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	07/01/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure that residents with a pressure injury or at risk for pressure injuries received necessary treatment and services, consistent with professional standards of practice, to prevent the development of pressure injuries and to promote healing for 1 (R54) of 5 Residents reviewed for pressure injuries.On 4/1/26 Wound Nurse Practitioner (NP)-Z changed treatment orders for R54's left hip pressure injury. The facility did not implement this order.Findings include:The facility's policy titled, Wound Management - Wound Prevention and Treatment and revised 10/11/2025 under policy documents The purpose of this program is to assist the facility in the care, services, and documentation related to the occurrence, treatment, and prevention of pressure as well as non-pressure-related wounds. Under provision and procedure #10 documents The pressure ulcer(s) will be evaluated weekly, and the nurse or physician will document the size, location, appearance, odor (if any), drainage (if any), and current treatment ordered.R54's diagnoses include adult failure to thrive, dementia, and cerebrovascular disease. R54's admission assessment dated [DATE] under the skin condition section documents for site 26) Left trochanter (hip). Under description documents Unstageable: 5 x (by) 3.5 x 0.1. 80% necrotic tissue, 10% slough, 10% gran. (granulation).R54's Braden scale assessment dated [DATE], 1/14/26, 1/21/26, 1/28/26, & 2/4/26 all have a score of 12 which indicates high risk for pressure injury development.R54's initial wound evaluation and management summary dated 1/14/26 by Wound Nurse Practitioner (NP)-Z documents unstageable (due to necrosis) of the left, lateral hip full thickness. Under wound size (L x W x D) (length times width times depth) documents 4.45 x 4.3 x 0.1 cm (centimeter). Thick adherent black necrotic tissue (eschar) is 80% and slough is 20%.R54's wound evaluation and management summary dated 1/21/26 by Wound NP-Z documents Stage 4 pressure wound of the left, lateral hip full thickness. Wound size is 3.3 x 3.8 x 1.0 cm. Thick adherent devitalized necrotic tissue is 80% and slough is 20%. Under additional note documents Post-debridement assessment of this previously unstageable necrotic wound has revealed the underlying deep tissue at the muscle/fascia level, which had been obscured by necrosis prior to this point. This wound has now revealed itself to be a Stage 4 pressure injury. This is not a wound deterioration.From 1/28/26 through 3/25/26 surveyor noted weekly assessments of R54's left hip pressure injury with treatments being completed according to physician's orders.R54's wound evaluation and management summary dated 4/1/26 by Wound NP-Z documents Stage 4 pressure wound of the left, lateral hip full thickness. Wound size is 2 x 1.5 x 0.3 cm. Undermining is 4.2 cm at 7 o'clock. Slough is 10% and granulation is 90%. Under dressing treatment plan for primary dressing documents add Iodosorb Gel once daily and as needed if saturated, soiled or dislodged. Cleanse with wound cleanser once daily and as needed if saturated, soiled or dislodged. Irrigate wound and allow to penetrate for 3-5 minutes. Continue Alginate Calcium w/ (with) silver once daily and as needed if saturated, soiled or dislodged. Discontinue Leptospermum Honey. Secondary dressing continue Foam with border once daily and as needed if saturated, soiled, or dislodged. Under peri wound documents continue skin prep once daily and as needed if saturated, soiled, or dislodged.R54's wound evaluation and management summary dated 4/8/26 by Wound NP-Z documents Stage 4 pressure wound of the left, lateral hip full thickness. Wound size is 1.9 x 1.5 x 0.4 (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cm. Undermining is 4.0 cm at 7 o'clock. Slough is 10% and granulation is 90%. Wound NP-Z continued the same treatment ordered on 4/1/26.R54's wound evaluation and management summary dated 4/15/26 by Wound NP-Z documents Stage 4 pressure wound of the left, lateral hip full thickness. Wound size is 1.7 x 1.4 x 0.4 cm. Undermining is 4.0 cm at 7 o'clock. Slough is 10% and granulation is 90%. Wound NP-Z continued the same treatment ordered on 4/1/26.R54 was discharged from the facility on 4/17/26.Surveyor reviewed R54's April TAR (treatment administration record) and noted from 4/1/26 to 4/15/26 the facility was completing the following treatment for R54's left lateral hip: Cleanse with NS (normal saline), pat dry; Apply manuka honey to wound bed, pack wound with calcium alginate silver and cover with border foam dressing; MWF (Monday, Wednesday, Friday) and PRN (as needed). The start date of this treatment is 3/20/26 and discontinued on 4/15/26. The facility did not implement the new daily treatment Wound NP-Z ordered on 4/1/26. From 4/1/26 to date of discharge the facility did not follow treatment orders for R54 left lateral hip pressure injury.On 7/1/26, at 8:20 a.m., surveyor met with Assistant Director of Nursing/Infection Preventionist (ADON/IP)-C, who is also the wound nurse and Director of Nursing (DON)-B to discuss R54's left hip pressure injury. At 8:38 a.m. Surveyor informed ADON/IP-C and DON-B surveyor did not see where the facility picked up the new order for R54's left hip pressure injury which Wound NP-Z ordered on 4/1/26. Surveyor informed ADON/IP-C and DON-B the facility was doing the incorrect treatment from 4/1/26 until R54's discharge on [DATE]. ADON/IP-C reviewed Wound NP-Z's wound assessment dated [DATE]. ADON/IP-C informed surveyor she wasn't sure why the treatment wasn't changed and stated to surveyor I messed up.