosis that include Polyneuropathy (multiple nerves throughout the body malfunction causing weakness, numbness and burning pain), Type 2 Diabetes, Chronic obstructive pulmonary disease (progressive, long-term lung condition that damages airways making it difficult to breathe), Heart failure, and Osteoarthritis (degenerative joint disease that causes pain, stiffness and joint damage). R105's Annual Minimum Data Set (MDS) assessment dated [DATE] documents R105 can express ideas and wants and is able to understand others. The MDS documents: R105 is cognitively intact; R105 does not exhibit physical or verbal behaviors directed towards others; R105 requires substantial/maximal assistance for toileting hygiene, bathing, and transfers; R105 is frequently incontinent of urine. R105's bladder incontinence care plan initiated on 8/21/25 documents the following intervention: Clean peri-area with each incontinence episode.Surveyor reviewed R105's comprehensive care plan and noted there is no mood or psychosocial concerns. Surveyor noted R105 does have a care plan related to resisting cares (like weights, activities of daily living cares, therapy) but no other behavior concerns are care planned. On 4/14/26 at 9:58 AM, Surveyor interviewed R105. R105 explained an incident that occurred at the facility with an unknown CNA, CNA-Q. R105 stated that it happened about 2 or 3 months ago and thinks it was January or February. R105 stated that R105 could not remember the name of CNA-Q and described CNA-Q as African American, small and shorter. R105 stated that R105 had overslept and was jostled awake by CNA-Q. R105 groaned and was groggy. R105 stated that CNA-Q told R105 that R105 had an attitude and that R105 was rude. R105 stated that CNA-Q had a chip on her shoulder and was in a bad mood. R105 stated that CNA-Q left R105's room. R105 informed Surveyor that R105 wears an incontinence brief and first-shift staff typically change R105's brief after breakfast, and around 1:30 -2 PM. R105 stated that CNA-Q did not change R105's incontinence brief after breakfast. R105 stated that CNA-Q did return to R105's room at lunch time. R105 stated that R105 told CNA-Q that R105 really needed to be changed. CNA-Q did not respond to R105. R105 stated that CNA-Q threw R105's lunch tray down on the bedside table and did not speak to R105. R105 stated that R105 begged CNA-Q to be changed. R105 stated that CNA-Q did not say a word and walked out of R105's room. R105 remembers falling asleep for a little bit after lunch. R105 stated that it was around 2:30 in the afternoon and R105 was upset that R105 had not been changed all day. R105 stated that R105 felt like garbage and felt useless. R105 got tearful with Surveyor and stated that the whole situation made R105 feel awful. R105 stated that R105 was cold because R105's incontinence brief and bed sheets were soaked with urine. R105 stated that R105 was wet and dirty and itchy where a lady shouldn't be itchy. R105 indicated that R105 tries to be a lady but that day R105 couldn't be a lady. R105 stated when second shift started, CNA-G came to R105's room. CNA-G looked at R105 and asked, what happened to you? R105 explained the events of the day. R105 stated that CNA-G stripped R105's bed, cleaned the mattress and remade the bed. CNA-G gave R105 a full bed bath and changed R105's incontinence brief for the first time that day after 3 pm. R105 stated CNA-G got R105 all clean and comfortable again. R105 stated, God bless CNA-G. R105 stated that CNA-G went to Assistant Director of Nursing (ADON)-E to inform ADON-E of the situation. R105 stated that one or two days later, Social Worker (SW)-R came to talk to R105 about the incident. R105 stated that R105 told both ADON-E and SW-R of the whole situation. R105 stated that after that, R105 never saw CNA-Q again.As Surveyor was leaving R105's room, R105 stated that R105 can understand someone having a bad day, but R105 stated I was physically abused. Severely abused.Surveyor noted that according to the definition of neglect documented in the facility abuse policy, neglect is the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Surveyor noted R105 described an allegation of neglect to Surveyor.Surveyor noted R105 informed CNA-G, ADON-E and SW-R of the allegation of neglect.Surveyor reviewed R105's (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	progress notes for documentation of the incident. No progress notes were found.On 4/13/26, Surveyor asked Nursing Home Administrator (NHA)-A for all facility self-reports from January 2026 to present. Surveyor reviewed the self-reports and noted the facility did not have a self-report regarding R105 and CNA-Q.On 4/14/26, Surveyor reviewed the grievance log from January 2026 to present. Surveyor noted the facility did not have a grievance filed regarding R105 and CNA-Q.On 4/14/26 at 12:19 PM, Surveyor interviewed CNA-G. Surveyor asked if CNA-G recalled an incident regarding R105 and the fact that R105 was not changed for an entire shift. CNA-G stated that CNA-G remembered the day. CNA-G stated that while getting shift-to-shift report from CNA-Q, CNA-Q told CNA-G that when CNA-Q went into R105's room, R105 kept asking to be changed. CNA-Q would tell R105 that CNA-Q would be back and did not go back to the room. CNA-G indicated that CNA-G wanted to go to R105's room to help R105. CNA-G stated that R105 told CNA-G about what had happened. CNA-G stated that R105 was in tears. CNA-G stated that R105's incontinence brief and bed were wet with urine. CNA-G stated that CNA-G got R105 all clean and dry. CNA-G stated that ADON-E and SW-R were made aware of the incident. CNA-G stated that SW-R went to speak with R105, but CNA-G does not know what happened after that. Surveyor asked for the name of CNA-Q. CNA-G stated that CNA-G does not know who CNA-Q was and can't remember what CNA-Q looked like. Surveyor asked when this incident occurred. CNA-G stated that it happened in January or February but could not remember the exact date.Surveyor noted that CNA-G described an allegation of neglect that had R105 in tears. Surveyor noted that CNA-G indicated that ADON-E and SW-R were made aware of the allegation of neglect.On 4/14/26 at 11:45 AM, Surveyor interviewed ADON-E. Surveyor asked if ADON-E recalled an incident where R105 reported that R105 did not have R105's incontinence brief changed for an entire shift. ADON-E indicated yes. ADON-E stated R105 needed R105's incontinence brief changed. A CNA came into R105's room and never went back to help R105. ADON-E stated that this happened about 3-4 months ago. ADON-E stated that a grievance was filled out and given to the Social Workers. Surveyor asked if R105 informed ADON-E how R105 felt. ADON-E stated that ADON-E remembers that R105 was crying. ADON-E had to hug and console R105. ADON-E stated that the accused CNA (CNA-Q) does not work at the facility anymore but did not give Surveyor the name of the former employee.Surveyor noted ADON-E described an allegation of neglect that had R105 in tears. Surveyor noted that ADON-E stated that ADON-E gave a grievance to the facility Social Workers (SW-R or SW-P).On 4/14/26 at 12:03 PM, Surveyor interviewed SW-R. SW-R informed Surveyor that there are 2 facility Social Workers, SW-R and SW-P. Surveyor asked if SW-R could speak about the incident that occurred with R105 and a facility CNA and an allegation that the CNA did not change R105's incontinence brief for an entire shift. SW-R stated that R105 has a lot of things going on. SW-R stated that nothing was jumping in SW-R's head. SW-R stated, let me look and SW-R will get back to Surveyor. At 12:57 PM, SW-R returned to Surveyor. SW-R stated SW-R looked through the records and did not find anything for the last 3 months regarding R105. SW-R stated again that SW-R does not remember anything. Surveyor asked what SW-R would do if a resident tearfully reported to SW-R of a time that staff refused to change an incontinence brief. SW-R stated that SW-R would consider that a reportable event and tell NHA-A. SW-R stated that SW-R looked though grievances and did not find a grievance related to R105 in the last months. Surveyor informed SW-R that SW-R was mentioned by R105 and 2 other facility staff members as having knowledge of R105's concern. SW-R stated that SW-R does not remember anything and stated it was a long time ago.On 4/14/26 at 1:30 PM, Surveyor interviewed SW-P. Surveyor asked if SW-P had received a grievance or report about R105 and a concern that R105 did not have R105's brief change for an entire shift. SW-P indicated that SW-P was not notified of that and did not get a report about an incident like that.Surveyor noted that SW-R and SW-P reported to Surveyor that they were not aware of R105's concern and there was no grievance for R105's neglect allegation.On 4/13/26 at 4:56 PM, Surveyor interviewed Medication Technician (MT)-F. Surveyor asked what MT-F would do if a resident reported a concern (like not being changed or being rough) about a different facility CNA. MT-F stated that MT-F would inform the Unit nurse and Unit manager (continued on next page)

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	525523	A. Building B. Wing	04/14/2026

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F 0600 Level of Harm - Actual harm Residents Affected - Few	right away. MT-F stated MT-F would have to report that. MT-F stated that MT-F would not sleep at night if MT-F did not report that.On 4/14/26 at 9:14 AM, Surveyor interviewed CNA-X. Surveyor asked what CNA-X would do if a resident reported a concern (like not being changed or being rough) about a different facility CNA. CNA-X stated that CNA-X would tell the unit nurse and a supervisor. On 4/14/26 at 11:01 AM, Surveyor interviewed CNA-H. Surveyor asked what CNA-H would do if a resident reported a concern (like not being changed or being rough) about a different facility CNA. CNA-H stated that CNA-H would report it to NHA-A immediately.Surveyor noted one out of the 3 facility staff interviewed stated that they would report an allegation of possible abuse or neglect to NHA-A. On 4/14/26 at 2:28 PM, Surveyor interviewed NHA-A. Surveyor asked what the expectation is for facility staff if an allegation of abuse or neglect is made by a resident against a CNA or other staff member. NHA-A stated that staff should call NHA-A. NHA-A has NHA-A's phone number posted all over the facility, so staff have access to get a hold of NHA-A for concerns like that. NHA-A stated NHA-A should be notified so an investigation can start. Surveyor asked if a resident reported that a CNA refused to change the resident's incontinence pad for an entire shift, would NHA-A consider that an allegation of abuse or neglect. NHA-A stated yes. Surveyor reviewed R105's allegation of neglect with NHA-A. Surveyor asked if NHA-A was aware of this allegation. NHA-A first stated I don't believe that I have heard of this. NHA-A then stated, I have not heard this. Surveyor shared the following concerns with NHA-A: R105 informed Surveyor that about 2 to 3 months ago (during January or February), an unknown CNA, CNA-Q, told R105 that R105 had an attitude and was rude. After that interaction in the morning, CNA-Q would not help R105 with all R105's needs for the rest of CNA-Q's shift. CNA-Q delivered R105's lunch and R105 asked to be changed. CNA-Q ignored R105's request. R105 went the entire shift with out any incontinence cares from CNA-Q. R105 informed Surveyor that this made R105 feel like garbage and useless. R105 got tearful with Surveyor while talking about this and stated that the whole situation made R105 feel awful. R105 informed Surveyor that R105 was cold because R105's incontinence pad and bed sheets were soaked with urine. R105 stated that R105 was wet, dirty and itchy where a lady shouldn't be itchy. CNA-G came to work on 2nd shift that day. CNA-G informed Surveyor that R105 was tearful and upset about the events of the day. CNA-G indicated that R105's bed sheets and incontinence brief were soaked with urine and CNA-G got R105 clean and dry as soon as CNA-G started work. CNA-G and R105 informed Surveyor that ADON-E and SW-R were made aware of the situation. ADON-E confirmed to Surveyor that R105 did communicate that R105 was not changed for an entire shift and was tearful during the interaction and needed consoling. ADON-E stated a grievance was initiated and given to facility social workers. SW-R stated that SW-R did not remember and did not have documentation of the incident. SW-P told Surveyor that SW-P was not informed of this incident.Surveyor noted that the facility failed to protect the resident from abuse and neglect by not intervening to stop the deprivation of care, not ensuring timely incontinence care, and not implementing measures to prevent recurrence, resulting in ongoing risk for physical harm, compromised dignity, and psychosocial harm fpr R105.On 4/14/26 at 3:17 PM, NHA-A, Director of Nursing (DON)-B, Director of Operations-C and Nurse Consultant-D were made aware of the above concerns. Surveyor asked if there were any questions. DON-B did not ask a question. Surveyor stated that if there is any additional information to please let Surveyor know. DON-B did not offer any verbal additional information about the above concern.On 4/16/26 at 12:24 PM, Surveyor received additional information from the facility. The additional information summary documented, in part: We would like to provide evidence to show that [R105] has a pre-existing condition that needs to be considered when determining if this single event caused [R105] harm. Grievance regarding the situation with [R105] was found. We have a timestamped email of when the grievance was scanned in, indicating that there was a grievance written at the time of the event. See attachment 1. Statement from [CNA-G] indicating she was the one who provided cares on 2nd shift and that other than being happy to see [CNA-G], [R105] displayed no other emotions. See attachment 2Statement from [DON-B]. See attachment 3Statement from [ADON-E]. See attachment 4[R105] was seen by psychiatry on (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	12/30/25 and [R105] appeared with irritable affect, variable eye contact, defensive statements, somatic complaints, and partially cooperative behavior [R105] also endorsed depression in this visit. See attachment 5[R105] was then seen by psychiatry on 1/30/2026 shortly after the grievance. At that visit, [R105] denied symptoms of anxiety, feels her sleep is adequate, and complains about food choices but appetite is overall adequate. Regarding depression [R105] stated not anymore. See attachment 6. [R105] had a medical appointment outside the facility on 1/20/26, the day after the grievance, attached note indicated that [R105] was pleasant and had no complaints. See attachment 7. [Nurse consultant-D] interviewed [R105] on 4/15/26. [Nurse consultant-D] had not had any previous interactions with [R105]. See attachment 8. PHQ-9 assessments from before and after the event improved mood. See attachment 9.1. Surveyor reviewed the grievance form dated 1/20/26 and completed by SW-R, which documents, in part: Resident name: [R105]. Person making complaint and relationship to resident: Self. Detail of complaint/grievance: [CNA-Q] was asked by [R105] to be changed following breakfast on 1/19/26. [CNA-Q] picked up tray and [R105] asked to use commode and be changed. [CNA-Q] said I'll get to you soon. [R105] stated she then put light on after 1pm as [R105] was never changed or used commode. Another CNA came in to answer light and stated [they] would get [CNA-Q]. [R105] shared [CNA-Q] turned light off. [R105] put light on, and 2nd shift, [CNA-G] answered light [at] 2:40 pm. [CNA-G] asked [R105] if [R105] was changed 1st shift and [R105] stated no. [R105] shared [CNA-Q] has been rude from start with [R105]. [R105] praised [CNA-G] as an excellent CNA. [CNA-G] changed sheets, assisted to commode and changed [R105's] clothing and cleaned up. [R105] asked that [CNA-Q] not provide cares on [R105] moving forward. What shift did the complaint/grievance occur: 6-2. Person investigating complaint/grievance: BLANK. Grievance official follow-up: BLANK. Grievance official's signature: BLANK. Date Resolved: BLANK. Documented: BLANK.Surveyor noted that this grievance was not listed on the facility grievance log requested by Surveyor on 4/13/26 at the start of Survey. Surveyor noted that this grievance form was not the same as the other resident grievance forms given to Surveyors during the Survey process. Surveyor noted that this is a handwritten grievance form as opposed to an electronic form that was given to Surveyors during the Survey process. Surveyor noted that SW-R filled out the grievance form on 1/20/26 but did not recall the grievance and was unable to provide the grievance to Surveyor when requested on Survey. Surveyor noted the grievance was not documented as investigated. Surveyor noted that there was no follow up to the grievance. Surveyor noted that there was no resolution to the grievance.Surveyor noted that R105's grievance documented that R105 asked multiple times during CNA-Q's shift to be changed and toileted, CNA-Q was aware and did not help R105 with R105's needs. Surveyor noted that according to the grievance, R105 needed R105's sheets and clothing changed, and needed to be cleaned up. Surveyor noted that R105's basic needs were refused by CNA-Q.Surveyor noted that the refusal to provide requested toileting and hygiene assistance constituted neglect and abuse, as it involved the willful deprivation of services necessary to maintain the resident's physical health, personal hygiene, dignity, and psychosocial well-being. 2. [NHA-A] phone conversation with [CNA-G] dated 4/15/26 at 12:53PM documents: Before when [Surveyor] asked me, I couldn't think of who it was, and then I thought about it more and it was [first name of CNA-Q] I think it was in January or February, I'm not sure. [CNA-Q] came up to me when I got there and said that [R105] wanted to get on the commode. So, I went in to go and help [R105] and [R105] said that every time [CNA-Q] went in there, [CNA-Q] would say [CNA-Q] was busy or would make an excuse and say [CNA-Q] would come back. So, [CNA-Q] procrastinated until the start of my shift. I went and told [SW-R] about it. [SW-R] said that [SW-R] would go and talk to [R105]. I told [SW-R] to wait a little bit because I wanted to clean [R105] up. When I got [R105] on the commode, [R105] had urine in [R105's] brief but didn't have a bowel movement on the commode. [R105] wasn't distraught, [R105] wasn't crying, [R105] was just happy to see me.Surveyor noted that this interview happened after the Survey process had concluded. Surveyor noted that CNA-G confirmed that CNA-Q was aware of R105's need for toileting and CNA-Q did not meet R105's basic (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	needs. Surveyor noted that CNA-G stated again in this statement, that CNA-G informed SW-R the same day. Surveyor noted SW-R was told of this incident on 1/19/26 and did not visit with R105 until the next day on 1/20/26 when SW-R filled out the grievance. Surveyor noted that CNA-G informed Surveyor on 4/14/26 that R105 was in tears but when CNA-G spoke to NHA-A on 4/15/26 CNA-G stated that R105 was not distraught or crying.3. Director of Nursing (DON)-B statement dated 4/16/26 documents: [CNA-Q] came to me on 1/19/26 to say that [R105] was refusing to be toileted when [R105] offered. DON-B went towards the room. [DON-B] heard [CNA-Q] offering to toilet [R105], but then [R105] declined at that time. [CNA-Q] came to get me sometimes when [CNA-Q] was going to go into [R105]'s room so I could hear. Each time [CNA-Q] offered when I was there, [R105] declined. This happened a few times throughout the day. I never heard [R105] ask to be taken to the commode or changed when I was outside the room. One of the times [CNA-Q] asked, [R105] said ?I do not feel like getting up right now'.Surveyor reviewed R105's progress notes from January to 4/14/26, Surveyor noted that R4 did refuse medications at times. Surveyor did not locate documentation from mid-January to mid-February documenting refusals of toileting or bathing in the progress notes. Surveyor noted with the additional information, facility did not provide documentation of refusals of toileting. Surveyor noted DON-B did not communicate these incidents of listening outside the room when speaking to NHA-A, DON-B, Director of Operations-C or Nurse Consultant-D during the exit meeting on 4/14/26. Surveyor noted that according to R105's grievance form, R105 did not tell CNA-G, or SW-R that R105 declined help from CNA-Q. Surveyor noted that during an interview with CNA-G on 4/14/26, CNA-G stated that while getting shift-to-shift report from CNA-Q, CNA-Q told CNA-G that when CNA-Q went in to R105's room, R105 kept asking to be changed. CNA-Q would tell R105 that CNA-Q would be back and CNA-Q did not go back to the room. 4. [ADON-E]. Statement taken by [NHA-A] on 4/16/26 regarding event in January. I don't remember what day it specifically was but I think that [R105] requested to see me. I think the event happened the day before. [R105] was upset that the day before [R105 didn't have to go to the bathroom when toileting was offered. When [R105] did request to go, [CNA-Q] said that [CNA-Q] didn't have time then, that [CNA-Q] would come back. Then [CNA-Q] never came back. [R105] said that the next shift changed [R105].Surveyor noted that ADON-E informed Surveyor on 4/14/26 at 11:45 AM, that R105 needed R105's incontinence brief changed. A CNA came into R105's room and never went back to help R105. ADON-E stated that ADON-E remembers that R105 was crying. ADON-E had to hug and console R105. Surveyor noted that during this interview with ADON-E, 2 days prior to this statement, ADON-E did not include that toileting was offered but only stated that R105 needed to be toileted, A CNA came into R105's room and never went back to help R105.5 and 6: R105's initial psychiatry evaluation dated 12/30/25 documents, in part: .[R105 is seen by writer for depression and [R105] does not take psychotropic medication. [R105] appears with irritable affect, variable eye contact, defensive statements, somatic complaints, and partially cooperative behavior. [R105 endorses frequent nausea for the last week, denies emesis, but is refusing meals and medication due to nausea. [R105] describes [R105's] sleep as off and on. [R105] endorses depression and states, yeah that's why they called you to see me because look, this place is a trash pit. [R105] is referring to [R105's] belongings in the room. [R105] moved to SNF about 4 weeks ago, per [R105] and is still settling in. [R105] refuses antidepressant therapy due to nausea but is open to starting sertraline in the future. Staff report irritability, but no other concerns about mood, behavior or cognition. Assessment/plan: Major depressive disorder, recurrent, mild.Stable, primarily depressed about living situation, elements of childhood abuse as well. We discussed starting [medication] will wait until nausea resolves .Surveyor noted that R105 was assessed to have mild depression- primarily depressed about living situation after a recent move to the facility 4 weeks prior. Medication was recommended to be started.R105's Follow up Psychiatric evaluation dated 1/30/26 documents, in part: . [R105] appears with irritable affect, obese but well-groomed, with good eye contact and has a variety of complaints about current living situation. Regarding depression [R105] states, not anymore. Assessment/plan: Major depressive disorder, (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	recurrent, mild. [R105] is very irritable today. We discussed starting [medication], [R105] refused, continue to suggest in future.Surveyor noted the follow up visit documented that R105 was very irritable and starting medication was recommended and discussed but ultimately refused by R105. Surveyor noted that both psychiatry visits listed that the plan was to start medication indicating that at both times, the doctor thought it was necessary, but R105 refused.Surveyor reviewed R105's comprehensive care plan with revisions and noted that R105 did not have a care plan regarding depression, mood or psychosocial concerns at any point while being admitted at the facility during this admission.7. R105's Hematology and Oncology visit note dated 1/20/26 documents, in part: [R105] is a pleasant [patient] here today for follow-up. On presentation today [R105] reports felling generally well, under the circumstances. [R105] continues to struggle with a number of chronic health problems.Surveyor noted that the facility provided Surveyor with only the first page of the Hematology visit note. Surveyor noted that facility stated that R105 did not have any complaints, but the note provided to Surveyor did not document that statement.8. Interview with [R105] completed by Nurse consultant-D, dated 4/15/26. During the conversation [R105] was tangential and laughing. Talking about the wasp that was flying outside [R105's] window. Talking about [R105's] sons and father and the mementos [R105 keeps in [R105] little box on the windowsill. [R105] was alert and very interactive and very upbeat. [R105 denied having any issues since that unspecified day. [R105] was hard to keep on track. I had a hard time ending the interview because [R105] was so talkative and had lots to talk about. Disappointed [R105] cannot return to the assisted living. Talking about [R105's] upcoming surgery. Summary of [R105's] statement. I think it was maybe a couple months ago, but I don't remember exactly. It was during the day. I don't remember the CNAs name, but she was black, short, maybe 5'3 and had [their] hair pinned up. [CNA-Q] came in that morning. I overslept. [CNA-Q] startled me when [CNA-Q] woke me up and I mumbled something at [CNA-Q]. [CNA-Q] told me not to be so rude. [CNA-Q] came back for my breakfast tray, and I said I usually use commode after breakfast, [CNA-Q] told me [CNA-Q] would be back. [CNA-Q] came back around lunch time with my lunch tray. I asked [CNA-Q] when I could be changed. [CNA-Q] stated when I was done with lunch. Then [CNA-Q] never came back. I turned on my call light maybe around 1:30. Then [CNA-G] came in when [CNA-G] shift started and I was happy to see [CNA-G] I really like [CNA-G]. You know I like [ADON-E] a lot too. They are no nonsense. [CNA-G] cleaned me up. I didn't want [CNA-Q] fired. I just wanted her to be re-instructed. [R105] stated [R105] did talk to [ADON-E] and [SW-R]. [R105 was asked if anyone else came into the room during the day. [R105] said probably the med tech or nurse, but [R105] couldn't remember.Surveyor noted that again R105 described letting CNA-Q know multiple times for help toileting and CNA-Q did not help R105 with R105's basic needs.9. R105's PHQ9 (a resident mood interview assessment) dated 10/31/25 documents a score of 2 indicating minimal or no depression.R105's PHQ9 dated 1/30/26 documents a score of 1 indicating minimal or no depression.Surveyor reviewed all additional information. Surveyor noted that R105 described to Surveyor on 4/14/26 an allegation of neglect. R105 described how that allegation made R105 feel. R105 was tearfully explaining that R105 felt like garbage, useless and felt like R105 had been abused. CNA-G stated to Surveyor that R105 was in tears after the allegation of neglect occurred. ADON-E stated to Surveyor that R105 was crying when talking to ADON-E about the alleged neglect. ADON-E had to hug and console R105. Surveyor noted that after a grievance was filed, there was no follow-up, investigation or resolution. Surveyor determined that the facility's failure to investigate, resolve, and implement corrective actions allowed the effects of the abuse and neglect to remain unaddressed and place

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that all alleged violations involving abuse or neglect were reported to the Administrator and the State Agency within the required reporting timeframe for 2 (R105 and R108) of 2 residents reviewed with an allegation of abuse. *R105 informed Surveyor that 2 or 3 months ago, an unknown facility Certified Nursing Assistant (CNA), CNA-Q, left R105 in urine-soaked bed linens and incontinence brief. R105 went the entire day shift without incontinence cares despite R105 asking CNA-Q to change and clean R105. R105 tearfully informed Surveyor that this made R105 feel like garbage and useless and R105 felt like R105 had been physically abused. CNA-G informed Surveyor that when CNA-G went into R105's room on second shift that same day, CNA-G noted that R105's bed linens and incontinence brief were soaked with urine. CNA-G helped get R105 clean and dry. R105 informed CNA-G that R105 had not been changed since 3rd shift. CNA-G informed Surveyor that R105 was in tears and upset. CNA-G reported this incident to Assistant Director of Nursing (ADON)-E and Social Worker (SW)-R. ADON-E informed Surveyor that R105 was crying and needed consoling when talking about this allegation of neglect. ADON-E initiated a grievance and gave the grievance to the facility Social Workers (SW). Neither SW-R nor SW-P had documentation of the allegation of neglect. Nursing Home Administrator (NHA)-A informed Surveyor that NHA-A was not aware of this allegation of neglect. This allegation of neglect was known by multiple facility staff members and was not immediately reported to NHA-A and was not reported to the State Agency. *R108 reported to Surveyor an allegation of abuse that was not immediately reported to Nursing Home Administrator (NHA)-A and was not reported to the State Agency. Findings include: The facility policy with a last reviewed date of 2/25/26 and titled, Abuse, Neglect and Exploitation, documents: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The facility will have written procedures to assist staff in identifying the different types of abuse- mental/verbal abuse, sexual abuse, physical abuse, and deprivation by an individual of goods and services. Possible indicators of abuse include, but are not limited to: Resident, staff or family report of abuse.Verbal abuse of a resident overheard, Physical abuse of a resident observed, Psychological abuse of a resident observed, Failure to provide care needs such as comfort, safety, feeding, bathing, dressing, turning and positioning. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. The facility will have written procedures that include: Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when (continued on next page)

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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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	applicable) within specified timeframes. Taking all necessary actions as a result if the investigation, which may include, but are not limited to, the following: Analyzing the occurrence (s) to determine why abuse, neglect, misappropriation of resident property or exploitation occurred, and what changes are needed to prevent further occurrences. Defining how care provision will be changed and/or improved to protect residents receiving services. Training of staff. Identification of staff responsible for implementation of corrective actions. The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies. 1.) R105 was admitted to the facility on [DATE] with diagnosis that include Polyneuropathy (multiple nerves throughout the body malfunction causing weakness, numbness and burning pain), Type 2 Diabetes, Chronic obstructive pulmonary disease (progressive, long-term lung condition that damages airways making it difficult to breathe), Heart failure, and Osteoarthritis (degenerative joint disease that causes pain, stiffness and joint damage). R105's Annual Minimum Data Set (MDS) assessment dated [DATE] documents R105 can express ideas and wants and is able to understand others. The MDS documents: R105 is cognitively intact; R105 does not exhibit physical or verbal behaviors directed towards others; R105 requires substantial/maximal assistance for toileting hygiene, bathing, and transfers; R105 is frequently incontinent of urine. R105's bladder incontinence care plan initiated on 8/21/25 documents the following intervention: Clean peri-area with each incontinence episode. Surveyor reviewed R105's comprehensive care plan and noted there is no mood or psychosocial concerns. Surveyor noted R105 does have a care plan related to resisting cares (like weights, activities of daily living cares, therapy) but no other behavior concerns are care planned. On 4/14/26 at 9:58 AM, Surveyor interviewed R105. R105 explained an incident that occurred at the facility with an unknown CNA, CNA-Q. R105 stated that it happened about 2 or 3 months ago and thinks it was January or February. R105 stated that R105 could not remember the name of CNA-Q and described CNA-Q as African American, small and shorter. R105 stated that R105 had overslept and was jostled awake by CNA-Q. R105 groaned and was groggy. R105 stated that CNA-Q told R105 that R105 had an attitude and that R105 was rude. R105 stated that CNA-Q had a chip on her shoulder and was in a bad mood. R105 stated that CNA-Q left R105's room. R105 informed Surveyor that R105 wears an incontinence brief and first-shift staff typically change R105's brief after breakfast, and around 1:30 -2 PM. R105 stated that CNA-Q did not change R105's incontinence brief after breakfast. R105 stated that CNA-Q did return to R105's room at lunch time. R105 stated that R105 told CNA-Q that R105 really needed to be changed. CNA-Q did not respond to R105. R105 stated that CNA-Q threw R105's lunch tray down on the bedside table and did not speak to R105. R105 stated that R105 begged CNA-Q to be changed. R105 stated that CNA-Q did not say a word and walked out of R105's room. R105 remembers falling asleep for a little bit after lunch. R105 stated that it was around 2:30 in the afternoon and R105 was upset that R105 had not been changed all day. R105 stated that R105 felt like garbage and felt useless. R105 got tearful with Surveyor and stated that the whole situation made R105 feel awful. R105 stated that R105 was cold because R105's incontinence brief and bed sheets were soaked with urine. R105 stated that R105 was wet and dirty and itchy where a lady shouldn't be itchy. R105 indicated that R105 tries to be a lady but that day R105 couldn't be a lady. R105 stated when second shift started, CNA-G came to R105's room. CNA-G looked at R105 and asked, what happened to you? R105 explained the events of the day. R105 stated that CNA-G stripped R105's bed, (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5 and 6: R105's initial psychiatry evaluation dated 12/30/25 documents, in part: .[R105 is seen by writer for depression and [R105] does not take psychotropic medication. [R105] appears with irritable affect, variable eye contact, defensive statements, somatic complaints, and partially cooperative behavior. [R105 endorses frequent nausea for the last week, denies emesis, but is refusing meals and medication due to nausea. [R105] describes [R105's] sleep as off and on. [R105] endorses depression and states, yeah that's why they called you to see me because look, this place is a trash pit. [R105] is referring to [R105's] belongings in the room. [R105] moved to SNF about 4 weeks ago, per [R105] and is still settling in. [R105] refuses antidepressant therapy due to nausea but is open to starting sertraline in the future. Staff report irritability, but no other concerns about mood, behavior or cognition. Assessment/plan: Major depressive disorder, recurrent, mild.Stable, primarily depressed about living situation, elements of childhood abuse as well. We discussed starting [medication] will wait until nausea resolves . Surveyor noted that R105 was assessed to have mild depression- primarily depressed about living situation after a recent move to the facility 4 weeks prior. Medication was recommended to be started. R105's Follow up Psychiatric evaluation dated 1/30/26 documents, in part: . [R105] appears with irritable affect, obese but well-groomed, with good eye contact and has a variety of complaints about current living situation. Regarding depression [R105] states, not anymore. Assessment/plan: Major depressive disorder, recurrent, mild. [R105] is very irritable today. We discussed starting [medication], [R105] refused, continue to suggest in future. Surveyor noted the follow up visit documented that R105 was very irritable and starting medication was recommended and discussed but ultimately refused by R105. Surveyor noted that both psychiatry visits listed that the plan was to start medication indicating that at both times, the doctor thought it was necessary, but R105 refused. Surveyor reviewed R105's comprehensive care plan with revisions and noted that R105 did not have a care plan regarding depression, mood or psychosocial concerns at any point while being admitted at the facility during this admission. 7. R105's Hematology and Oncology visit note dated 1/20/26 documents, in part: [R105] is a pleasant [patient] here today for follow-up. On presentation today [R105] reports felling generally well, under the circumstances. [R105] continues to struggle with a number of chronic health problems. Surveyor noted that the facility provided Surveyor with only the first page of the Hematology visit note. Surveyor noted that facility stated that R105 did not have any complaints, but the note provided to Surveyor did not document that statement. 8. Interview with [R105] completed by Nurse consultant-D, dated 4/15/26. During the conversation [R105] was tangential and laughing. Talking about the wasp that was flying outside [R105's] window. Talking about [R105's] sons and father and the mementos [R105 keeps in [R105] little box on the windowsill. [R105] was alert and very interactive and very upbeat. [R105 denied having any issues since that unspecified day. [R105] was hard to keep on track. I had a hard time ending the interview because [R105] was so talkative and had lots to talk about. Disappointed [R105] cannot return to the assisted living. Talking about [R105's] upcoming surgery. Summary of [R105's] statement. I think it was maybe a couple months ago, but I don't remember exactly. It was during the day. I don't remember the CNAs name, but she was black, short, maybe 5'3 and had [their] hair pinned (continued on next page)

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	525523	A. Building B. Wing	04/14/2026

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	up. [CNA-Q] came in that morning. I overslept. [CNA-Q] startled me when [CNA-Q] woke me up and I mumbled something at [CNA-Q]. [CNA-Q] told me not to be so rude. [CNA-Q] came back for my breakfast tray, and I said I usually use commode after breakfast, [CNA-Q] told me [CNA-Q] would be back. [CNA-Q] came back around lunch time with my lunch tray. I asked [CNA-Q] when I could be changed. [CNA-Q] stated when I was done with lunch. Then [CNA-Q] never came back. I turned on my call light maybe around 1:30. Then [CNA-G] came in when [CNA-G] shift started and I was happy to see [CNA-G] I really like [CNA-G]. You know I like [ADON-E] a lot too. They are no nonsense. [CNA-G] cleaned me up. I didn't want [CNA-Q] fired. I just wanted her to be re-instructed. [R105] stated [R105] did talk to [ADON-E] and [SW-R]. [R105 was asked if anyone else came into the room during the day. [R105] said probably the med tech or nurse, but [R105] couldn't remember. Surveyor noted that again R105 described letting CNA-Q know multiple times for help toileting and CNA-Q did not help R105 with R105's basic needs. 9. R105's PHQ9 (a resident mood interview assessment) dated 10/31/25 documents a score of 2 indicating minimal or no depression. R105's PHQ9 dated 1/30/26 documents a score of 1 indicating minimal or no depression. Surveyor reviewed all additional information. Surveyor noted that R105 described to Surveyor on 4/14/26 an allegation of neglect. R105 described how that allegation made R105 feel. R105 was tearful

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility did not ensure all allegations of abuse or neglect were thoroughly investigated for 2 (R105 and R108) of 2 residents reviewed for an allegation of abuse. *R105 informed Surveyor of an allegation of neglect. R105 told Surveyor that after the incident occurred, R105 spoke to Certified Nursing Assistant (CNA)-G, Assistant Director of Nursing (ADON)-E and Social Worker (SW)-R of the allegation of neglect. This allegation was not immediately reported to Nursing Home Administrator (NHA)-A and an investigation into the allegation of neglect was not completed. *R108 reported to Surveyor an allegation of abuse that was not thoroughly investigated by facility staff. Findings include: The facility policy with a last reviewed date of 2/25/26 and titled, Abuse, Neglect and Exploitation, documents: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The facility will have written procedures to assist staff in identifying the different types of abuse- mental/verbal abuse, sexual abuse, physical abuse, and deprivation by an individual of goods and services. Possible indicators of abuse include, but are not limited to: Resident, staff or family report of abuse.Verbal abuse of a resident overheard, Physical abuse of a resident observed, Psychological abuse of a resident observed, Failure to provide care needs such as comfort, safety, feeding, bathing, dressing, turning and positioning. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. Written procedures for investigations include: Identifying staff responsible for the investigation. Investigating different types of alleged violations. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses and others who might have knowledge of the allegations. Focusing the investigation on determining if abuse neglect, exploitation, and/or mistreatment has occurred, the extent, and the cause. Providing complete and thorough documentation of the investigation. The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation Examples include but are not limited to: Responding immediately to protect the alleged victim and integrity of the investigation. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed. Increased supervision of the alleged victim and residents. Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator. Providing emotional support and counseling to the resident during and after the investigation, as needed. 1.) R105 was admitted to the facility on [DATE] with diagnosis that include Polyneuropathy (multiple nerves throughout the body malfunction causing weakness, numbness and burning pain), Type 2 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Diabetes, Chronic obstructive pulmonary disease (progressive, long-term lung condition that damages airways making it difficult to breathe), Heart failure, and Osteoarthritis (degenerative joint disease that causes pain, stiffness and joint damage). R105's Annual Minimum Data Set (MDS) assessment dated [DATE] documents R105 can express ideas and wants and is able to understand others. The MDS documents: R105 is cognitively intact; R105 does not exhibit physical or verbal behaviors directed towards others; R105 requires substantial/maximal assistance for toileting hygiene, bathing, and transfers; R105 is frequently incontinent of urine. R105's bladder incontinence care plan initiated on 8/21/25 documents the following intervention: Clean peri-area with each incontinence episode. Surveyor reviewed R105's comprehensive care plan and noted there is no mood or psychosocial concerns. Surveyor noted that R105 does have a care plan related to resisting cares (like weights, activities of daily living cares, therapy) but no other behavior concerns are care planned. On 4/14/26 at 9:58 AM, Surveyor interviewed R105. R105 explained an incident that occurred at the facility with an unknown CNA (Certified Nursing Assistant), whom was later determined to be CNA-Q. R105 stated that it happened about 2 or 3 months ago and thinks it was January or February 2026. R105 stated that R105 could not remember the name of CNA-Q and described CNA-Q as African American, small and shorter. R105 stated that R105 had overslept and was jostled awake by CNA-Q. R105 groaned and was groggy. R105 stated that CNA-Q told R105 that R105 had an attitude and that R105 was rude. R105 stated that CNA-Q had a chip on her shoulder and was in a bad mood. R105 stated that CNA-Q left R105's room. R105 informed Surveyor that R105 wears an incontinence brief and first-shift staff typically change R105's brief after breakfast, and around 1:30 -2 PM. R105 stated that CNA-Q did not change R105's incontinence brief after breakfast. R105 stated that CNA-Q did return to R105's room at lunch time. R105 stated that R105 told CNA-Q that R105 really needed to be changed. CNA-Q did not respond to R105. R105 stated that CNA-Q threw R105's lunch tray down on the bedside table and did not speak to R105. R105 stated that R105 begged CNA-Q to be changed. R105 stated that CNA-Q did not say a word and walked out of R105's room. R105 remembers falling asleep for a little bit after lunch. R105 stated that it was around 2:30 in the afternoon and R105 was upset that R105 had not been changed all day. R105 stated that R105 felt like garbage and felt useless. R105 got tearful with Surveyor and stated that the whole situation made R105 feel awful. R105 stated that R105 was cold because R105's incontinence brief and bed sheets were soaked with urine. R105 stated that R105 was wet and dirty and itchy where a lady shouldn't be itchy. R105 indicated that R105 tries to be a lady but that day R105 couldn't be a lady. R105 stated when second shift started, CNA-G came to R105's room. CNA-G looked at R105 and asked, what happened to you? R105 explained the events of the day. R105 stated that CNA-G stripped R105's bed, cleaned the mattress and remade the bed. CNA-G gave R105 a full bed bath and changed R105's incontinence brief for the first time that day after 3 pm. R105 stated CNA-G got R105 all clean and comfortable again. R105 stated, God bless CNA-G. R105 stated that CNA-G went to Assistant Director of Nursing (ADON)-E to inform ADON-E of the situation. R105 stated that one or two days later, Social Worker (SW)-R came to talk to R105 about the incident. R105 stated that R105 told both ADON-E and SW-R of the whole situation. R105 stated that after that, R105 never saw CNA-Q again. As Surveyor was leaving R105's room, R105 stated that R105 can understand someone having a bad day, but R105 stated I was physically abused. Severely abused. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor noted that according to the definition of neglect documented in the facility abuse policy, neglect is the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Surveyor noted R105 described an allegation of neglect to Surveyor. Surveyor noted R105 informed CNA-G, ADON-E and SW-R of the allegation of neglect. Surveyor reviewed R105's progress notes for documentation of the incident. No progress notes were found. On 4/13/26, Surveyor asked Nursing Home Administrator (NHA)-A for all facility self-reports from January 2026 to present. Surveyor reviewed the self-reports and noted the facility did not have a self-report regarding R105 and CNA-Q. On 4/14/26, Surveyor reviewed the grievance log from January 2026 to present. Surveyor noted the facility did not have a grievance filed regarding R105 and CNA-Q. On 4/14/26 at 12:19 PM, Surveyor interviewed CNA-G. Surveyor asked if CNA-G recalled an incident regarding R105 and the fact that R105 was not changed for an entire shift. CNA-G stated that CNA-G remembered the day. CNA-G stated that R105 told CNA-G about what had happened. CNA-G stated that R105 was in tears. CNA-G stated that R105's incontinence brief and bed were wet with urine. CNA-G stated that CNA-G got R105 all clean and dry. CNA-G stated that ADON-E and SW-R were made aware of the incident. CNA-G stated that SW-R went to speak with R105, but CNA-G does not know what happened after that. Surveyor noted that CNA-G described an allegation of neglect. Surveyor noted that CNA-G indicated that ADON-E and SW-R were made aware of the allegation of neglect. Surveyor noted that CNA-G did not make NHA-A aware of the allegation of neglect so that a thorough investigation could be completed. On 4/14/26 at 11:45 AM, Surveyor interviewed ADON-E. Surveyor asked if ADON-E recalled an incident where R105 reported that R105 did not have R105's incontinence brief changed for an entire shift. ADON-E indicated yes. ADON-E stated R105 needed R105's incontinence brief changed. A CNA came into R105's room and never went back to help R105. ADON-E stated that the accused CNA (CNA-Q) does not work at the facility anymore but did not give Surveyor the name of the former employee. ADON-E stated that a grievance was filled out and given to the Social Workers. Surveyor noted ADON-E described an allegation of neglect. Surveyor noted that ADON-E stated that ADON-E gave a grievance to the facility Social Workers (SW-R or SW-P). Surveyor noted ADON-E did not make NHA-A aware of the allegation of abuse so that a thorough investigation could be completed. On 4/14/26 at 12:03 PM, Surveyor interviewed SW-R. SW-R informed Surveyor that there are 2 facility Social Workers, SW-R and SW-P. Surveyor asked if SW-R could speak about the incident that occurred with R105 and a facility CNA and an allegation that the CNA did not change R105's incontinence brief for an entire shift. SW-R stated that R105 has a lot of things going on. SW-R stated that nothing was jumping in SW-R's head. SW-R stated, let me look and SW-R will get back to Surveyor. At 12:57 PM, SW-R returned to Surveyor. SW-R stated SW-R looked through the records and did not find anything for the last 3 months regarding R105. SW-R stated again that SW-R does not remember anything. Surveyor asked what SW-R would do if a resident tearfully reported to SW-R of a time that staff (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	refused to change an incontinence brief. SW-R stated that SW-R would consider that a reportable event and tell NHA-A. SW-R stated that SW-R looked though grievances and did not find a grievance related to R105 in the last months. Surveyor informed SW-R that SW-R was mentioned by R105 and 2 other facility staff members as having knowledge of R105's concern. SW-R stated that SW-R does not remember anything and stated it was a long time ago. On 4/14/26 at 1:30 PM, Surveyor interviewed SW-P. Surveyor asked if SW-P had received a grievance or report about R105 and a concern that R105 did not have R105's brief change for an entire shift. SW-P indicated that SW-P was not notified of that and did not get a report about an incident like that. Surveyor noted that SW-R and SW-P reported to Surveyor that they were not aware of R105's concern and there was no grievance for R105's neglect allegation. On 4/14/26 at 9:14 AM, Surveyor interviewed CNA-X. Surveyor asked what CNA-X would do if a resident reported a concern (like not being changed or being rough) about a different facility CNA. CNA-X stated that CNA-X would tell the unit nurse and a supervisor. On 4/14/26 at 11:01 AM, Surveyor interviewed CNA-H. Surveyor asked what CNA-H would do if a resident reported a concerns (like not being changed or being rough) about a different facility CNA. CNA-H stated that CNA-H would report it to NHA-A immediately. On 4/14/26 at 2:28 PM, Surveyor interviewed NHA-A. Surveyor asked what the expectation is for facility staff if an allegation of abuse or neglect is made by a resident against a CNA or other staff member. NHA-A stated that staff should call NHA-A. NHA-A has NHA-A's phone number posted all over the facility, so staff have access to get a hold of NHA-A for concerns like that. NHA-A stated NHA-A should be notified so an investigation can start. Surveyor asked if a resident reported that a CNA refused to change the resident's incontinence pad for an entire shift, would NHA-A consider that an allegation of abuse or neglect. NHA-A stated yes. Surveyor reviewed R105's allegation of neglect with NHA-A. Surveyor asked if NHA-A was aware of this allegation. NHA-A first stated I don't believe that I have heard of this. NHA-A then stated, I have not heard this. Surveyor shared the following concerns with NHA-A: R105 informed Surveyor that R105 reported an allegation of neglect to CNA-G, ADON-E and SW-R. Multiple staff were aware of this allegation and did not inform NHA-A so a thorough investigation could be completed. On 4/16/26 at 12:24 PM, Surveyor received additional information from the facility. The facility was able to locate the grievance form for R105. Surveyor reviewed the grievance form dated 1/20/26 and completed by SW-R, which documents, in part: Resident name: [R105]. Person making complaint and relationship to resident: Self. Detail of complaint/grievance: [CNA-Q] was asked by [R105] to be changed following breakfast on 1/19/26. [CNA-Q] picked up tray and [NAME] asked to use commode and be changed. [CNA-Q] said I'll get to you soon. [R105] stated she then put light on after 1pm as [R105] was never changed or used commode. Another CNA came in to answer light and stated [they] would get [CNA-Q]. [R105] shared [CNA-Q] turned light off. [R105] put light on, and 2nd shift, [CNA-G] answered light [at] 2:40 pm. [CNA-G] asked [R105] if [R105] was changed 1st shift and [R105] stated no. [R105] shared [CNA-Q] has been rude from start with [R105]. [R105] praised [CNA-G] as an excellent CNA. [CNA-G] changed sheets, assisted to commode and changed [R105's] clothing and cleaned up. [R105] asked that [CNA-Q] not provide cares on [R105] moving forward. What shift did the complaint/grievance occur: 6-2. Person investigating complaint/grievance: BLANK. Grievance official (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	follow-up: BLANK. Grievance official's signature: BLANK. Date Resolved: BLANK. Documented: BLANK. Surveyor noted that this grievance was not listed on the facility grievance log requested by Surveyor on 4/13/26 at the start of Survey. Surveyor noted that this grievance form was not the same as the other resident grievance forms given to Surveyors during the Survey process. Surveyor noted that this is a handwritten grievance form as opposed to an electronic form that was given to Surveyors during the Survey process. Surveyor noted that SW-R filled out the grievance form on 1/20/26 but did not recall the grievance and was unable to provide the grievance to Surveyor when requested on Survey. Surveyor noted the grievance was not documented as investigated. Surveyor noted that there was no follow up to the grievance. Surveyor noted that there was no resolution to the grievance. Surveyor noted that R105's grievance documented that R105 asked multiple times during CNA-Q's shift to be changed and toileted, CNA-Q was aware and did not help R105 with R105's needs. Surveyor noted that according to the grievance, R105 needed R105's sheets and clothing changed, and needed to be cleaned up. Surveyor noted that R105's basic needs were refused by CNA-Q. No additional information was provided as to why the facility did not complete a thorough investigation of R105's allegations of potential neglect. 2.) R108 was admitted to the facility on [DATE] with diagnoses of Intracerebral Hemorrhage(life threatening type of stroke caused by ruptured blood vessel bleeding into the brain tissue), Type 2 Diabetes Mellitus(adult onset of trouble controlling blood sugar), Hyperlipidemia(high levels of fat particles in blood), Metabolic Encephalopathy(brain dysfunction resulting from underlying condition that disrupts the metabolic processes), Depression(mood disorder that causes persistent feelings of sadness and loss of interest), Alzheimer's(progressive disease that destroys memory and other important mental functions), and Vascular Dementia(brain damage caused by multiple strokes). R108's Quarterly Minimum Data Set (MDS) completed 3/3/26 documents R108's Brief Interview for Mental Status (BIMS) score to be 12, indicating moderately impaired skills for daily decision making. Surveyor reviewed R108's comprehensive care plan and noted there is no mood, behavior, or psychosocial concerns. On 4/13/26, at 11:47 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-W. CNA-W shared that R108 had reported that R108 was afraid of CNA-V. R108 had communicated that CNA-V was mean and aggressive towards R108. CNA-W shared that CNA-V had thrown a breakfast tray at R108. CNA-W reported that R108 was upset with CNA-T the next day because R108 assumed that CNA-T had reported the incident and was not protecting R108 because CNA-V was still being aggressive towards R108. CNA-W shared that CNA-V approached CNA-T in the dining room and started yelling at CNA-T in regard to the concern. CNA-W also shared that R108 was very upset with CNA-T the next day stating: I reported her to you, you didn't protect me. On 4/13/26, at 1:53 PM, Surveyor interviewed CNA-T. CNA-T explained that on Sunday, March 22,2026, R108 had expressed that CNA-V was very rough with cares and felt abused. R108 also reported to CNA-T that CNA-V threw R108's breakfast tray at her. CNA-T stated that CNA-T reported the allegation to Licensed Practical Nurse (LPN)-U on 3/22/26. CNA-T shared that R108 did not feel safe on that day. On 3/23/26, CNA-T wanted to make sure the allegation was followed up on so CNA-T communicated with Social Worker (SW)-P the allegations of CNA-V being rough with morning (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cares, making R108 get up and throwing the breakfast tray at R108. CNA-T shared to Surveyor that on that date, R108 was very afraid of CNA-V and that R108 is still currently afraid of CNA-V. Surveyor observed CNA-T go directly to SW-P and observed both in conversation. On 4/14/26, at 9:15 AM, Surveyor interviewed R108. R108 confirmed that there was an incident where CNA-V threw the breakfast tray at R108. R108 recalls saying something and then CNA-V stated, then don't eat it. R108 stated it was the tone of CNA-V's voice. CNA-V was not speaking to R108 right, it was in a mean way. R108 states that no one came to talk to R108 about the incident. R108 does not recall having any issues with cares. On 4/14/26, at 9:56 AM, Surveyor interviewed SW-P in regard to R108's allegation. SW-P does recall that CNA-T informed SW-P on March 23,2026 about the incident involving CNA-V and R108. SW-P recalled it was communicated that CNA-V ripped the covers off. SW-P informed Director of Nursing (DON)-B and Nursing Home Administrator (NHA)-A. SW-P also recalls putting in a grievance. SW-P explained after that, SW-P does not get involved in the investigation process. Surveyor asked if SW-P knew about the breakfast tray being thrown at R108. SW-P stated SW-P was not aware of that incident, only that CNA-V had been aggressive with R108. SW-P recalls CNA-T being upset about the incident with CNA-V and R108 as R108 was upset with CNA-T the next day. SW-P did not write out a statement after interviewing R108 about the incident on March 23,2026. SW-P informed Surveyor that SW-P learned about the incident of the breakfast tray being thrown at R108 after discussing with CNA-T the conversation CNA-T had with Surveyor yesterday. SW-P informed Surveyor that SW-P did not report the incident of the tray being thrown at R108 to either NHA-A or DON-B. SW-P stated SW-P would normally report something like that but did not because there was a lot going on and there was no morning meeting. On 4/14/26, at 11:49 AM, Surveyor spoke with NHA (Nursing Home Administrator)-A. NHA-A confirmed that NHA-A is the grievance officer and handles the investigations of abuse and neglect. NHA-A will delegate to the social workers to interview the residents. NHA-A does not recall being told about an allegation of abuse involving R108. NHA-A stated, there was so much going on in March with the survey, I don't remember much. Surveyor shared the concern that R108's allegation that CNA-V was rough with morning cares and threw the breakfast tray at R108 was reported to CNA-T who reported it LPN-U. CNA-T again reported the incident to SW-P. Surveyor shared the concern that both incidents were not investigated thoroughly. Surveyor shared that SW-P indicated a grievance had been completed in regard to CNA-V being rough with R108, but the facility grievance log does not document any grievance for R108 on March 23, 2026. Surveyor shared that CNA-V has been allowed to provide cares to residents with no investigation of the allegations of abuse involving R108. NHA-A confirmed that a thorough investigation should have started on 3/22/26, the day of the incident when CNA-T reported it to LPN-U. On 4/14/26, at 1:01 PM, Surveyor was not able to interview LPN-U. On 4/14/26, at 2:40 PM, NHA-A informed Surveyor that any sort of abuse or neglect concerns should be reported right away and agreed there was not follow-up with the incidents involving R108. NHA-A again confirmed that a thorough investigation should have been completed back when the incident occurred on March 22,2026. NHA-A stated the facility submitted an initial alleged misconduct report involving R108 and CNA-V has been removed from resident care areas. No additional information was provided as to why the facility did not complete a thorough investigation of R108's allegations of abuse as reported on March 22,2026.

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	04/14/2026

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility did not ensure that food was palatable, attractive and at a safe and appetizing temperature. This has the potential to affect 2 (R102 and R109) out of 5 residents receiving meals by the facility kitchen.*R102 was served peaches that appeared to be moldy and had a fly on R102's meal.*R109 filed a grievance documenting R109 received a lunch tray with a fly on it.Findings Include:The facility's undated Food Storage policy and procedure documents: Policy: Sufficient storage facilities will be provided to keep foods safe, wholesome, and appetizing. 1.) R102 was admitted to the facility on [DATE] with diagnoses of Unspecified Protein-Calorie Malnutrition, Severe (deficiency of both protein and energy), Hypoglycemia (blood sugar drops below normal levels), Adult Failure to Thrive(decline in overall health in older adults), Hypothyroidism (underactive thyroid), Thrombocytopenia(low number of platelets in the blood), Gastro-Esophageal Reflux Disease(stomach contents leak backward from stomach into the esophagus(food pipe), Chronic Kidney Disease(progressive damage and loss of function in the kidneys), and Dementia(loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life). R102 discharged from the facility on 3/23/26. R102's significant change Minimum Data Set (MDS) completed 2/6/26 documents a Brief Interview for Mental Status (BIMS) score to be 15, indicating R102 demonstrated cognitively intact daily decision-making skills. R102's MDS also documents R102 was independent with eating.On 4/13/26, at 3:15 PM, Surveyor reviewed photographs of R102's food trays provided by Anonymous (AN)-L. Surveyor observed a picture of a bowl of peaches with what appeared to be white fuzzy mold on the peaches. Another picture shows a fly sitting on top of the mixed vegetables served on the plate. On 4/13/26, at 3:34 PM, Surveyor spoke with AN-L via telephone about the pictures. Surveyor asked AN-L how the pictures were obtained. AN-L stated that R102 took pictures of every meal and would send the pictures daily to AN-L. AN-L shared that Licensed Practical Nurse (LPN)-M found the mold on the peaches and informed R102 that R102 could not eat the peaches.On 4/14/26, at 11:37 AM, Surveyor interviewed LPN-M via telephone. LPN-M verified that LPN-M was in R102's room when R102's lunch tray was delivered. LPN-M observed what appeared to be white fuzzy mold on the peaches and observed some areas of green fungi mold on the peaches. LPN-M removed the peaches off of R102's tray right away and told R102, R102 could not eat the peaches. LPN-M stated, that is horrible to put something like that on a resident's tray.On 4/14/26, at 11:55 AM, Surveyor spoke with Nursing Home Administrator (NHA)-A in regard to the concern about potential mold on R102's peaches and the concern about R102 having flies on their food. NHA-A does not recall being informed about mold or a fly concern. NHA-A shared that the facility has been working a lot on dietary and service. Surveyor shared that R102 was served food that was not attractive and palatable. No additional information was provided. 2.) R109 was admitted to the facility on [DATE] with diagnoses of Unspecified Protein-Calorie Malnutrition(deficiency of both protein and energy), Type 2 Diabetes Mellitus(adult onset of trouble controlling blood sugar), Hemiplegia and Hemiparesis Following Cerebral Infarction(complete paralysis on one side of body and partial/incomplete weakness on one side following stroke), Parkinson's Disease(disorder of the central nervous system that affects movement, often including tremors), Peripheral Vascular Disease(circulatory condition in which narrowed blood vessels reduce blood flow to limbs), and Atherosclerotic Heart Disease of the Native Coronary Artery(plaque buildup narrows the arteries that supply blood to the heart). R109 discharged from the facility on 4/8/26. R109's admission MDS completed 4/2/26 documents R109's BIMS score to be a 14, indicating R109 is cognitively intact for daily decision making. Surveyor reviewed all facility grievances from October 2025 to present. Surveyor noted that there was grievance filed on 3/31/26 by R109 documenting that R109 received a lunch tray with a fly on it. The grievance documents that Dietary Manager (DM)-K discussed with R109 the concern. There is no documentation (continued on next page)

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	525523	A. Building B. Wing	04/14/2026

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that DM-K addressed the concern of the fly. On 4/13/26, at 2:43 PM, Surveyor interviewed DM-K in regards the concern about the fly. DM-K stated that DM-K was unable to speak with R109 because R109 was discharged the next day. DM-K stated that DM-K has not seen a fly herself but stated there may be flies because the steam table on the second floor is located right next to a door. DM-K provided documentation that stated: Received a concern from Social Worker (SW)-P that R109 had a fly in R109's food. The following day when I was going to visit R109, R109 was discharged . I did however, talk to my staff and informed them of the situation and told them to be more observant as we prepare food, especially because our location is in very close proximity to an outside entrance.Surveyor noted that R109 filed the grievance on 3/31/26, but was not discharged the next day on 4/1/26, but rather R109 was discharged on 4/8/26.On 4/14/26, at 11:19 AM, Surveyor interviewed Maintenance Director (MD)- N. MD-N stated that no one had informed the maintenance department that there was a fly issue. MD-N stated that pest control comes in monthly and when notified, will also address specific concerns.On 4/14/26, at 11:55 AM, Surveyor spoke with Nursing Home Administrator (NHA)-A regarding R109 having flies on their food. NHA-A does not recall being informed about a fly concern. NHA-A shared that the facility has been working a lot on dietary and service. Surveyor shared that R109 was served food that was not attractive and palatable. No additional information was provided.