STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525600	A. Building B. Wing	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aria at Mitchell Manor	5301 W Lincoln Ave West Allis, WI 53219

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 49011 Based on observation, interview, and record review, the Facility did not eliminate accident hazards in the resident environment affecting 22 of 22 residents, of which, according to the Brief Interview for Mental Status scores of residents on this first floor unit, four have moderately impaired cognition and two have severe cognitive impairment. One (R3) of 3 residents reviewed for falls did not have their fall interventions in place. The Facility did not ensure insulin/blood glucose medications were kept in a secure location when not in use. R3's fall interventions were not in place on 8/22/2024 and 8/26/2024. Findings include: 1.) The Facility policy and procedure titled Medication Administration-General Guidelines revised in December of 2019 documents (in part): Policy: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so . Procedures: . B. Administration . 16. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by . On 8/22/2024, at 9:12 am, Surveyor was making observations in the 114-124 hallway of the facility and noticed a treatment cart with a basket on top containing approximately 12 insulin/blood glucose medication pens, insulin syringes, lancets, and a glucometer with no staff around. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/22/2024, at 9:22 am, two Licensed Practical Nurses (LPN) returned to the cart and moved it to a charting area and proceeded to use the computer located there. On 8/22/2024, at 9:28 am, both LPNs left the charting area and walked down the other hallway on the unit. The cart was left unattended with the basket on top with insulin/blood glucose medications and supplies fully accessible. On 8/22/2024, at 9:31 am, the LPNs returned to the charting area and resumed working on the computer. Surveyor approached and asked if it was common practice to leave the insulin pens/blood glucose medications on the treatment cart. LPN-D and LPN-E responded that yes, they do that when using the medications, otherwise the basket is stored in the bottom drawer of the cart and excess pens are kept in the fridge because they are only good for 28 days unrefrigerated. On 8/22/2024, at 9:40 am, Surveyor observed the LPN's outside a resident room in the 101-112 hallway getting gowns on. They then entered the resident's room and shut the door behind them leaving the cart in the hallway with the basket with insulin/blood glucose medication pens on top unattended and fully accessible. On 8/22/2024, at 1:16 pm, Surveyor interviewed Assistant Director of Nursing (ADON)-C and asked if insulin/blood glucose medication should be left unattended to which the response was no. On 8/22/2024, at 1:17 pm, Surveyor spoke with Director of Nursing (DON)-B and was informed any medication, including insulin/blood glucose medication should be locked when not in use. On 8/22/2024, at 3:02 pm, Surveyor Spoke with Nursing Home Administrator-A and DON-B and let them know of the concern that the insulin/blood glucose medication basket was observed three times by Surveyor left out and unattended. No additional information was provided. 20483 2.) The facility's policy titled, Fall Policy and last reviewed on 7/17/24 under the Policy Statement documents All residents will receive adequate supervision, assistance, and assistive devices to prevent falls. Each resident will be evaluated for safety risks, including falls and accidents. Care plans will be created and implemented based on the individual's risk factors to aid in preventing falls. All Falls are to be investigated and monitored. R3's diagnoses includes Alzheimer's Disease, chronic atrial fibrillation, hypertension, dementia and delusional disorders. The at risk for falls care plan initiated 4/5/19 & revised on 3/28/24 documents the following interventions: * Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Initiated 4/5/19. * My caregivers will ensure that I am wearing appropriately fitting foot wear and clothing. Initiated 4/5/19. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* My caregivers will provide me with a safe environment free of clutter. Initiated 4/5/19. * Anticipate and meet the resident's needs. Initiated 4/8/19. * Be sure The resident's call light is within reach and encourage the resident to use it for assistance as needed. Initiated 4/8/19. * Fall mat to right side of bed, when I am in bed. Initiated 9/1/20 & revised 6/23/21. * Bed to be at lowest position. Initiated 9/21/20 & revised on 6/23/21. * Soft touch call light. Initiated 9/21/20 & revised on 6/23/21. * Right sided Body Pillow. Initiated 11/17/20 & revised 6/23/21. The fall risk scoring tool dated 6/21/24 documents a score of 10. A score of 10 indicates high risk for falls. The quarterly MDS (minimum data set) with an assessment reference date of 6/25/24 assesses R3 as having short term & long term memory problems and has severe impairment for cognitive skills for daily decision making. R3 is assessed as requiring substantial/maximal assistance for toileting hygiene & rolling left & right and dependent for chair/bed to chair transfer. R3 is always incontinent of urine and bowel. R3 has not had any falls since prior assessment period. The CNA (Certified Nursing Assistant) Kardex as of 8/26/24 under the Resident Care section includes * Soft touch call light. The safety section documents * Approach resident slowly, tell her repeated what you are about to do. * Bed to be at lowest position. * Fall mat to right side of bed, when I am in bed. * Right sided Body Pillow. On 8/22/24, at 9:07 a.m., Surveyor observed R3 in bed on their back. Surveyor observed there is not a body pillow along the right side. There is not a soft touch call light and R3 has a red button type call light. On 8/22/24, at 10:21 a.m., Surveyor observed R3 in the dining room sitting in a Broda chair which is slightly reclined back wearing green pressure relieving boots. On 8/22/24, at 1:38 p.m., Surveyor observed R3 continues to be sitting in a Broda chair in the dining room. On 8/22/24, at 3:21 p.m., Surveyor observed R3 in bed on her back towards the mattress attached to the wall on R3's left. Surveyor observed R3's bed is up high and is not at the lowest position. There is not a mat on the floor on the right side and there is not a body pillow along R3's right side. The red button type call light is on the small dresser next to R3's bed and not within R3's reach. On 8/22/24, at 3:42 p.m., Surveyor observed R3 is in bed on her back. Surveyor observed the bed is now down low and there is a floor mat on the right side. Surveyor observed there is still not a body pillow along the right side and the call light is within reach but the call light is not a soft touch. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/22/24, at 4:03 p.m., Surveyor observed R3 in bed. Surveyor observed there is not a body pillow on the right side of R3's bed. On 8/26/24, at 7:11 a.m., Surveyor observed R3 wearing a gown, awake in bed on her back holding onto the call light cord. Surveyor observed R3 does not have a soft touch call light. Surveyor observed the bed is down low, there is a body pillow along the right side & a mat on the floor. On 8/26/24, at 8:08 a.m., Surveyor observed R3 in bed on her back, dressed for the day. R3's bed was up high and is not at the lowest position. A minute later CNA (Certified Nursing Assistant)-F entered R3's room asked R3 if she was ready to get out of bed and was going to get the lift. CNA-F then left R3's room. R3's bed was not lowered to the lowest position when CNA-F left R3's room. On 8/26/24, at 8:10 a.m., CNA-F entered R3's room and informed R3 she was going to turn her to put the sling under her. CNA-F positioned R3 from side to side to place the Hoyer sling under R3. After placing the sling under R3, CNA-F asked CNA-H, who was assisting R3's roommate, if he could help her get R3 up. Surveyor observed CNA-F then left R3's room. Surveyor observed R3's bed was in the high position and there is not a body pillow along the right side. On 8/26/24, at 8:14 a.m., CNA-F entered R3's room and placed gloves on. CNA-F placed a pillow between R3's legs, the body pillow along the right side of R3's bed, and raised the head of the bed. Surveyor observed the call light is now the soft pad. CNA-F stayed by R3's bed. On 8/26/24, at 8:18 a.m., Surveyor asked CNA-F about R3's call light. CNA-F informed Surveyor R3 used to have the button type but couldn't press it that's why it was changed to the pad. Surveyor asked when R3 is in bed should there be a body pillow on the right side. CNA-F replied yes. On 8/26/24, at 8:26 a.m., Surveyor observed CNA-F and CNA-H transfer R3 from the bed into the Broda chair using the Hoyer lift. On 8/26/24, at 9:04 a.m., Surveyor asked LPN (Licensed Practical Nurse)-G if she knew why R3 didn't have the soft touch call light last week and early this morning. LPN-G informed R3 needs the soft pad because she is non verbal. Surveyor asked LPN-G if the fall interventions should be in place for R3. LPN-G replied yes and explained R3 has a floor mat, the bed down low at all times, a body pillow which she thinks is on the right side and there is mat on the wall for some bruising. On 8/26/24, at 11:14 a.m., Surveyor asked DON (Director of Nursing)-B if staff should be following a residents care plan and/or Kardex. DON-B replied yes. Surveyor informed DON-B of the observations of R3 not having a soft touch call light, R3's bed up high and not at the lowest position, the body pillow not on the right side and the mat not on the floor.