

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525600	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2026
NAME OF PROVIDER OR SUPPLIER Aria at Mitchell Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility did not store, prepare, distribute and serve food in accordance with professional standards for food service safety for two kitchen refrigerators this has the potential to affect all 45 Residents residing in the facility. *Temperature logs were not up to date for two refrigerators in the kitchen. Findings include: The Facility Policy and Procedure Manual titled Food Storage, dated 2019, documents in part: Procedure.12. Refrigerated food storage. b. TCS (Time and Temperature Control for Safety) foods must be maintained at or below 41 degrees F (Fahrenheit) unless otherwise specified by law. Periodically take temperatures of refrigerated foods to assure temperatures are maintained at or below 41 degrees F. A sample Temp (temperature) Log - Cooler is included with the Policy and Procedure Manual. The instructions are: Record temperatures for each cooler in the department (walk-in and reach-in units). Record time and temperature, and provide initials, twice per day (AM and PM). Notify supervisor immediately if cooler temperature is not within acceptable range of 41 degree F - 33 degrees F. On 06/28/2026, at 8:10 AM, Surveyor observed the temperature log on the walk in refrigerator. Surveyor noted it was last filled out on 6/26/26 for the AM shift. On 06/28/2026, at 8:15 AM, Surveyor interviewed Lead Cook-G regarding the temperature log. Lead Cook-G looked at the temperature log and stated yes it was not completed yesterday. Lead Cook-G stated that they are the person who should have completed it. On 06/28/2026, at 8:20 AM, Surveyor observed the temperature log for the refrigerator in the kitchen cooking area. Surveyor noted the 26th and 27th PM readings were not completed. Lead Cook-G confirmed these two reading were not done. On 06/29/2026, at 1:11 PM, Surveyor interviewed Dietary Manager-H regarding the temperature logs for the two refrigerators not being up to date. Dietary Manager-H stated they are aware Surveyor observed the two refrigerators with temperature logs not completed to date. Dietary Manager-H has already spoken with the staff member on PM shift that missed those temperature readings.		

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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and record review, the facility did not ensure it completed accurate mandatory submission of staffing information based on payroll data in a uniform electronic format to the Centers for Medicare & Medicaid Services (CMS). This had the potential to affect all 45 residents residing in the facility. Staffing information for Quarter 2 (January 1 - March 31, 2026) of the Payroll Based Journal (PBJ) was not accurately submitted to CMS. Findings include: The CMS Electronic Staffing Data Submission Payroll-Based Journal, Long-term Care Facility Policy Manual, dated June 2022, indicates: Chapter 1: Overview, 1.1 introduction .(U) mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS .1.2 Submission Timelines and Accuracy. Direct care staffing and census data will be collected quarterly and is required to be timely and accurate .Report Quarter: staffing and census data will be collected for each fiscal quarter. Staffing data includes the number of hours paid to work by each staff member each day within a quarter. Census data includes the facility's census on the last day of each of the three months in a quarter. The fiscal quarters are as follows: Fiscal Quarter, Date range: (quarter) 1 October 1-December 31, (quarter) 2 January 1-March 31, (quarter) 3 April 1-June 30, (quarter) 4 July 1-September 30 . Surveyor reviewed the PBJ Staffing Data Report, CASPER Report 1705D, for Fiscal year 2026 (run on 6/17/2026) which indicated the Facility had excessively low weekend staffing for the 2nd Quarter (January 1 - March 31, 2026). Surveyor reviewed the Facility's weekend schedules from January 1 through March 31, 2026. Surveyor noted licensed nurses and certified nursing assistants present on each shift, for each unit. Surveyor noted these schedules consistently had five or six nurses, one medication technician and 11 or 12 Certified Nursing Assistants (CNA) per 24 hours. Surveyor reviewed the Facility Assessment, not dated, for position licensed nurses providing direct care total number of staff on duty each day (on average based on census) is listed as 6. Nurse aides is listed as 13. On 06/29/2026, at 2:20 PM, Surveyor interviewed CNA Scheduler-J regarding the scheduling of shifts. CNA Scheduler-J stated ideally on 1st shift they schedule five CNA, two nurses and a Medication Technician. On 2nd shift there is a PM supervisor, five CNA and two nurses. On the night shift the full time Registered Nurse (RN) works with three CNA. On the RN's days off two nurses are scheduled. Surveyor asked how to determine needs on the floor and CNA Scheduler-J stated it depends on the acuity of the residents. Surveyor asked how to fill open shifts or call ins and CNA Scheduler-J stated that the Nursing Home Administrator (NHA)-A or the scheduler will cover. For nurses there is an order for call in coverage that is followed. They do not use agency. On the weekends they try to schedule five CNA, but working with four per shift (AM/PM) would not be considered short. Surveyor asked about low weekend staffing from January through March. CNA Scheduler-J stated there was nothing out of the ordinary going on. CNA Scheduler-J or NHA-A could work or pick up (hours), the system must not be adding scheduler or NHA-A's hours when they pick up. On 06/30/2026, at 10:47 AM, Surveyor interviewed Director of Nursing (DON)-B and NHA-A regarding the January through March staffing and that the facility triggered for low weekend staff. NHA-A stated that we do not work short, either CNA Scheduler-J or NHA-A are available to work. DON-B stated that the Assistant DON, nurse supervisor, or DON-B will work if there is a need. NHA-A stated they will talk to payroll and corporate to determine why they triggered for low weekend staffing in the 2nd quarter. On 06/30/2026, at 11:37 (continued on next page)		

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	AM, Surveyor interviewed NHA-A who stated they spoke with the Regional Director of Operations and was told there is no way to fix the low weekend staffing because on weekends all of the administration staff are not here. Surveyor noted administration staff should be coded differently. NHA-A stated they will continue to review. On 06/30/2026, at 2:03 PM, NHA-A stated they have no new information on why facility triggered for low weekend staffing, NHA-A assured Surveyor that they do not leave staff to work short on the weekends. They have a call in system and the floor is always covered. On 07/01/2026, at 8:01 AM, Surveyor interviewed CNA-O who stated that staffing is ok, there are no issues or differences on the weekends. CNA-O stated there are a few of us who like to pick up extra shifts for extra money so coverage is good. On 07/01/2026, at 8:02 AM, Surveyor interviewed CNA-F who is a Medication Technician. CNA-F stated staffing is good, as a medication technician, if staffing is short they pull me to work the floor and that rarely happens. On weekends staffing is not an issue, it is the same as during the week. On 07/01/2026, at 8:05 AM, Surveyor interviewed CNA-K who stated that staffing is wonderful at the facility, weekends are the same as during the week and there are no issues. On 07/01/2026, at 8:08 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-D who stated that the staffing is good here, LPN-D really likes it here. Weekends are great because residents aren't going out for appointments so no rush to get them out the door. It's a more relaxed time to spend with the residents.		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, the facility did not implement policy and procedures related to screening employees for a prior history of abuse, neglect, exploitation of residents, or misappropriation of resident property affecting residents residing on the third floor. The facility did not ensure their abuse policy was implemented when Registered Nurse (RN)-M and Housekeeper-N did not have Background Information Disclosure (BID), Department of Justice (DOJ), and Integrated Background Information System (IBIS) background checks updated within four years of working at the facility. Certified Nursing Assistant (CNA)-I did not have Department of Justice (DOJ), and Integrated Background Information System (IBIS) background checks updated within four years of working at the facility. Certified Nursing Assistant (CNA)-E's Background Information Disclosure (BID) was not dated, it could not be determined if the form was completed within the last four years. Findings include: The facility policy and procedure titled Abuse Prevention Program Facility Procedures Training Program and Staff Materials, not dated, documents in part: This facility is committed to protecting our residents from abuse, neglect, exploitation, misappropriation of property and mistreatment by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, staff from other agencies providing services to the individual, family members or legal guardians, friends, or other individuals. The facility will not knowingly employ individuals who have been found guilty of abuse, neglect, exploitation, misappropriation of property or mistreatment by a court of law; or have disciplinary action against their license by a state licensing body as the result of a finding of abuse, neglect, exploitation, misappropriation of property, or mistreatment. On 6/28/2026, Surveyor requested from Nursing Home Administrator (NHA)-A the personnel files for eight sampled employees to review for the required background checks. 1.) Registered Nurse (RN)-M was hired on 12/06/2021. The Background Information Disclosure (BID) form was completed 11/01/2021, and the Department of Justice (DOJ) letter and the Integrated Background Information System (IBIS) forms were completed 11/3/2021. Four years have lapsed since the background check information has been submitted. 2.) Housekeeper-N was hired 12/1/2020. The BID form was completed 6/29/2026, and the DOJ letter and IBIS form were completed 6/29/2026. Housekeeper-N's BID form, DOJ letter, and IBIS form were completed 6/29/2026 after Surveyor requested paperwork. 3.) Certified Nursing Assistant (CNA)-I was hired 12/1/2020. The BID form was completed 6/28/2026, and the DOJ letter and IBIS form were completed 6/29/2026. CNA-I's DOJ letter and IBIS form were completed 6/29/2026 after Surveyor requested paperwork. 4.) Certified Nursing Assistant (CNA)-E was hired 12/1/2020. CNA-E's BID form was not dated; it could not be determined if the form was completed within the last four years. On 06/29/2026, at 9:00 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A regarding the BID, DOJ and IBIS forms that were provided. Surveyor explained that RN-M, Housekeeper-N and CNA-I had outdated forms. NHA-A stated that NHA-A saw the outdated forms and has requested new forms to update the employee records. NHA-A is doing a sweep of all employee files to make sure no other employee records are outdated. On 6/30/2026, at 8:41 AM, Surveyor interviewed NHA-A regarding CNA-E's BID not having a date completed documented. NHA-A was unable to locate the page with the date. NHA-A stated the forms are outdated because these were long time employees. An audit was started yesterday to make sure everyone is in compliance.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure acceptable parameters of nutritional status were maintained or fluid intake was monitored for 4 (R7, R40, and R5) of 5 sampled residents reviewed for nutrition and hydration. *R7 had significant weight loss three times in 6 months that were not identified or acted on. R7 had a weight loss of 14 percent in 6 months and 9 percent in one month. *R40 had a significant weight loss of 7.9 percent in one month that was not identified or acted on. *R5 was on a daily fluid restriction. The facility did not monitor R5's daily fluid intake. Findings include: The facility policy and procedure titled Weight Management dated 3/1/2021 last revised 4/1/2025 documents: PROCEDURE: 1. All residents admitted to the facility will be weighed according to the following schedule: upon admission and weekly times four weeks. 2. All residents will be weighed every month unless otherwise ordered by the physician or deemed necessary by the dietician or the interdisciplinary team. 3. Monthly weights should be obtained by the 7th of each month. 4. The Dietician should evaluate weights, notify appropriate disciplines of significant changes, and initiate corrective measures. 5. A re-weight will be obtained for any weight change identified as a significant change from previous weight unless the physician has ordered other parameters. 6. All weights will be documented in the resident's electronic medical record. 7. If possible, the weights should be obtained at the same time of day, preferably in the morning and with the same scale to ensure consistency. 8. The scale will be zeroed out before weighing the resident by the staff member obtaining the weight. 9. For residents being weighed in a wheelchair, be sure to obtain the wheelchair weight first, including any cushions/devices in use, and subtract weight from the total weight each time the resident is weighed. 10. The resident's nurse will notify the physician and the resident or resident representative of any significant unexpected or unplanned weight changes. The facility policy and procedure titled Nutrition/Hydration Status Maintenance dated 1/1/2021 last revised 10/17/2025 documents: PROCEDURE: . 2. Monitoring and Documentation: a. Residents will be weighed per facility protocol and as clinically indicated. Weight variances exceeding +/- 5% in 30 days or +/- 10% in 180 days will prompt evaluation and documentation of potential causes and interventions. b. Nursing, dietary, and therapy staff will coordinate to identify and address any barriers to adequate nutrition or hydration, such as swallowing difficulties, poor dentition, mood disorders, fluid restrictions, other medical conditions affecting intake, or functional decline. c. All nutrition- and hydration-related interventions, refusals, and changes in condition will be documented in the medical record, including any education provided and resident or family preferences. 1.) R7 was admitted to the facility on [DATE] with diagnoses of Type 2 diabetes, cancer of the left ovary, and major depressive disorder. R7's Significant Change Minimum Data Set (MDS) assessment dated [DATE] documented R7 had moderate cognitive impairment with a Brief Interview for Mental (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Status (BIMS) score of 12 and required set up or clean up assistance with eating and maximal to total assistance for all other activities of daily living. R7 was on a therapeutic diet and did not trigger the Nutritional Care Area Assessment for further evaluation. R7's Nutritional Care Plan was initiated on 2/5/2021 and last revised on 9/4/2025 with the potential for nutritional problems related to diet restrictions, risk of malnutrition, insulin dependent diabetes, congestive heart failure, diuretics, chronic kidney disease, anemia, and no teeth with R7 preferring to eat without dentures. On 12/5/2025, R7 weighed 180.5 pounds. On 1/1/2026, R7 weighed 185.6 pounds. On 1/8/2026, Registered Dietician (RD)-Q completed and documented a Quarterly Nutrition Assessment in R7's medical record. RD-Q documented R7 remained on a no added salt/low sodium diet with supplementation of 4 ounces of Glucerna twice daily. R7 was able to feed self independently after tray was set up and intakes were 76%-100% with some 51%-75%. The plan was to continue the supplement as R7's weights have remained stable over the past year. R7 had not had a significant weight gain since starting the supplement in 2022. RD-Q documented they would continue to monitor intakes and trends. On 2/3/2026, R7 weighed 176.5 pounds, a loss of 9.1 pounds, or 4.9 percent in one month. No reweight was documented and no documentation was found indicating the physician or RD-Q were notified by nursing staff of the significant weight loss. On 3/5/2026, R7 weighed 180.1 pounds. On 4/6/2026, R7 weighed 169.9 pounds, a loss of 10.2 pounds, or 5.7 percent in one month. On 4/6/2026, RD-Q completed and documented a Quarterly Nutrition Assessment in R7's medical record. RD-Q documented R7 remained on a no added salt/low sodium diet with supplementation of 4 ounces of Glucerna twice daily. R7 was able to eat independently after the tray was set up. Intakes appeared slightly decreased from the last Quarterly Nutrition Assessment ranging from 26%-100% completion. R7 had been working with Speech Therapy since 2/2026 due to coughing with intake. R7 was discharged from services on 4/8/2026 after meeting their goals. RD-Q documented R7 showed a significant weight loss of 5.7 % (10 pounds) in one month and 8.5% (15.7 pounds in three months. Weight is out of usual body weight and intakes do appear decreased. RD-Q documented a reweight would be requested to confirm the loss. Surveyor noted no reweight was documented and the physician was not notified of the significant weight loss. On 5/7/2026, R7 weighed 170.5 pounds. On 6/8/2026, R7 weighed 155.1 pounds, a loss of 15.4 pounds, or 9 percent in one month. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/12/2026 at 8:30 AM in the progress notes, the Nurse Practitioner (NP) documented in their monthly follow-up note R7's vital signs and chart were reviewed. R7's weight on 6/8/2026 was 155.1 pounds, significantly down from 170.5 pounds on 5/7/2026 representing a notable weight loss of approximately 15 pounds. Blood sugars were reviewed and were running mostly in the low to mid 100s; no changes were warranted at that time. The NP documented R7 had wounds at that time. Surveyor noted increased nutrition is necessary when healing wounds and weight loss is not desirable. R7 lost 30.5 pounds in 5 months, or 16.43 percent, from 1/1/2026 to 6/8/2026. No reweights were obtained after the weight losses on 2/3/2026, 4/6/2026, or 6/8/2026. No documentation was found indicating the physician or Registered Dietician (RD)-Q were notified by nursing staff of the significant weight losses at the time the weights were obtained. In an interview on 6/28/2026 at 10:21 AM, Surveyor asked R7 if they had been losing weight recently. R7 stated yes, they were not hungry and did not have much of an appetite except for spaghetti and they only have that once a week. R7 was not upset about the weight loss but did not know why it was occurring. In a phone interview on 6/30/2026 at 1:05 PM, Surveyor asked RD-Q and RD Manager-R how they are notified or become aware of significant weight loss. RD-Q stated they go through the monthly weights independently and are occasionally notified of weight changes, but mostly it is through RD-Q's own review. RD-Q stated the nutrition assessment for each resident is completed with the MDS cycle and RD-Q will complete the nutrition and hydration Care Area Assessments with the comprehensive MDS assessments. Surveyor asked RD-Q and RD Manager-R if they would expect the facility to call and notify them of a significant weight loss. RD Manager-R stated they were the dietician at the facility prior to RD-Q, and they would discuss weight concerns during morning meetings. Surveyor asked RD Manager-R how often they were at the facility in a week. RD Manager-R stated once a week the dietician is at the facility. Surveyor asked RD-Q if they were aware of R7's significant weight loss in February, April, and June of 2026. RD-Q stated they attended the morning meetings and did not hear about R7's weight loss. RD-Q reviewed their notes and stated a reweight was requested in April 2026 as well as this month, June 2026. RD-Q stated R7's weight did not seem to be R7's ordinary weight and that is why there was a request for a reweight. Surveyor asked if RD-Q was contacted about the weight loss. RD-Q stated, no, RD-Q found the weight loss on their own when reviewing the chart. RD-Q stated when looking at R7's record, a reweight was not documented. RD-Q stated R7 did not have a change in eating habits and how much is being eaten. Surveyor asked RD-Q if they would expect nursing staff to call them. RD-Q stated a lot of times they will just bring it up in morning meetings or they will ask if it seems out of the ordinary to anyone else. Surveyor asked RD-Q what the facility protocol was for getting reweights. RD-Q stated at a sister facility the weight policy says if there is a 5- or 10-pound weight change, they are to get a reweight. RD-Q confirmed they were not notified by the facility of R7's significant weight changes. In an interview on 6/30/2026 at 1:41 PM, Surveyor asked Licensed Practical Nurse (LPN)-X what the policy was for getting resident weights. LPN-X stated a weight is gotten when the resident is a new admission, weekly times four weeks, and then monthly unless the weights are ordered differently. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	admission MDS dated [DATE] documented R40 as having severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 6 and needed set-up assistance for eating. R40 was receiving physical and occupational therapy. R40 had an order for a mechanical soft diet on admission. R40's Activities of Daily Living (ADL) Care Plan initiated on 5/29/2026 documented R40 was able to eat independently. On 5/29/2026, R40 weighed 131.4 pounds. On 6/1/2026, R40 weighed 131.4 pounds. On 6/4/2026 at 12:36 PM in the progress notes, Registered Dietician (RD)-Q documented the Nutrition Admit Assessment. RD-Q documented (R40) transferred to the facility from an assisted living due to a decline in mobility, significant weight loss, and overall decline in nutritional status. (R40) had refused the majority of meals with some meal intake 0-25%. RD-Q documented (R40) had a limited weight history available with the last primary care physician visit on 6/5/2025 with a weight of 175.2. RD-Q documented the weight history shows a significant weight loss of 25.2% (44 pounds) in one year. RD-Q documented concern for further decline in nutrition status and weight loss due to meal refusals and poor intakes. RD-Q documented current supplementation remains appropriate and recommended consideration of an appetite stimulant if appropriate and within goals of care. On 6/10/2026, R40 weighed 118.8 pounds, a loss of 12.6 pounds or 9.6 percent in one week. R40 was admitted to hospice services on 6/12/2026 with the primary diagnosis of Parkinson's disease. No Significant Change MDS was initiated or completed to comprehensively assess the decline in ADLs or weight loss to coordinate care for R40 with the facility and hospice. Cross reference F637. On 6/17/2026, R40 weighed 116.7 pounds. On 6/21/2026, R40 weighed 118.6 pounds. On 6/26/2026, R40 weighed 121.0 pounds. R40 lost 10.4 pounds from admission on [DATE] to 6/26/2026, or 7.9 percent in one month. No documentation was found that RD-Q or a physician was notified of the significant weight loss. In an interview on 6/28/2026 at 1:15 PM, Surveyor asked R40 if they had recently lost weight. R40 stated probably but was not sure because they only weighed R40 a couple of times. Surveyor observed R40 lying flat on the back with jerking, tremor-type movements of the arms. R40 stated they only liked breakfast and would eat lunch and dinner if they served breakfast three times a day. In a phone interview on 6/30/2026 at 1:05 PM, Surveyor asked RD-Q and RD Manager-R how they are (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Aria at Mitchell Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 5301 W Lincoln Ave West Allis, WI 53219	
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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	notified or become aware of significant weight loss. RD-Q stated they go through the monthly weights independently and are occasionally notified of weight changes, but mostly it is through RD-Q's own review. RD-Q stated the nutrition assessment for each resident is completed with the MDS cycle and RD-Q will complete the nutrition and hydration Care Area Assessments with the comprehensive MDS assessments. Surveyor asked RD-Q and RD Manager-R if they would expect the facility to call and notify them of a significant weight loss. RD Manager-R stated they were the dietician at the facility prior to RD-Q, and they would discuss weight concerns during morning meetings. Surveyor asked RD Manager-R how often they were at the facility in a week. RD Manager-R stated once a week the dietician is at the facility. Surveyor asked RD-Q if they were familiar with R40. RD-Q stated they last saw R40's weight for the admission MDS and have not had a chance to look at R40's weights. RD-Q stated they talked to Director of Nursing (DON)-B about R40's nutrition status and about the significant weight loss prior to admission. Surveyor shared with RD-Q and RD Manager-R the concern R40 has lost over 10 pounds in the first month of admission. RD-Q stated they attended morning meetings and did not hear about R40's weight loss. Surveyor shared that R40 had been placed on hospice on 6/12/2026. RD-Q stated with R40 refusing meals and the low intake, RD-Q anticipated weight loss. RD-Q stated they attempted to meet with R40 but R40 refused to speak to RD-Q. RD-Q stated the speech therapy notes said the same thing about refusing to speak to them. Surveyor shared with RD-Q the conversation with R40 about liking the breakfast meal and would eat breakfast three times a day. RD Manager-R stated they were not sure if the kitchen gets the resident preferences but would bring it up to the kitchen staff to talk to R40. RD-Q stated they were not notified by nursing staff that R40 had a weight loss. In an interview on 6/30/2026 at 1:41 PM, Surveyor asked Licensed Practical Nurse (LPN)-X what the policy was for getting resident weights. LPN-X stated a weight is gotten when the resident is a new admission, weekly times four weeks, and then monthly unless the weights are ordered differently. LPN-X stated the nurse on the floor enters the weight into the resident's electronic medical record. Surveyor asked LPN-X if the nurse can view the previous weight to see if the weight is similar or if there is a variance. LPN-X stated yes, the previous weight is visible. Surveyor asked LPN-X if the weight is significantly higher or lower, is there a pop-up to alert the nurse to that weight change. LPN-X stated yes. Surveyor asked LPN-X what is done when there is a significant weight change. LPN-X stated they would get a reweight, maybe that day or the next day; it depended on what was going on at the time on the unit. Surveyor asked LPN-X if they were aware of R40's weight loss. LPN-X stated R40 is good about drinking the Ensure supplement but has to be fed because R40 shakes. Surveyor asked LPN-X if staff were aware that R40 needs to be fed. LPN-X stated yes, because otherwise the food would go everywhere and R40 would not get any of it in their mouth. Surveyor shared with LPN-X R40's Care Card which documented R40 was independent with eating. LPN-X stated that was not right; there was no way R40 could feed themselves. Surveyor asked LPN-X what they would have done if they had been the nurse to put the weight in with the significant weight loss. LPN-X stated they would have gotten a reweight and would let the Director of Nursing (DON) know. Surveyor asked if the dietician would be involved in the conversation. LPN-X stated the dietician would bring in magic cup or another supplement and the DON would be the one that would notify the dietician or physician. In an interview on 6/30/2026 at 1:58 PM, Surveyor asked DON-B how RD-Q becomes aware of significant weight loss. DON-B stated RD-Q looks at the monthly weights. Surveyor shared with (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	DON-B the concern R40 had lost 10 pounds in the first month of admission. DON-B stated the initial weight may have been a hospital weight. Surveyor shared with DON-B the admission weight on 5/29/2026 of 131.4 pounds was the same weight on 6/1/2026. DON-B stated the second weight is suspicious being exactly the same as the previous weight. Surveyor shared with DON-B the concern R40's Care Plan does not match R40's ability to eat independently. Surveyor shared LPN-X's interview stating R40 needs to be fed due to the jerking motion of the arms. DON-B stated if staff notice a decline, they should let management know. Surveyor shared with DON-B if R40's Significant Change MDS had been initiated with the election of hospice, these changes and deficits may have been caught and addressed. Surveyor shared with DON-B the concern R40 had a significant weight loss that RD-Q was not aware of and it is the policy of the facility to have RD-Q notify the physician. No documentation was found that the physician was notified and RD-Q stated they were not aware of R40's weight loss. 3.) The facility's policy titled, Nutrition/Hydration Status Maintenance and revised 10/17/25 under Procedure #3. documents Fluid Restrictions: Residents with a physician-ordered fluid restriction shall have the restriction implemented and monitored in accordance with the physician's order and individualized plan of care. a. For residents on a fluid restriction: i. The total daily fluid allowance will be clearly communicated to nursing, dietary, and other applicable staff. ii. Fluids shall be distributed throughout the day to promote comfort, compliance, and adequate symptom management while adhering to the prescribed restriction. iii. Nursing staff will accurately document fluid intake in accordance with the residents' care plan and facility policy. R5's diagnoses include end stage renal disease and dependence on renal dialysis. R5's potential for fluid volume deficit (dehydration) r/t (related to) fluid restriction initiated & revised 6/3/25 document the following interventions: *Fluid restriction of 2000 ml(milliliters)/24 hours, 360 nursing, 1640 dietary. Initiated & revised 6/3/25. *Monitor fluid intake. Initiated 6/3/25. *Monitor/report S & S (signs and symptoms) dehydration: dry mouth, poor skin turgor, dark/concentrated urine or decreased urinary output, sunken eyes, constipation, confusion/altered mental status, warm/dry skin. Initiated 6/3/25. *Notify physician when indicated. Initiated 6/3/25. R5's physician orders include an order dated 1/6/26 which documents Dietary: Fluid restrictions 2000 ml/24 hours - 120 ml every shift for nursing & 540 every shift with dietary. R5's nutrition note dated 4/28/26 written by RD (Registered Dietitian)-Q documents CBW (current body weight): 4/28- 140.6#. Significant loss of 6.6% (10#) x 1 month. Resident has frequent weight changes d/t fluid status. Resident also noted to have decreased intake throughout hospital stay. 2 meals charted since readmission at 0-50%. Resident does have an order for Glucerna QD (every day) to (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	support intakes. Have not received labs from dialysis RD this month r/t (related to) resident's hospital admission. Hosp (hospital) Labs: 4/27- Ca (calcium): 10.6H, alb (albumin): 3.4L. 4/17- A1C (glycated hemoglobin): 6.6% improved from 6.9% on 1/2026. Notified NP & facility re: significant weight change via email on 4/28. R5's significant change MDS (minimum data set) with an assessment reference date of 5/20/26 has a BIMS (brief interview mental status) score of 15 which indicates cognitively intact. R5 is assessed as requiring set up for eating. R5's nutritional CAA (care area assessment) dated 5/21/26 under analysis of findings for nature of problem/condition documents BMI (body mass index): 25.7 &ndash; overweight. Significant loss x (times) 1 month r/t (related to) fluid changes/decreased intake. Therapeutic diet appropriate for dx (diagnosis) management. Under care plan considerations for describe impact of this problem/need on the resident and your rationale for care plan decision documents see clinical notes. R5's nutrition note dated 6/23/26 written by RD-Q documents 140.6#. Current weight shows no significant weight changes at 1/3/6 months. Ongoing communication with resident's HD (hemodialysis) RD. Estimated dry weight: 140.8#. Labs: 6/18 Hgb (hemoglobin) 9.2L (low), glucose 54L, the rest were WDL (within desired limits). Facility glucose trends over the past week: mid 100s to low 200s. PO (by mouth) intakes continue to be variable ranging from 0-100%. Receives Glucerna QD (every day) to support intakes &ndash; accepts daily per MAR (medication administration record). R5's physician progress note dated 6/26/26 written by Nurse Practitioner (NP)-AA under assessment and plan includes documentation of Continue low-dose metoprolol tartrate 25 mg (milligrams) every 12 hours. Monitor for symptoms of volume overload. Fluid removal managed via hemodialysis three times weekly. R5's Certified Nursing Assistant (CNA) Kardex as of 6/29/26 under the eating/nutrition section documents *EATING: The resident is independent with eating with staff to provide set up assistance. *MONITOR-MEAL PERFORMANCE. Surveyor noted R5's Kardex does not include R5's fluid restriction. Surveyor reviewed R5's June TAR (treatment administration record) which includes Dietary: Fluid restriction 2000 ml/24 hours &ndash; 120 ml every shift for nursing & 540 every shift with dietary -every shift &ndash; Start date 1/6/26. Surveyor noted there is a check mark with initials daily for each shift. The TAR does not indicate the number of fluids R5 actually consumed each shift. On 6/30/26, at 7:18 a.m., surveyor observed R5's breakfast tray on R5's over bed table. Surveyor observed that there is a cup of coffee, glass of juice and R5's breakfast plate is covered. On 6/30/26, at 10:31 a.m., surveyor asked CNA-S if R5 has any type of food or fluid restriction. CNA-S replied no not that I know of. On 6/30/26, at 10:32 a.m., surveyor asked CNA-K if R5 has any type of food or fluid restriction. CNA-K (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	replied not that I know of, but you can check the Kardex. On 6/30/26, at 10:36 a.m., CNA-K informed surveyor R5 is still on fluid restriction. Surveyor asked CNA-K how he found out R5 is on a fluid restriction. CNA-K informed surveyor he spoke with the nurse. On 6/30/26, at 10:37 a.m., surveyor observed there are three water glasses in R5's room. There is a water glass dated 6/29 AM (morning) partially filled on R5's over bed table. There are two water glasses on the dresser next to R5's recliner. One water glass is dated 6/29 with initials documented approximately half filled, and another water glass not dated which is full. On 6/30/26, at 10:42 a.m., surveyor asked Licensed Practical Nurse (LPN)-X if R5 is under a fluid restriction. LPN-X replied, let me look. LPN-X then informed surveyor R5 is on a 2000 fluid restriction in a 24-hour period and is non-compliant. Surveyor asked LPN-X if residents on fluid restrictions can have water glasses in their room. LPN-X informed surveyor they should get water in their room. Surveyor asked LPN-X if the amount of fluid R5 actually consumes is documented anywhere to ensure R5 is staying within their fluid restrictions. LPN-X replied no. On 6/30/26, at 11:44 a.m., surveyor asked Director of Nursing (DON)-B how the facility monitors a resident's fluid restriction. DON-B explained she keeps on the board who is on fluid restriction. DON-B informed surveyor when there is an order for fluid restriction, she contacts the dietitian for specific breakdown for staff to follow. There is a sign inside the resident's room and at the nurse's station with the breakdown per shift of how much nursing and dietary are allowed. This information is transferred into the care plan. Surveyor asked if a resident is on fluid restriction, are water glasses allowed in the room. DON-B replied only if it's figured in what they receive. Surveyor informed DON-B surveyor has observed water glasses in R5's room. Surveyor informed DON-B surveyor noted R5 is on a 2000 ml fluid restriction and asked if R5's actual fluid consumption is monitored & documented to ensure R5 stays within the fluid restriction. DON-B replied other than the care plan and order, no. On 6/30/26, at 1:22 p.m., surveyor spoke with RD-Q and WI (Wisconsin) area manager-R on the telephone to inquire about resident's fluid restrictions. RD-Q informed surveyor they have a sheet with breakdown for fluid that she references. Surveyor informed RD-Q surveyor noted R5 is on a 2000 ml fluid restriction and asked if anyone is monitoring R5's actual fluid intake. RD-Q informed surveyor she doesn't believe it's tallied up. WI area manager-R informed surveyor usually nursing does, its nursing observing so they can see if a resident is compliant and can notify the physician. RD-Q informed surveyor she hasn't seen any documentation that R5 is non-compliant with the fluid restriction. On 6/30/26, at 1:47 p.m., surveyor asked Activity Assistant-CC if she was aware of any resident on a fluid restriction. Activity Assistant-CC informed surveyor she was not aware of any.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility did not ensure that drugs and biologicals used in the facility were labeled and include the expiration date, when applicable, for 5 (R34, R2, R36, R44, & R5) of 9's resident's insulin.*R34 & R2 insulin pens were together in the bottom of the medication cart and not in bags.*R36 & R44's insulin bottles were together in the bottom of the medication cart and not in a medication container.R5's lispro insulin was not dated when open & used.Findings include:The facility's policy titled, Storage of Medications and revised January 2018 under policy documents Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Under procedures for the section Expiration Dating (Beyond-use dating) D. documents When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. 1) The nurse shall place a date opened sticker on the medication and enter the date opened and the new date of expiration (NOTE: the best stickers to affix contain both a date opened and expiration notation line). The expiration date of the vial or container will be [30] days unless manufacturer recommends another date or regulations/guidelines require different dating.1.) On 6/29/26, at 1:16 p.m., surveyor observed in the 3rd floor medication cart in the bottom drawer a compartment type container. On the right side of the container, the first compartment contained a Lantus Solostar insulin pen for R34 and a second insulin pen, NovoLog mix 70/30 for R2. These two pens were not in a bag or any other medication container.2.) On 6/29/26, at 1:21 p.m., surveyor observed in another compartment of the container was a Lispro insulin bottle for R36 and a Humulin R insulin bottle for R44. These two insulin bottles were not in a medication container.On 6/29/26, at 1:23 p.m., surveyor asked Licensed Practical Nurse (LPN)-D if insulin pens are usually kept in a bag. LPN-D replied yes, but some don't have a bag.3.) On 6/29/26, at 1:24 p.m., surveyor observed in the bottom drawer, all the way to the right a bottle of Lantus insulin for R5 that was open, used and not dated.On 6/29/26, at 1:27 p.m., surveyor asked LPN-D if insulin bottles should be dated when they are opened. LPN-D informed surveyor they should be dated for 28 days.On 6/29/26, at 3:51 p.m., surveyor asked Assistant Director of Nursing/Infection Preventionist (ADON/IP)-C if insulin bottles should be dated when opened. ADON/IP-C replied yes absolutely. Surveyor asked ADON/IP-C if insulin pens are placed in bag. ADON/IP-C informed surveyor each resident has a bag with their name. Surveyor informed ADON/IP-C of the observation of insulin pens and bottles not in a bag or container and R5's insulin not dated when opened.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review the facility did not ensure each resident is treated with dignity and respect that promotes maintenance or enhancement of quality of life for 1 (R39) of 13 residents.*On 6/28/26 Certified Nursing Assistant (CNA)-S stood while feeding R39.Findings include:The facility's policy titled, Resident Rights - Exercise of Rights and revised 4/20/25 under policy statement documents All residents have rights guaranteed to them under Federal and State laws and regulations. This policy is intended to lay the foundation for the resident rights requirements in long-term care facilities. Each resident has the right to be treated with dignity and respect. All activities and interactions with residents by any staff, temporary agency staff, or volunteers must focus on assisting the resident in maintaining and enhancing his or her self-esteem and self-worth and incorporating the resident's goals, preferences, and choices. When providing care and services, staff will respect individuality and honor and value their input. Under procedure #2 documents The facility will treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. 9. Each resident will be treated with dignity and respect.R39's diagnoses includes Parkinson's Disease and Dementia.R39's quarterly minimum data set (MDS) with an assessment reference date of 3/31/26 has a BIMS (brief interview mental status) score of 3 which indicates severe cognitive impairment. R39 is assessed as requiring set up or clean up assistance.On 6/28/26, starting at 12:12 p.m., surveyor observed the lunch meal in the 3rd floor dining room. During this observation, at 12:27 p.m., surveyor observed CNA-S walk over to R39, pick up a spoon and start to feed R39 their lunch. Surveyor observed CNA-S stood the entire time she was feeding R39. At 12:33 p.m., surveyor observed CNA-S finish feeding R39 and removed the clothing protector from R39. On 6/30/26, at 8:58 a.m., surveyor asked Director of Nursing (DON)-B what the expectation is when staff are assisting resident to eat. DON-B replied they are sitting next to the resident not standing over them. Surveyor informed DON-B of the observation during the lunch meal of CNA-S standing and not sitting when feeding R39. DON-B informed surveyor she can't say why CNA-S stood and did not sit.		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation and interview the Facility did not ensure 1 (R45) of 12 residents were provided privacy during personal cares.*R45 was not ensured privacy during wound care when R45's door was left open during the care.Findings include:The Facility Policy and Procedure titled Resident Rights - Exercise of Rights last revised 4/20/25, documents (in part): Procedure.2. The facility will treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality.3. The facility will protect and promote the rights of the resident.On 06/30/2026, at 7:48 AM, Surveyor observed wound care for R45. R45 was turned toward the wall with R45's bare, back side exposed to the door. During wound care Assistant Director of Nursing (ADON)-C dropped the clean border foam dressing on the ground. Licensed Practical Nurse (LPN)-L opened the door to leave the room to get a new dressing. LPN-L left the door open while looking for a new dressing. Another Surveyor approached and asked LPN-L a question and the doorremained open with R45's buttock exposed to the hallway.On 06/30/2026, at 7:49 AM, ADON-C used their foot to kick the door shut. ADON-C was supporting R45 on R45's side with R45's bare backside to the door.On 06/30/2026, at 9:06 AM, Surveyor interviewed ADON-C regarding how they felt about LPN-L leaving the door open when LPN-L left the room. ADON-C stated did you see me kick it shut, I had my back to the door and felt a breeze and realized it was open. ADON-C was concerned R45 was exposed to the hallway.On 06/30/2026, at 10:42 AM, Surveyor interviewed DON-B regarding privacy while cares were being performed. DON-B stated oh no, that should not happen.On 7/01/2026, at 8:16 AM, Surveyor interviewed R45 regarding the door being left open while wound care was being done. R45 replied that they did not notice as they were facing towards the window. R45 stated they would prefer the door shut so they are not exposed.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review the facility did not ensure a resident who uses an as needed (PRN) psychotropic has an order limited for 14 days for 1 (R5) of 5 residents reviewed for unnecessary medication.R5 has an order for PRN lorazepam (Ativan) with an order date of 5/14/26. There is no end date for R5's PRN lorazepam and no documented rationale for continued use.Findings include:The facility's policy titled, Psychotropic Drug Use and revised 4/1/25 under policy F. documents PRN (as needed) orders for psychotropic are limited to 14 days, except if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond the 14 days, her/she should document their rationale in the resident's medical record and indicate the duration of the PRN order.R5's diagnosis includes anxiety disorder.R5's psych note dated 5/7/26 by Advanced Practice Nurse Prescriber (APNP) Psychiatry-BB under history present illness includes documentation of She continues to utilize Lorazepam for anxiety and a panicked feeling. She gets 0.25 mg every eight hours as needed for anxietyand 0.5 mg QHS (every hour sleep) scheduled. Under assessment/plans includes documentation of F41.0 Panic Disorder (Episodic Paroxysmal Anxiety) - Stable and managed with lorazepam. She continues to experience intermittent anxiety and restlessness but remains at her behavioral baseline. She was able to discuss concerns appropriately and responded well to reassurance regarding her room change. She continues dialysis three times weekly and acknowledged concerns regarding vaping during treatments after discussion. No acute anxiety symptoms or panic episodes were observed during today's visit. Staff will continue to monitor for changes in anxiety, behaviors, and coping abilities.R5's physician orders include with an order date of 5/14/26 Lorazepam oral tablet 0.5 mg (milligrams) (Lorazepam) Controlled Drug. Give 0.25 mg by mouth every 8 hours as needed for anxiety. Surveyor noted R5's physician orders does not have an end date for PRN Lorazepam.R5's NP note dated 6/5/26 by NP-AA under assessment and plan documents *F41.9- Anxiety Disorder, Unspecified *: Patient having lots of anxiety; does see behavioral health. Patient is a high fall risk. Continue current anxiolytics; do not increase dosage due to fall risk. Continue sertraline 25 mg PO at bedtime. Continue lorazepam 0.5 mg PO at bedtime and lorazepam 0.25 mg PO every 8 hours PRN anxiety per facility orders. Behavioral health follow-up as arranged by facility.Surveyor noted R5's NP-AA's notes dated 6/12/26, 6/19/26, & 6/24/26 under assessment and plan for anxiety disorder has the same verbiage of NP-AA's note dated 6/5/26.Surveyor was unable to locate an end date for R6's PRN Lorazepam and documented rationale for its continued use.On 6/30/26, at 11:40 a.m., surveyor asked Director of Nursing (DON)-B if PRN psychotropic medications have end dates. DON-B explained that the pharmacist will send their recommendations with stop dates. DON-B informed APNP Psychiatry-BB has not been in since the pharmacy recommendation which is dated 5/31/26. Surveyor informed DON-B R5's PRN Lorazepam did not have a stop date when R5's PRN Lorazepam was ordered on 5/14/26 and there is no documented rationale for continued use of the PRN Lorazepam.On 7/1/26 DON-B provided surveyor with pharmacy recommendation dated 5/31/26 signed by APNP Psychiatry-BB on 6/29/26 which has a prn duration of 90 days and clinical rationale of necessary for psychosocial comfort. Surveyor noted this was not reflected in R5's medical record or current orders.		

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not initiate or complete a comprehensive Significant Change Minimum Data Set (MDS) assessment within 14 days after a significant change was identified for 1 (R40) of 12 sampled residents reviewed. R40 started hospice services on 6/12/2026. On 6/30/2026, 18 days after the election of hospice, a Significant Change MDS assessment had not been scheduled or completed. Findings include: The Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual dated 10/2025 documents: An SCSA (Significant Change in Status Assessment) is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The ARD (Assessment Reference Date) must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). An SCSA must be performed regardless of whether an assessment was recently conducted on the resident. This is to ensure a coordinated plan of care between the hospice and nursing home is in place. A Medicare-certified hospice must conduct an assessment at the initiation of its services. This is an appropriate time for the nursing home to evaluate the MDS information to determine if it reflects the current condition of the resident, since then nursing home remains responsible for providing necessary care and services to assist the resident in achieving their highest practicable well-being at whatever stage of the disease process the resident is experiencing. R40 was admitted to the facility on [DATE] with a diagnosis of Parkinson's disease. R40's admission MDS dated [DATE] documented R40 as having severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 6 and needing set up assistance for eating, moderate assistance with oral hygiene and bed mobility, and dependent with toileting. R40 was receiving physical and occupational therapy. On 6/12/2026, R40 was admitted to hospice. On 6/30/2026, Surveyor noted a Significant Change MDS had not been scheduled to capture the onset of hospice to coordinate R40's care. In an interview on 6/30/2026 at 9:08 AM, Surveyor asked MDS Licensed Practical Nurse (LPN)-Y what the facility process was for scheduling, completing, and signing MDS assessments. LPN-Y stated they schedule the MDS assessments and complete the assessments, and then a Registered Nurse (RN) or the Regional RN signs the assessments. Surveyor asked LPN-Y what would constitute the need for a Significant Change MDS assessment. LPN-Y stated that any time a resident goes out to the hospital, they are looked at for the potential of having a significant change and if they return with a fracture, have intravenous antibiotics, or have any skilled nursing needs on readmission, a Significant Change MDS assessment would be started. LPN-Y stated if the resident has a fall in the facility or if they are completing a Quarterly MDS and notice a decline in activities of daily living (ADLs), then they will change it to a Significant Change MDS assessment. Surveyor asked LPN-Y about a resident that elects hospice. LPN-Y stated a Significant Change MDS assessment is done for a resident that either starts hospice or stops hospice with an ARD seven days after signing onto hospice and then they have 14 days to complete the assessment. Surveyor asked LPN-Y if they were aware R40 signed onto hospice services on 6/12/2026. LPN-Y was not aware R40 had elected hospice. LPN-Y stated they usually find out about hospice at morning meetings and the facility did not have all the meetings they normally do because things kept coming up that needed to be done. LPN-Y stated they had never missed a Significant Change MDS assessment before and would schedule one at that time. Surveyor noted a Significant Change MDS assessment was entered into the computer charting system with an ARD of (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/3/2026.On 6/30/2026 at 3:30 PM, Surveyor shared with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B the concern R40 did not have a Significant Change MDS assessment with the start of hospice services to coordinate care with the hospice agency and the facility as well as capture the declines R40 was showing with ADLs and weight loss.		

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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 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 (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility did not ensure 1 (R2) of 1 residents reviewed for Post-traumatic stress disorder (PTSD) receive culturally competent, trauma informed care in accordance with professional stands of practice and accounting or resident's experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of R2.R2 has a diagnosis of PTSD. There is not a PTSD assessment to identify R2's past history of trauma nor is there a person-centered PTSD care plan which includes what triggers R2's PTSD and interventions. Findings include: The facility's policy titled, Trauma Informed Care and dated 10/24/22 under policy documents The facility will ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice, as well as residents' preferences and experiences. Residents will be screened and assessed upon admission in order to identify any history of trauma and/or post-traumatic stress disorder (PTSD). Residents who display or are diagnosed with a mental disorder, psychosocial adjustment difficulty, and/or PTSD will be provided with appropriate treatment and services to attain the highest practicable level of mental and psychosocial wellbeing. Under procedures #8 documents The IDT (interdisciplinary team) Team will ensure that an individualized resident centered care plan is developed for resident that has experienced a traumatic event. The care plan will include but is not limited to the following: *Identification of the stressor/past life trauma. *Identification of interventions that mitigate against re-traumatization. *Identify triggers that could cause re-traumatization. *Clinical manifestations experience by the resident. *Resident-specific goals for preventing re-traumatization. *Interventions including referral for Psychological and Psychiatry services as indicated. *Appropriate recreational activities and or therapeutic relaxing interventions. *The need to obtain assistance from outside agencies and support groups in the community. *The specific cultural, spiritual and professional interventions that would be beneficial for the resident. 12. Residents will be assessed for any history of trauma on each annual assessment and with a significant change in condition. Identified Traumatic events will be care planned for as listed in #8.R2's diagnosis includes post-traumatic stress disorder. R2 has a behavior problem depressed mood r/t (related to) depression, anxiety, bipolar, PTSD, ADHD (Attention-Deficit/Hyperactivity Disorder) care plan initiated & revised 11/22/22 that documents the following interventions: *Administer medications as ordered. Monitor/document for side effects and effectiveness. Initiated 11/18/22. *Anticipate and meet the resident's needs. Initiated 11/18/22. *Behavior monitoring. 1. Depressed Mood. Interventions: 1. Visit 1:1. 2. Visiting with spouse/family. 3. Inform nurse of behavior change. 4. Sees psych services. Initiated 11/18/22 & revised 10/25/23. *Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Initiated 11/18/22. *Monitor prn (as needed) behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. Initiated 11/18/22 and revised 3/29/24. *Provide a program of activities that is of interest and accommodates residents' status. Initiated 11/18/22. Surveyor noted that this behavior care plan does not identify R2's past history of trauma, does not include what triggers may cause R2's re-traumatization and does not include person centered interventions to address R2's PTSD. R2's behavior note dated 3/23/26 at 1559 (3:59 p.m.) written by Social Services Director (SSD)-DD documents Resident reviewed during March Behavior meeting. Resident has diagnosis of anxiety, depression, insomnia, ADHD (continued on next page)		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Attention-Deficit/Hyperactivity Disorder), PTSD. Resident is taking Buspar 15mg (milligrams) TID (three times daily), Wellbutrin 100mg TID, Trazodone 50mg daily, Adderall 20mg BID (twice daily), Prozac 40mg daily and prochlorperazine 5mg TID. Resident is followed by psych services at facility, psych to try a dose reduction but resident hesitant psych will continue to follow up with resident. Resident to be reviewed quarterly or as needed. R2's quarterly social service reassessment dated [DATE] does not address R2's PTSD. R2's quarterly MDS (minimum data set) with an assessment reference date of 3/31/26 has a BIMS (brief interview mental status) score of 15 which indicates cognitively intact. R2 is assessed as having a mood score of 00 and is assessed as not having any behavior. For active diagnosis under psychiatric/mood disorder PTSD is marked yes. R2's psychiatry note dated 4/27/26 by Advance Practice Nurse Prescriber (APNP)-BB under chief complaint documents Follow up psychiatric evaluation and medication management. Under history of present illness includes documentation of 04/27/2026 At today's visit he was seen in his room lying in bed watching videos on his phone. He remains at his baseline. He denied any concerns related to depression or anxiety and stated, I'm good. He continues to decline medication changes and prefers to stick to his routine. Staff deny any concerns regarding mood, behavior, or cognition. Sleep is restful with trazodone, and he denies daytime drowsiness. Cognition appears to be at baseline with a BIMS score of 11. Under post medical/surgical history includes Post-traumatic Stress Disorder, Unspecified. PTSD is not included under assessment/plan. R2's behavior note dated 6/22/26 at 1558 (3:58 p.m.) written by SSD-DD documents Resident reviewed during June behavior meeting. Resident has diagnosis of depression, anxiety, ADHD, and insomnia. Resident is taking Buspar 15mg TID, Wellbutrin 100mg TID, Trazodone 50mg daily, Adderall 20mg BID, Prozac 20mg daily and Compazine 5mg TID. Resident has hx (history) of depressed mood, self-isolation. Resident is followed by psych services at facility. Resident to be reviewed quarterly or as needed. On 6/28/26, at 3:31 p.m., surveyor observed R2 sitting in a Broda chair in R2's room. Surveyor asked R2 about their PTSD. R2 stated it may be from ADHD but didn't want to discuss this further with surveyor. Surveyor asked R2 if there is anything that gets them upset. R2 informed surveyor if someone is in their face or when there is loud talking, they go off. R2's Certified Nursing Assistant (CNA) Kardex as of 6/29/26 under the behavior/mood section documents *Behavior monitoring. 1. Depressed Mood. Interventions 1. Visit 1:1; 2. Visiting with spouse/family (Surveyor noted R2 was never married); 3. Inform nurse of behavior change; 4. Sees psych services. *If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident. *Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Under the section monitoring includes documentation of *Monitor prn (as needed) behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. R2's CNA Kardex does not address R2's PTSD and any triggers which may re-traumatize R2. On 6/29/26, at 11:56 a.m., surveyor asked Certified Nursing Assistant (CNA)-S to inquire about R2. CNA-S informed surveyor R2 does really good with her and she talks to R2 about what she is going to do for them. Surveyor asked CNA-S if she has ever been told what topics she shouldn't speak with R2 about or anything she shouldn't do which may trigger R2's PTSD. CNA-S replied no. On 6/29/26, at 12:03 p.m., surveyor asked CNA-EE if anyone has spoken to her about what may trigger R2's PTSD. CNA-EE replied no. On 6/29/26, at 12:04 p.m., surveyor asked Social Services Director (SSD)-DD what she can tell surveyor about R2's PTSD. SSD-DD replied I don't know too much about it, an outside psych provider diagnosed R2 with it. SSD-DD explained R2 doesn't really go into details about R2's PTSD with her and R2 has not had a moment of PTSD either. Surveyor asked (continued on next page)		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	SSD-DD if she does PTSD (trauma informed care) assessments. SSD-DD replied I've never done one before, no. Surveyor asked SSD-DD if PTSD is something she would care plan for. SSD-DD replied I think I do have it in my behavior care plan, would have to double check. Surveyor informed SSD-DD surveyor had reviewed R2's care plan and did note a behavior care plan but this care plan does not include what triggers R2's PTSD and person-centered interventions for R2's PTSD. SSD-DD stated to surveyor R2 has never spoken to her about their PTSD so how could she care plan. Surveyor shared with SSD-DD surveyor had asked R2 about their PTSD. R2 informed surveyor it may be from their ADHD and really didn't want to speak with surveyor about it but did tell surveyor R2 doesn't like when someone is too close or speaks loudly. On 6/29/26, at 12:30 p.m., surveyor spoke with APNP Psychiatry-BB on the telephone. Surveyor asked APNP Psychiatry-BB what she could tell surveyor about R2's PTSD. APNP Psychiatry-BB replied you know I have to be honest it's a historical diagnosis. APNP Psychiatry-BB explained she doesn't have a lot of data and a lot of times a resident comes in with their diagnoses. APNP Psychiatry-BB informed surveyor R2 doesn't engage deeply with her. PTSD is on R2's diagnoses list but can't tell surveyor much about it. APNP Psychiatry-BB informed surveyor R2's diagnosis of PTSD is dated 11/7/22 which was well before she started his care explaining she's been with the company as a psych np for a year. On 6/29/26, at 1:00 p.m., surveyor asked Director of Nursing (DON)-B who is responsible for PTSD (trauma informed care) assessments. DON-B replied that would be [name], the Social Service Director. Surveyor asked DON-B if SSD-DD would create a PTSD care plan. DON-B replied yes.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review the Facility did not ensure there was a medication error rate below 5 percent. There were 4 medication errors in 30 opportunities which resulted in a medication error rate of 13.33%. Medication errors were identified for 1 (R44) of 2 residents observed. R44 did not receive the correct dose of Amantadine HCl & Valproic Acid, did not receive Multivitamins Plus Iron child oral tablet chewable 18 mg (milligrams) and Clear lax was not initially administered enterally according to physician orders. Findings include: 1.) On 6/29/26, at 8:28 a.m., surveyor observed Licensed Practical Nurse (LPN)-D prepare R44's medication. LPN-D poured 5 ml (milliliter) of Amantadine Hydrochloride 50 mg (milligrams)/5 ml into a medication cup. LPN-D then poured 5 ml of Valproic acid 250 mg/5 ml into another medication cup. On 6/29/26, at 9:19 a.m., surveyor observed LPN-D cleaned the end of R44's G (gastrostomy) tube with an alcohol wipe stating he has feeding & meds and then flushed R44's feeding tube with 30 cc (cubic centimeters) of water. LPN-D administered 5 ml of Valproic Acid, flushed R44's tube with 30 cc of water and then administered 5 ml of Amantadine HCl. On 6/29/26, starting at 7:24 p.m., surveyor reviewed R44's physician orders and noted an order dated 4/30/26 which documents Amantadine HCl Oral Solution 50 mg/5ml (Amantadine HCl) Give 15 ml enterally two times a day for treat Dyskensia. LPN-D administered 5 ml not 15 ml according to physician orders. This resulted in a medication error for R44. Surveyor reviewed R44's physician orders and noted an order dated 6/16/26 which documents Valproic Acid Oral Solution 250mg/5ml. (Valproate Sodium) Give 24 ml enterally three times a day for Epilepsy. LPN-D administered 5 ml not 24 ml according to physician orders. This resulted in a medication error for R44. This observation resulted in two medication errors for R44. 2.) On 6/29/26, at approximately 8:50 a.m., surveyor observed LPN-D remove one tablet Multivitamin with Minerals from a bottle into a medication cup with other medication tablets. At 8:59 a.m. surveyor observed LPN-D remove a second tablet of Multivitamin with Minerals from the bottle into a medication cup with other medication tablets including the previous multivitamins with minerals tablet. At 9:04 a.m., LPN-D poured all the medication tablets into an envelope and crushed R44's medication. At 9:31 a.m., LPN-D stated she's going to add 20 ml to get them (referring to the crushed tablets) mushy and will keep putting water in there. LPN-D flushed R44's G-tube with 30 cc of water, administered a portion of the crushed medication, added additional water and repeated this process multiple times. On 6/29/26, starting at 7:24 p.m., surveyor reviewed R44's physician orders and noted an order dated 4/30/26 which documents Multivitamins Plus Iron Child Oral Tablet Chewable 18 Mg (Pediatric Multiple Vitamins w/ (with) Iron. Give 1 tablet enterally one time a day for supplement. Another order dated 4/30/26 which documents Thera M Plus Oral Tablet (Multivitamins w/Minerals) Give 1 tablet enterally one time a day for supplement. LPN-D did not administer Multivitamins Plus Iron Child Oral Tablet Chewable 18 Mg (Pediatric Multiple Vitamins w/ Iron. This resulted in a medication error for R44. This observation resulted in the third medication error for R44. 3.) On 6/29/26, at approximately 8:50 a.m., Surveyor observed LPN-D pour a packet of Potassium Chloride 20 meq (milliequivalent) into a cup & add water. LPN-D then poured 17 grams of Clear Lax into the cup containing Potassium Chloride 20 meq and added additional water for 240 ml. LPN-D then mixed the two medications together. On 6/29/26, at 9:25 a.m., LPN-D flushed R44's G tube with 30 cc of water and asked R44 if he wanted to drink or put in the tube. R44 asked LPN-D what it was. LPN-D informed R44 potassium and Miralax. LPN-D put a straw in the mixture and R44 drank a small amount. LPN-D raised the head of the bed, R44 drank a little more and then stopped drinking. LPN-D then administered the potassium chloride & clear lax via R44's G-tube. Upon completion, LPN-D flushed R44's G tube with 30 cc of (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525600	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2026
NAME OF PROVIDER OR SUPPLIER Aria at Mitchell Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	water.On 6/29/26, starting at 7:24 p.m., Surveyor reviewed R44's physician orders and noted an order dated 4/30/26 Polyethylene Glycol 3350 Powder (Polyethylene Glycol 3350 (Bulk)), Give 17 gram enterally one time a day for constipation. LPN-D initially administered this medication orally which was the incorrect route. This resulted in a medication error for R44.This observation resulted in R44's fourth medication error.On 6/30/26, at 9:01 a.m., Surveyor asked Director of Nursing (DON)-B should nurses follow physician orders during medication pass. DON-B replied yes. Surveyor then informed DON-B of the four medications observed for R44 with LPN-D.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review the facility did not maintain an infection prevention and control program designed to reduce the transmission of disease and infection for 1 (R44) of 2 Residents during medication administration.* Appropriate hand hygiene was not observed during R44's medication administration. Findings include: The facility's policy titled, Infection Control - Hand Hygiene, and last revised 4/1/25 under policy statement documents The facility's policy is to perform hand hygiene per national standards from the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO). On 6/29/26, at 8:28 a.m., surveyor observed Licensed Practical Nurse (LPN)-D prepare R44's medication. LPN-D poured 5 ml (milliliter) of Amantadine Hydrochloride 50 mg (milligrams)/5 ml into a medication cup and 5 ml of Valproic acid 250 mg/5 ml into another medication cup. From a blister pack, LPN-D punched one tablet cefuroxime axetile 250 mg and one tablet Amlodipine 5 mg into a medication cup. LPN-D then poured 30 cc (cubic centimeters) of critical care protein. At 8:37 a.m., after pouring R44's critical care protein, LPN-D cleaned off the top of the medication cart with a disinfectant wipe. Surveyor observed LPN-D did not perform any hand hygiene after disinfecting the top of the medication cart. LPN-D then continued with preparing R44's medication including folic acid 400 mcg (micrograms) which LPN-D placed gloves on as the physician orders required 2.5 tablets. LPN-D broke one tablet of folic acid in half. LPN-D continued to wear her gloves until she completed preparing R44's medication. At 9:04 a.m., LPN-D crushed R44's medication together except for Clonazepam 0.5 mg which was crushed separately. At 9:10 a.m., LPN-D removed her gloves and threw the gloves away in the garbage container on the medication cart. LPN-D then placed gloves & a gown on and entered R44's room. Surveyor observed LPN-D did not perform any hand hygiene after removing her gloves. At 9:12 a.m., LPN-D entered R44's room with R44's medication. LPN-D placed paper towels on a chair and filled a graduate with 360 cc of water. LPN-D informed surveyor she was going to check R44's blood sugar. After LPN-D checked R44's blood sugar, LPN-D removed her gloves, went to the room door and asked for gloves. LPN-D placed a new pair of gloves on. Surveyor observed LPN-D did not perform any hand hygiene after removing her gloves. LPN-D flushed R44's G (gastrostomy) tube, administered R44's medications, flushing in between and upon completion. At 9:38 a.m., LPN-D rinsed the syringe used to administer R44's medication, removed her gloves stating now we can leave and come back to give insulin. LPN-D removed her gown and cleansed her hands at the medication cart. On 6/30/26, at 9:01 a.m., surveyor asked Director of Nursing (DON)-B what the expectation regarding hand hygiene during medication pass is. DON-B informed surveyor at least an alcohol-based hand sanitizer between patients, if known contamination then soap & water at a minimum. Surveyor asked DON-B after removing gloves, should a nurse perform hand hygiene. DON-B replied yes, the same. Surveyor informed DON-B of the observations of LPN-D not performing hand hygiene while preparing and administering R44's medication.		

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NAME OF PROVIDER OR SUPPLIER Aria at Mitchell Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure the pneumococcal immunization education was provided and the refusal was documented for 1 (R40) of 5 sampled residents reviewed for immunizations.*R40 did not have documentation of education with the benefits of the pneumococcal vaccine and the refusal or acceptance of the vaccine in the medical record.Findings include:The facility policy and procedure titled Infection Control - Influenza, Covid and Pneumococcal Immunizations for Residents documents: PROCEDURE: . Pneumococcal Immunization: 1. Before offering the pneumococcal immunization, each resident and or resident representative receives education regarding the benefits and potential side effects of the vaccine; 2. Each resident is offered pneumococcal immunization unless the immunization is medically contraindicated or the resident has already been immunized; 3. The resident and or resident representative has the opportunity to refuse immunization; and 4. The resident's medical record includes documentation that indicates; as a minimum, the following: a. That the resident or resident representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and b. That the resident received the pneumococcal vaccination or did not receive the pneumococcal vaccination due to medical contraindication or refusal. 5. Pneumococcal immunization will be offered in accordance with CDC.R40 was admitted to the facility on [DATE].Review of R40's immunization record showed R40 was due to receive the Prevnar 20 vaccination. No documentation was found in R40's medical record that R40 was provided education on the pneumococcal immunization or R40's refusal to receive the immunization.In an interview on 6/30/2026 at 11:01 AM, Surveyor asked Assistant Director of Nursing (ADON)-C and Director of Nursing (DON)-B what the facility process was for offering immunizations to newly admitted residents. DON-B stated DON-B or ADON-C will approach the new resident with the immunization information and document the education was given along with either the acceptance or refusal of the immunization. ADON-C stated the second shift nursing supervisor will also ask new residents about the immunizations as well. Surveyor shared with ADON-C and DON-B the concern R40 did not have any documentation that education was provided or the response of R40 to the question of getting or refusing the pneumococcal immunization. DON-B reviewed R40's medical record and agreed there was no documentation. DON-B shared R40's hospital discharge paperwork that documented R40 had declined the immunization at the hospital. Surveyor shared the facility still had the obligation to present the same information to R40 upon admission to the facility. DON-B agreed.		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure the COVID-19 immunization education was provided and the refusal was documented for 1 (R40) of 5 sampled residents reviewed for immunizations.*R40 did not have documentation of education with the benefits of the COVID-19 vaccine and the refusal or acceptance of the vaccine in the medical record.Findings include:The facility policy and procedure titled Infection Control - Influenza, Covid and Pneumococcal Immunizations for Residents documents: PROCEDURE: . Covid Immunization: 1. Before offering the covid immunization, each resident and or the resident representative will receive education regarding the benefits and potential side effects of the vaccine; 2. Each resident is offered covid immunization unless the immunization is medically contraindicated or the resident has already been immunized. 3. The resident and or the resident representative has the opportunity to refuse immunization; and 4. The resident's medical record includes documentation that indicates, as a minimum, the following: a. That the resident or resident representative was provided education regarding the benefits and potential side effects of covid immunization, and b. That the resident either received the covid vaccination or did not receive the covid vaccination due to medical contraindications or refusal. 5. Covid immunization will be offered in accordance with CDC.R40 was admitted to the facility on [DATE].Review of R40's immunization record showed R40 was due to receive the COVID-19 vaccination. No documentation was found in R40's medical record that R40 was provided education on the COVID-19 immunization or R40's refusal to receive the immunization.In an interview on 6/30/2026 at 11:01 AM, Surveyor asked Assistant Director of Nursing (ADON)-C and Director of Nursing (DON)-B what the facility process was for offering immunizations to newly admitted residents. DON-B stated DON-B or ADON-C will approach the new resident with the immunization information and document the education was given along with either the acceptance or refusal of the immunization. ADON-C stated the second shift nursing supervisor will also ask new residents about the immunizations as well. Surveyor shared with ADON-C and DON-B the concern R40 did not have any documentation that education was provided or the response of R40 to the question of getting or refusing the COVID-19 immunization. DON-B reviewed R40's medical record and agreed there was no documentation. DON-B shared R40's hospital discharge paperwork that documented R40 had declined the immunization at the hospital. Surveyor shared the facility still had the obligation to present the same information to R40 upon admission to the facility. DON-B agreed.		