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	02/04/2026

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 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 address grievances by ensuring documentation of the concern, conducting a thorough investigation of the issues identified or provide resolution of the concerns brought to the attention of facility staff, for 1 (R1) of 3 residents reviewed for grievances.On 11/14/25 and 12/23/25, a representative for R1 expressed concerns to facility staff regarding the care R1 was receiving. The facility did not investigate and ensure a follow-up to the concerns expressed or provide details of a resolution regarding the grievance. Findings include:Policy Review: Grievance Policy, revised 2/12/25.Policy Statement: [NAME] Healthcare's policy is to provide a system whereby residents and/or representatives can voice concerns about the quality of services received at the facility.Procedure: 1. When a grievance is noted (either verbal or written), the resident or their representative may speak to any member of the facility staff and report the nature of the grievance or submit a written grievance form. 2. At the time of the grievance, the staff member will attempt to resolve the issue or direct the resident/representative to the appropriate department head or staff member for further action and/or notify the Grievance Officer.3. Upon notification of a resident grievance, information sufficient to identify the individual registering the concern, the resident's name (if not the individual submitting the report), date of receipt, nature of the matter, and location of the resident will be recorded.4.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.5. After thorough research has been conducted, the Department Heads and/or Grievance Officer will work with staff identified as key individuals critical to problem resolution for the specifically identified concern. All efforts will be made to efficiently and expeditiously resolve the grievance. 6. All grievances receive immediate priority and must be investigated with efforts made toward resolution within 7 days.7. The resident will be provided with a verbal follow-up to their grievance. A representative for R1 alleged they had reported care concerns to Director of Care Transitions - C regarding care issues that occurred on 11/13/25 and 12/22/25. On 11/14/25 the representative shared facility staff were providing cares to R1 (on 11/13/25) when they became very frustrated when R1 needed frequent adjustments in bed. It was reported that staff had called R1 names and yelled at R1 for using the call light and wasting staffs time by having them come in so oftenOn 12/23/25, R1's representative again contacted Director of Care Transitions- C reporting on 12/22/25, a CNA came into R1's room extremely agitated and aggressive that R1 had pushed her call light. R1's representative said that the CNA took her anger out on R1 and came behind her, grabbed her around her torso and yanked her backwards in the bed resulting in fractures to R1's left 7th and 8th ribs. The representative for R1 reported to the State Survey agency that they were not aware of any action taken for the first incident and that R1 was transported to the hospital the next day for the 2nd incident.On 2/3/26, Surveyor conducted a (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review of the facility's grievance log and noted that there were no documented concerns from R1 or any Representative of R1.On 2/4/26 at 9:58 AM, Surveyor interviewed Director of Care Transitions- C regarding grievances that had been reported to them by R1's representative. Director of Care Transitions- C stated that although he remembers talking with R1's representative, he does not recall exactly what it was all about. Director of Care Transitions- C stated that he recalls there were a few questions and concerns mentioned by R1's representative but he did not take any notes about the concerns. Director of Care Transitions- C stated that he does not work inside the buildings and is not aware of the process for handling grievances. Director of Care Transitions- C stated that he would just forward and email to the Director of Nursing (DON)-B or the Administrator-A. Surveyor asked if there is any documented evidence that he communicated the concerns to DON- B or Administrator- A. Director of Care Transitions- C stated that he had nothing documented in his phone or email.On 2/4/26 at 10:15 AM, Surveyor interviewed Administrator-A and DON- B regarding the representative's concerns for R1 from 11/13/25 and 12/22/25. DON- B acknowledged that she had spoken with R1's representative because the representative had questions about the 12/22/25 incident. DON- B stated that she had answered all of the questions and reviewed R1's medical chart with R1's representative. Surveyor asked DON- B what the questions were that R1's representative had. DON- B stated she just wanted to know how this could have happened. (referring to R1's diagnosis of 7th and 8th rib fractures upon admission to the hospital on [DATE]). DON- B stated that she never questioned whether the staff did something to R1 and that R1 had a history of fractures and was very fragile. Surveyor stated to DON- B that R1's representative was asking for an explanation/investigation into how the CNA repositioned R1 wondering if that was how R1 suffered the rib fractures. R1's representative was aware of R1's medical history. DON- B again stated that she did not consider the representatives' questions as an allegation of abuse or a grievance to address. Surveyor stated that the concern was that R1 had been repositioned several times prior to 12/22/25 without incident and the allegation is that the CNA was in a hurry and angry and grabbed R1 from the torso, resulting in injuries. This is why the Representative wanted to know how this could have happened, when it was done so many times prior without incident. Administrator- A then stated that the concerns brought forth by R1's representative should have neem handled as formal grievance and investigated as such.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility did not ensure that they reported allegations of possible abuse or mistreatment to the State Survey Agency for 1 (R1) of 3 sampled residents.On 12/22/25, R1 was repositioned in bed by a facility Certified Nursing Assistant (CNA-D) when R1 experienced severe pain in her left ribs. R1 was sent to the emergency room and diagnosed with a fracture to the 7th and 8th anterior left ribs. The facility did not ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury to other officials including to the State Survey Agency in accordance with State law through established procedures.Findings include:Policy Review: (Company name) Healthcare Abuse Prevention Program (undated)This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property , and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to ensure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property and mistreatment of residents.IV. Internal reporting Requirements and Identification of Allegations:Any allegation of abuse or any incident that results in serious bodily injury will be reported to the required regulatory agencies immediately, but not more than two hours of the allegation of abuse. Any incident that does not involve abuse and does not result in serious bodily injury shall be reported within 24 hours. On 2/3/26, Surveyor conducted a medical record review for R1. R1 was originally admitted to the facility on [DATE] with diagnoses of left pelvic fracture, chronic respiratory failure, severe protein-calorie malnutrition, muscle weakness, dysphagia, pressure ulcer of sacral region, gastroesophageal reflux disease (GERD) and repeated falls. R1 needed the assistance of 1 staff for activities of daily living, toileting and bed mobility.A review of R1's plan of care noted the following:The resident (R1) has an activities of daily living (ADL) self-care performance deficit r/t (related to) multiple fractures (pelvic, sternal and vertebral), rheumatoid arthritis, acute respiratory failure with O2 (oxygen) dependence. Interventions include:Provide Adaptive equipment necessary during transferBED MOBILITY: The resident requires assistance by 1 staff to turn and reposition in bed every 2-3 hours and as necessary. Bilateral bed rails to help promote bed mobility.TRANSFER: The resident requires assistance by 1 staff member using 2WW to transferEncourage the resident to participate to the fullest extent possible with each interaction.Encourage the resident to use bell to call for assistance.Monitor/document/report PRN (as needed) any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function.Praise all efforts at self care.PT/OT (physical therapy/occupational therapy) evaluation and treatment as per MD (physician) orders.A review of R1's Physician orders document the following: Q2-3hr (every 2 to 3 hours) repositioning with wedge from right side to back. every 2 hours for Prophylaxis related to NONDISPLACED FRACTURE OF ANTERIOR WALL OF LEFT ACETABULUM, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING (S32.415D) Order date is 11/17/2025. Nursing Note dated 12/22/2025 at 9:15 PM eINTERACT SBAR (Situation Background Assessment Recommendation) Summary for Providers Situation: The Change In Condition/s reported on this CIC (change in condition) Evaluation are/were: Pain (uncontrolled). Nursing observations, evaluation, and recommendations are: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	While being repositioned by CNA, resident started c/o (complaints of) severe pain in her Left Ribs. Pain is sharp and stabbing and hurts upon palpation. R1 has a Hx (history) of rib fractures. Writer observed no redness, swelling or bruising at site. R1 repositioned to her right side and given PRN (as needed) Tramadol, which was ineffective. Sent to (name of hospital) ER (emergency room) at R1's request for further eval and treatment. Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: A. Recommendations: Dr. updated. Ok with sending the resident to ER.Physician Progress Note dated 12/23/2025 at 10:34 AM; Patient (R1) currently admitted to (name of hospital). Chart reviewed in EPIC (name of hospital electronic medical record) Care Everywhere and updated. Pain in ribs noted last night in patient with known osteoporosis and multiple other pathologic rib fractures.X-ray report below from 12/22/25:1.Suspected left eighth and possibly seventh anterior rib fractures. (anterior rib fracture is a break in the rib bone near the front of the chest, usually caused by direct impact like car accidents, falls, or less commonly, severe coughing) Old bilateral rib fractures are also noted.2. Several thoracic compression fractures are identified and can be seen previously. There is slight apparent increase in the degree of compression of the T7 superior endplate.3. No acute cardiopulmonary findings.Will follow and assume care after hospitalization with pain control and continued management of osteoporosis and myelodysplastic syndrome.On 2/3/2026, Surveyor conducted a review of the hospital Discharge summary, dated [DATE], and noted the following: History of present illness: (R1) Was brought in from rehab facility when she while turning developed severe pain involving chest and hip and was found to have rib fractures and had been admitted for pain control . Plan: admitted as inpatient. Placed on telemetry. Evidence of sacral and coccyx pressure decubitus wound care. Severe pain due to rib fractures and history of pelvic. Added Dilaudid and oxycodone for pain control.On 12/23/25, R1's representative contacted Director of Care Transitions- C reporting on 12/22/25, a CNA came into R1's room extremely agitated and aggressive that R1 had pushed her call light. R1's representative said that the CNA took her anger out on R1 and came behind her, grabbed her around her torso and yanked her backwards in the bed resulting in fractures to R1's left 7th and 8th ribs. The representative for R1 reported to the State Survey agency that they were not aware of any action taken for the first incident and that R1 was transported to the hospital the next day for the 2nd incident. (Cross-reference F585). On 2/4/26 at 8:30 AM, Surveyor interviewed DON (Director of Nursing)- B regarding R1's broken ribs and the allegation that this injury occurred while CNA (Certified Nursing Assistant)- D was repositioning R1 in bed. DON- B stated they made a conclusion that an investigation into the incident was not needed because they spoke with the Physician and based on all of R1's comorbidities and risk factors and previous fractures that there was not concern for abuse or mistreatment. R1 is very fragile so things like this can happen. DON- B stated she spoke with CNA- D who stated that while repositioning R1 in bed, she heard a crack. CNA-D immediately went and got the nurse who completed an assessment on R1. R1 initially did not want to go to the hospital for further evaluation. Surveyor asked DON- B if this incident was reported to the State Survey agency as potentially being an incident of abuse or neglect. DON- B stated again that with R1's history of fractures and comorbidities the facility did not feel they had to report the incident.On 2/4/26 at 10:15 AM, Surveyor interviewed Administrator- A and DON- B regarding the concerns from R1's representative for the cares she received on 11/13/25 and 12/22/25. DON- B acknowledged that she had spoken with R1's Representative because the Representative had questions about the 12/22/25 incident. DON- B stated that she had answered all of the questions and reviewed R1's medical chart with R1's Representative. Surveyor asked DON- B what the questions were that R1's Representative had. DON- B stated that she just wanted to know how this could have happened; referring to R1's (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diagnosis rib fractures upon admission to the hospital on [DATE] . DON- B stated that she never questioned whether the staff did something to R1 and that R1 had a history of fractures and was very fragile. DON- B again stated that she did not consider the representatives' questions as an allegation of abuse or neglect. Surveyor stated that the concern was that R1 had been repositioned several times prior to 12/22/25 without incident and the allegation is that the CNA was in a hurry and angry and grabbed R1 from the torso, resulting in injuries. This is why the Representative wanted to know how this could have happened, when it was done so many times prior without incident. As of the time of exit, the facility was unable to provide additional information as to why they did not report to the State Survey Agency the potential mistreatment of R1 during repositioning in bed on 12/22/25.

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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 record review and staff interview, the facility did not ensure that they thoroughly investigated allegations of possible abuse or mistreatment/ neglect for 1 (R1) of 3 sampled residents.R1 was repositioned in bed by CNA (Certified Nursing Assistant)-D on 12/22/25. While R1 was being repositioned with the assistance from CNA-D, R1 complained of severe pain to her ribs. R1 was sent to the emergency room on [DATE] where R1 was diagnosed with a fracture to the 7th and 8th anterior ribs. On 12/23/25 a representative for R1 raised concerns regarding possible mistreatment to R1 leading to t he sustained rib fractures. The facility did not thoroughly investigate the incident.Findings include:Policy Review: (Name of Company) Healthcare Abuse Prevention Program (undated)This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property , and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to ensure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property and mistreatment of residents.VI. Internal Investigation1. All incidents will be documented, whether or not abuse, neglect, exploitation, mistreatment or misappropriation of resident property occurred, was alleged or suspected. 3. For resident injuries not involving an allegation of abuse or neglect, the Administrator will appoint a person to gather further facts to make a determination as to whether the injury should be classified as an injury of unknown source. An injury should be classified as an injury of unknown source when both of the following conditions are met:* the source of the injury was not observed by any person pr the source of the injury could not be explained by resident; and* The injury is suspicious because of the extent of the injury or the location of the injury (e.g. the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time of the incidence of injuries over time.4. Investigation Procedures: The appointed investigator will, at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident, if interviewable. Any written statements that have been submitted will be reviewed, along with any pertinent medical records or other documents. Residents to whom the accused had regularly provided care, and employees with whom the accused had regularly worked, will be interviewed. On 2/3/26, Surveyor conducted a medical record review for R1. R1 was originally admitted to the facility on [DATE] with diagnoses of left pelvic fracture, chronic respiratory failure, severe protein-calorie malnutrition, muscle weakness, dysphagia, pressure ulcer of sacral region, gastroesophageal reflux disease (GERD) and repeated falls. R1 needed the assistance of 1 staff for activities of daily living, toileting and bed mobility.A review of R1's plan of care noted the following:The resident (R1) has an activities of daily living (ADL) self-care performance deficit r/t (related to) multiple fractures (pelvic, sternal and vertebral), rheumatoid arthritis, acute respiratory failure with O2 (oxygen) dependence. Interventions include:Provide Adaptive equipment necessary during transferBED MOBILITY: The resident requires assistance by 1 staff to turn and reposition in bed every 2-3 hours and as necessary. Bilateral bed rails to help promote bed mobility.TRANSFER: The resident requires assistance by 1 staff member using 2WW (wheeled walker) to transferEncourage the resident to participate to the fullest extent possible with each interaction.Encourage the resident to use bell to call for assistance.Monitor/document/report PRN (as needed) any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function.Praise all efforts at self care.PT/OT (physical therapy/occupational therapy) evaluation and (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	treatment as per MD (physician) orders.A review of R1's Physician orders document the following: Q2-3hr (every 2 to 3 hours) repositioning with wedge from right side to back. every 2 hours for Prophylaxis related to NONDISPLACED FRACTURE OF ANTERIOR WALL OF LEFT ACETABULUM, SUBSEQUENT ENCOUNTER FOR FRACTURE WITH ROUTINE HEALING (S32.415D) Order date is 11/17/2025. Nursing Note dated 12/22/2025 at 9:15 PM eINTERACT SBAR (Situation Background Assessment Recommendation) Summary for Providers Situation: The Change In Condition/s reported on this CIC (change in condition) Evaluation are/were: Pain (uncontrolled). Nursing observations, evaluation, and recommendations are: While being repositioned by CNA, resident started c/o (complaints of) severe pain in her Left Ribs. Pain is sharp and stabbing and hurts upon palpation. R1 has a Hx (history) of rib fractures. Writer observed no redness, swelling or bruising at site. R1 repositioned to her right side and given PRN (as needed) Tramadol, which was ineffective. Sent to (name of hospital) ER (emergency room) at R1's request for further eval and treatment. Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: A. Recommendations: Dr. updated. Ok with sending the resident to ER.Physician Progress Note dated 12/23/2025 at 10:34 AM; Patient (R1) currently admitted to (name of hospital). Chart reviewed in EPIC (name of hospital electronic medical record) Care Everywhere and updated. Pain in ribs noted last night in patient with known osteoporosis and multiple other pathologic rib fractures.X-ray report below from 12/22/25:1.Suspected left eighth and possibly seventh anterior rib fractures (anterior rib fracture is a break in the rib bone near the front of the chest, usually caused by direct impact like car accidents, falls, or less commonly, severe coughing). Old bilateral rib fractures are also noted.2. Several thoracic compression fractures are identified and can be seen.previously. There is slight apparent increase in the degree of compression of the T7 superior endplate.3. No acute cardiopulmonary findings.Will follow and assume care after hospitalization with pain control and continued management of osteoporosis and myelodysplastic syndrome.On 2/3/2026, Surveyor conducted a review of the hospital Discharge summary, dated [DATE], and noted the following: History of present illness: (R1) Was brought in from rehab facility when she while turning developed severe pain involving chest and hip and was found to have rib fractures and had been admitted for pain control . Plan: admitted as inpatient. Placed on telemetry. Evidence of sacral and coccyx pressure decubitus wound care. Severe pain due to rib fractures and history of pelvic. Added Dilaudid and oxycodone for pain control.On 12/23/25, R1's representative contacted Director of Care Transitions- C reporting on 12/22/25, a CNA came into R1's room extremely agitated and aggressive that R1 had pushed her call light. R1's representative said that the CNA took her anger out on R1 and came behind her, grabbed her around her torso and yanked her backwards in the bed resulting in fractures to R1's left 7th and 8th ribs. The representative for R1 reported to the State Survey agency that they were not aware of any action taken for the first incident and that R1 was transported to the hospital the next day for the 2nd incident. (Cross-reference F585). On 2/4/26 at 8:30 AM, Surveyor interviewed DON (Director of Nursing)- B regarding R1's broken ribs and the documentation that this injury occurred while CNA (Certified Nursing Assistant)- D was repositioning R1 in bed. DON- B stated they made a conclusion that an investigation into the incident was not needed because they spoke with the Physician and based on all of R1's comorbidities and risk factors and previous fractures that there was not concern for abuse or mistreatment. R1 is very fragile so things like this can happen. DON- B stated she spoke with CNA- D who stated that while repositioning R1 in bed, she heard a crack. CNA-D immediately went and got the nurse who completed an assessment on R1. R1 initially did not want to go to the hospital for further evaluation. DON- B stated that CNA- D was following the plan of care because R1 can be repositioned in bed with the assist of 1. Surveyor asked DON- B if the facility looked into the allegation (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA- D repositioned R1 in a hurry, or was upset with R1 or even intentionally grabbed R1 with force. DON- B stated that CNA- D followed the plan of care and would not have hurt R1 on purpose. Surveyor asked DON- B if she had interviewed any other staff who worked on the evening of 12/22/25 who may have knowledge of CNA-D's demeanor that night or if there were concerns between R1 and CNA- D. DON- B stated that she did not speak with other staff or other residents; she did not see the need to further investigate this. DON- B stated again, R1's primary doctor said the injury is of known source and that is because of R1's comorbidities and being fragile.On 2/4/26 at 10:15 AM, Surveyor interviewed Administrator- A and DON- B regarding the representative for R1's concerns for the cares she received on 12/22/25. DON- B acknowledged that she had spoken with R1's representative because the representative had questions about the 12/22/25 incident. DON- B stated that she had answered all of the questions and reviewed R1's medical chart with R1's representative. Surveyor asked DON- B what questions were that R1's representative had. DON- B stated that she just wanted to know how this could have happened; referring to R1's diagnosis of rib fractures upon admission to the hospital on [DATE] . DON- B stated that she never questioned whether the staff did something to R1 and that R1 had a history of fractures and was very fragile. DON- B again stated that she did not consider the Representatives' questions as an allegation of abuse or neglect. Surveyor stated that the concern was that R1 had been repositioned several times prior to 12/22/25 without incident and the allegation is that CNA-D was in a hurry and angry and grabbed R1 from the torso, resulting in injuries. This is why the Representative wanted to know how this could have happened, when it was done so many times prior without incident. As of the time of exit, the facility was unable to provide additional information as to why they did not thoroughly investigate the potential mistreatment of R1 during repositioning in bed on 12/22/25.