STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525646	A. Building B. Wing	06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avina of Pewaukee	N26 W23977 Watertown Rd. Waukesha, WI 53188

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview and record review, the facility did not ensure grievances and recommendations discussed during resident group meetings (Resident Council) were acted upon promptly for 3 of 3 Supplemental (R23, R21, and R28) and 1 of 1 Sampled Resident (R53). Resident council meeting minutes from March, April, and May of 2025 all include concerns regarding staff using ear buds and cell phones while providing cares. During the resident council meeting with surveyors, R23, R21, and R28 indicated concerns regarding staff using ear buds and cell phones while providing cares. R53 indicated a concern with staff using ear buds and cell phones while providing cares. Evidenced by: The facility policy titled, Resident Council Meetings, date implemented 2/1/25, includes, in part: Policy: This facility supports the rights of residents to organize and participate in resident groups, including a Resident Council. This policy provides guidance to promoting structure, order, and productivity in these group meetings .Policy Explanation and Compliance Guidelines: .7. The facility shall act upon concerns and recommendations of the Council, make attempts to accommodate recommendations to the extent practicable, and communicate its decisions to the Council. Resident Council Minutes provided by the facility, include, in part: March 31, 2025 .Nursing staff on ear buds while doing cares. April 28, 2025 .Staff still on cell phones and ear buds while doing cares. May 28, 2025 .Nursing Staff on ear buds and cell phones while giving med (medications) and cares. On 6/2/25 at 11:35 AM, Surveyors completed the Resident Council meeting. The following resident concerns were voiced regarding staff use of ear buds and cell phones while providing cares: R23 indicated it is happening twice a day. Staff say, Oh, I'm not talking to you, while in the room doing cares. R23 indicated, well, who are they talking to then? R23 indicated it makes him feel mad, that they aren't doing their job, and that they are supposed to be off their phones. (continued on next page)

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R21 indicated it happens 2 to 3 times a week and that It's frustrating. R21 indicated it makes her feel irritated, especially when she's not sure if they're on the phone. R28 indicated they are on their phones the whole time when putting her on the toilet and that it makes her feel frustrated. Surveyors asked residents what the facility has said they are doing to correct this. Residents indicated they say they are going to talk to staff about it. On 6/3/25 at 8:25 AM, Surveyor interviewed R53 as part of the initial screening process. R53 indicated that staff are talking through their ear buds while doing cares and that staff all have phones in their pocket. R53 indicated that it is daily with one staff member and another staff member dispenses meds with ear buds in and it concerns her. Is she talking to another nurse, a doctor, a girlfriend? R53 indicated it makes her feel like she is not being taken care of as good as she should be. On 6/9/25 at 12:45 PM, Surveyor interviewed DON B (Director of Nursing) and reviewed the concerns on the March, April, and May resident council meeting minutes regarding staff use of ear buds and cell phones during cares. Surveyor asked DON B what follow-up had been completed regarding this. DON B indicated when they are notified when it is happening, they go down and tell the staff they aren't to have their ear buds and phone in patient care areas and correct it in the moment. Surveyor asked DON B what follow-up had been done to address the resident council concerns. DON B indicated she would have to look. Surveyor asked DON B if she was aware this had been a resident concern. DON B indicated, yes. On 6/9/25 at 1:37 PM, Surveyors noted the following documents had been left in the conference room: Cell phone and Telephone Policy, Orientation Nutrition Services Education, Guidelines, and Standards, (includes information about cell phone use), and staff education on cell phones/air pods use with attendance records for April 2025. Sticky notes attached indicated there was no PIP (process improvement plan) for cell phones, educate as we see it, and used in orientation for new staff as well. On 6/9/25 at 4:32 PM, Surveyor interviewed DON B and confirmed the education documents provided were completed in April. DON B indicated this was correct. Surveyor asked if they had any follow-up from the May resident council meeting as the ear buds/cell phone use was still listed as a concern. NHA A (Nursing Home Administrator) was present as well and indicated, no, we educate as we see it.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure the right to request, refuse and/or discontinue treatment and to formulate an advanced directive for 2 of 25 Residents (R34 and R53). R34 and R53's charts did not contain current copies of their advanced directive and/or did not contain evidence of advanced care planning, other than code status, for a time when they are not able to make their own healthcare decisions. Evidenced by: The facility policy titled, Residents' Rights Regarding Treatment and Advanced Directives, with an implementation date of 2/1/25, indicates, in part: Policy: It is the policy of this facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate advance directives . Policy Explanation and Compliance Guidelines: 1. On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive. 2. The facility will provide the resident or resident representative information, in a manner that is easy to understand, about the right to refuse medical or surgical treatment and formulate an advance directive. 3. Upon admission, should the resident have an advance directive, a copy will be placed on the chart as well as communicated to the staff via EMR (Electronic Medical Record) .7. During the care planning process, the facility will identify, clarify, and review with the resident or legal representative whether they desire to make any changes related to any advance directives. 8. Decisions regarding advance directives and treatment will be periodically reviewed as part of the comprehensive care planning process, the existing care instructions and whether the resident wishes to change or continue these instructions . Example 1 R34 was admitted to the facility on [DATE]. On 6/3/25 at 10:44 AM During record review portion of the initial pool process, surveyor was unable to find evidence of an advanced directive or documentation of a discussion with R34 regarding advanced care planning options. On 6/3/25 at 1:15 PM, A note was left in the conference room for surveyor with R34 and R53's names and the information no note POA documents was discussed, handwritten on the note. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/3/25 at 2:47 PM, Surveyor interviewed SSD BB (Social Services Director) and asked what the process for advanced directives is when a resident is admitted . SSD BB indicated he will check to see if they have anything in [PCC] the electronic health record that came from the hospital. If not, he will ask admissions and see if she can track one down. Some people will say they have one and then it takes a while for them to get a copy here and then once we get it we will scan it in. If they don't have one we will talk to them about completing one. Surveyor asked SSD BB if the conversations they have with residents who do not have an advanced directive are documented. SSD BB indicated that it is probably not always documented and that they could be better about that. Surveyor asked SSD BB if a resident has an advanced directive, and they are awaiting someone to bring in a copy is this information documented. SSD BB indicated, sometimes. Surveyor asked SSD BB if the resident refuses to complete an advanced directive, is that documented. SSD BB indicated if that occurred, he would document it in a progress note. Surveyor asked SSD BB what information he could share regarding R34 and whether he had an advanced directive. SSD BB indicated R34 was short term rehab but now is considered Long Term so he will have the long term care SW CC (Social Worker) come talk to surveyor. On 6/3/25 at 2:58 PM, Surveyor interviewed SW CC and asked what information she could share regarding R34's advanced directive. SW CC indicated she spoke with R34 about his POA (Power of Attorney) documents and he said he wanted to discuss with his daughters before signing any documents, so I told him I would check back. Surveyor asked SW CC when she spoke with R34. SW CC indicated, today. Surveyor asked SW CC what prompted her to speak with R34 today. SW CC indicated every once in a while she will go through charts and see if anything is missing and so she didn't realize he didn't have any. Surveyor asked if anyone discussed R34's advanced directive with her today. SW CC indicated SSD BB did this morning. Surveyor asked SW CC if there is a process for ensuring residents who transfer from short term rehab to long term rehab have an advanced directive in place or evidence of a discussion with the resident about advanced directive options. SW CC indicated there is not really a process right now and they are trying harder to do it on admission. On 6/3/25 at 3:11 PM, Surveyor interviewed SSD BB who indicated he did ask SW CC to look into R34's advanced directive this morning. Surveyor asked SSD BB what prompted him to ask SW CC to look into it. SSD BB indicated, because he knew we were looking into it. Surveyor asked SSD BB if they had looked into it prior to surveyors asking about it. SSD BB indicated, no. Example 2 R53 was admitted to the facility on [DATE]. On 6/3/25 at 8:58 AM, During record review portion of the initial pool process, surveyor was unable to find evidence of an advanced directive or documentation of a discussion with R53 regarding advanced care planning options. On 6/3/25 at 2:47 PM, Surveyor asked SSD BB what information he could share regarding R53 and whether she had an advanced directive. SSD BB indicated he knew that R53 has one and that her brother has it and needs to bring it in. Surveyor asked SSD BB if he would expect the document to have been obtained by this time given her admission date of August of 2024. SSD BB indicated, yes. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/5/25 at 10:06AM Surveyor interviewed NHA A (Nursing Home Administrator) and asked what the process is for advanced directives. NHA A indicated the SW (Social Worker) should visit with the resident and ensure if they have an advanced directive that a copy is obtained. Surveyor asked NHA A how long the SW should wait before reapproaching if a copy has not been obtained. NHA A indicated, maybe in the next couple days and that sometimes we can look in the hospital record if we have access. NHA A indicated, if a resident does not have one, then the SW would offer to help them make one and if they say no, then document. Surveyor asked NHA A who is responsible for ensuring this process is completed. NHA A indicated the SW is the designated person, but they work as a team. NHA A also indicated that they have already completed an audit of all charts regarding advanced directives.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Example 5: On 6/4/25 at 1:56 PM, R329 approached surveyor and indicated she just moved on to her current unit yesterday and indicated, This place is horrible. Surveyor observed R329's room with her and R329 indicated the following concerns: 1. It's filthy and there's a lot of dirt. 2. Behind the bed: The floor is dirty behind the bed, the plaster is peeling in multiple areas on the entire wall, it looks like there is blood on the wall. (Resident referring to a pinkish/red substance on the wall). 3. Behind the door to the room -- there is an oblong shaped hole in the wall and pushed into the hole is a round metal piece that looks like the remains of a door stopper for where the door handle hits. Of note, when the door was opened, the handle lines up to this area. 4. No shower head in the bathroom. 5. Black marks on shower floor surrounding. 6. Light above sink not working. 7. [NAME] substance on the outside of the wastebasket in the bathroom of which R329 indicated, That's disgusting. On 6/4/25 at 4:16 PM, Surveyor interviewed CNA Q (Certified Nursing Assistant) in R329's room. Surveyor observed the areas above and reviewed R329's concerns with CNA Q. Surveyor asked CNA Q if she would want her home to look like this and if she would consider it homelike. CNA Q indicated, no and that the room would not be considered homelike. Based on observation, interview, and record review, the facility failed to ensure all residents have a homelike environment for 3 of 3 sampled residents (R46, R47, R12) and 2 of 2 supplemental residents (R329 and R40). Surveyor observed environmental concerns. R47 voiced concerns about the environment. R46 voiced concerns regarding cleanliness of bedroom. R12's floor was sticky. R40 voiced concerns regarding the cleanliness of their bedroom. R329 voiced concerns regarding the cleanliness of bedroom. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Evidenced by: The facility provided Surveyor a cleaning checklist that is utilized. Checklist states, in part; .Thorough Cleaning Procedure, .Clean doors and door frames .Wall Washer all areas from ceiling to floor .Clean all vertical furniture and cabinets .Dust mop floor and move all items .Wet mop floors .Bathroom: wash sink with cream cleanser, clean pipe's under sink and toilet, clean mirrors, clean counter tops, medicine cabinets, and above lights, clean cabinets, clean all towel racks, clean inside and out and refill all dispensers, clean toilet top to bottom, clean all handrails, wipe down call light and light switches, clean baseboards, sweep and mop . Example 1 On 6/2/25 Surveyor observed the 200 hallway. Surveyor observed a dark substance dried on the floor and wrappers from food on the common area floor. Surveyor observed this as well at the end of the day on 6/2/25. Surveyor observed black marks and missing paint on the common area walls. On 6/4/25 at 8:32 AM, Surveyor observed HSK P (Housekeeper) cleaning common area cupboards. Surveyor observed black colored water running down the cupboards. Surveyor asked HSK P how often common areas are cleaned at the facility? HSK P stated, Daily. On 6/4/25 at 1:19 PM, Surveyor observed Housekeeping cleaning bedrooms on 200 hallway. Surveyor observed Housekeeper in R47's bedroom with cleaning supplies. Surveyor asked R47 if housekeeping was in room and cleaned room today. R47 indicated housekeeping was in bedroom and didn't clean very well. R47 told Surveyor to look in bathroom. Surveyor observed garbage on the floor, a full garbage bin, and a white powder on bathroom floor. R47 indicated housekeeping did not sweep or mop anything and that it is frustrating. Example 2 R46 was admitted to the facility on [DATE] with a diagnoses including chronic respiratory failure, chronic pain, depression, anxiety, and muscle weakness. R46 most recent Minimum Data Set (MDS) dated [DATE] indicates R46 has a Brief Interview for Mental Status (BIMS) of 14 indicating R46 is cognitively intact. On 6/2/25 at 11:07 AM, R46 indicated she sees housekeeping staff around the facility, but the facility still isn't clean. R46 indicated the floors are dirty. R46 indicated her bedroom floor is filthy and that there are always little bugs flying around. Surveyor observed dark dried substance on R46's bedroom floor and splatters of light brown substance on R46's bedroom wall. R46 indicated she doesn't know what the splatters are and that they have been there. R46 indicated her granddaughter said she can't believe that R46 uses her bathroom because it's always so dirty. Surveyor observed the garbage bin overflowing with garbage in bathroom and the toilet and bathroom floor was visibly dirty. Surveyor asked R46 about the dings and marks on walls. R46 indicated the dings, marks, and missing paint was there when she arrived. R46 indicated there are times she will get a Kleenex wet and try to clean up her bedroom. R46 indicated she doesn't understand why it's always so dirty. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/4/25 at 3:46 PM, MNT J (Maintenance) indicated the 500 hallway was remodeled last fall and that they fixed the dings on the walls, black scuff marks, patched holes, and painting was done at that time for 500. MNT J indicated they will be eventually getting to the 200 hallway. Maintenance J indicated there are always projects and things coming up that need to be done, so for 200 it's more about finding the time to complete it. On 6/5/25 at 10:35 AM, HS K (Housekeeping Supervisor) indicated she has three staff on during the day and one staff is specifically assigned to cleaning floors. HS K indicated it is expected that housekeeping cleans every bedroom every day. HS K indicated this includes: cleaning toilets, emptying garbage, cleaning mirrors, deep cleaning bathrooms, and sweeping and mopping bedroom and bathrooms. HS K indicated this also includes restocking all bathroom supplies. HS K indicated there are two staff at the facility on the weekends as well. HS K indicated it is expected that staff deep clean bedrooms and common area. HS K indicated if there are splatters on the walls staff should wipe down walls. Surveyor shared with HS K observations and resident concerns. HS K indicated understanding of the concerns. On 6/9/25 at 8:33 AM, NHA A (Nursing Home Administrator) indicated she would expect the environment to be homelike. NHA A indicated she would expect bedrooms and common areas to be clean. The facility failed to ensure all residents have a homelike and comfortable environment. Example 3 On 6/5/25 at 10:56 AM, Surveyor was called into R40's room. R40 pointed to her wall and stated that the black marks on her wall were in her room before she moved in, and that the facility has still not cleaned them. R40 indicated to Surveyor that she wanted her walls cleaned. Surveyor observed multiple circular, black marks across the wall near R40's door. Example 4 On 6/3/25 at 9:15 AM, Surveyor entered R12's room. As Surveyor was walking across R12's room, Surveyor noted the floor to be excessively sticky. As Surveyor approached R12's bed, Surveyor's left shoe stuck to the ground and Surveyor's shoe was pulled off her foot due to the stickiness of the floor.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that each resident is free from physical restraints that are not required to treat the resident's medical symptoms for 1 of 1 residents reviewed (R67). R67 was placed in a low Broda chair (a specialty wheelchair that assists with positioning) that has brakes located on the back of the wheels at the bottom of the chair. R67's brakes were engaged while R67's was at the dining table, not allowing R67 to move the chair. Evidenced by: The facility's policy titled Restraint Free Environment dated 2/1/2025 states in part .Physical Restraint refers to any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Physical restraints may include, but are not limited to: .Using devices in conjunction with a chair, such as trays, tables, cushions, bars or belts, that the resident cannot remove and prevents the resident from rising . R67 was admitted to the facility on [DATE] with diagnoses that include: progressive supranuclear ophthalmoplegia (degenerative neurological disorder that affects movement, balance, and eye control), dementia with other behavioral disturbance, acute and chronic respiratory failure with hypoxia (low oxygen levels), and cognitive communication deficit. R67's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/12/25 indicates a Brief Interview for Mental Status (BIMS) score of 3 out of 15, indicating severe cognitive impairment. Section GG indicates R67 has impairment on both sides of his upper and lower extremities. R67 requires substantial/maximal assistance with toileting hygeiene, showering/bathing, lower body dressing, and putting on/taking off footwear. Section GG also indicates R67 requires partial/moderate assistance with rolling left and right, moving from sitting to lying, and lying to sitting on the side of the bed. Additionally, R67 requires substantial/maximal assistance with moving from sitting to standing, transferring between a chair and a bed, transferring to a toilet, and transferring to a tub or shower. R67's Comprehensive Care Plan states, in part: Focus: The resident has an ADL (Activities of Daily Living) self-care performance deficit related to recent fall with hospitalization with bout of COVID/Pneumonia and cognitive issues with progressive supreanuclear opthalmoplegia. Date initiated: 2/5/25. Revision on: 2/15/25. Goal: The resident will improve current level of function through the review date. Date initiated: 2/5/25. Revision on: 3/19/25. Target date: 9/3/25. Interventions: (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ambulation: Res (Resident) to walk with staff with assist of 1, 2ww (Two Wheeled Walker) up to 75 ft (Feet). Date initiated: 2/19/25. Low broad chair. Resident is able to self-propel. Date initiated: 2/7/25. Revision on 3/12/25. Eating: The resident requires assistance by 1 staff for set up and supervision to eat. Date initiated: 2/5/25. Revision on 2/18/25. Transfer: The resident requires assistance by 1 staff with 2ww and gait belt to move between surfaces. Date initiated: 2/5/25. Revision on 2/8/25. On 6/3/25 at 2:30 PM, Surveyor observed R67 slowly self-propelling by shuffling his feet around the common room of his hall. On 6/4/25 at 7:58 AM, Surveyor observed R67's wheelchair to have both rear wheel locks engaged. R67 is unable to self-propel at this time due to his wheels being locked. (Of note: R67's rear locks do not have the ability to be disengaged from the front of the wheelchair) On 6/4/25 at 8:14 AM, Surveyor observed R67 actively trying to push away from the table and self-propel but is unable to due to his rear wheel locks being engaged. On 6/4/25 at 8:34 AM, Surveyor observed R67 attempting to push away from the table to self-propel but is unable to due to his rear wheel locks being engaged. On 6/4/25 at 8:40 AM, Staff disengaged R67's rear wheel locks and R67 is now able to self-propel around the common room. On 6/4/25 at 9:11 AM, Surveyor observed AD T (Activities Director) push R67 up to a table, after assisting him around the facility to meet with some staff. AD T engaged R67's rear wheel locks and walked away. R67 attempted to self-propel but is unable to due to his rear wheel locks being engaged. On 6/4/25 at 9:35 AM, Surveyor observed CNA W (Certified Nursing Assistant) disengage R67's rear wheel locks and R67 immediately started to self-propel around the common area. On 6/4/25 at 1:15 PM, Surveyor interviewed CNA W. Surveyor asked CNA W if wheel locks can be a restraint. CNA W indicates, yes and that some people may put on the locks to help him stay near the table when he eats. Surveyor asked CNA W if R67 can reach his wheel locks to disengage them himself. CNA W indicates, no. On 6/4/25 at 4:04 PM, Surveyor interviewed LPN M (Licensed Practical Nurse). Surveyor asked LPN M if wheel locks can be a restraint. LPN M indicates, yes. Surveyor asked LPN M if R67 can reach his wheel locks to disengage them himself. LPN M indicates, no. On 6/4/25 at 3:56 PM, Surveyor interviewed CNA II. Surveyor asked CNA II. if wheel locks can be a restraint. CNA II indicates, yes. Surveyor asked CNA II if R67 can reach his wheel locks to disengage them himself. CNA II indicates, no, R67 can't reach his wheel locks. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/4/25 at 4:47 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B under what circumstances are wheel locks to be used. DON B indicates for transfers. Surveyor asked DON B if there are any other instances wheel locks should be engaged. DON B indicates, no. Surveyor asked DON B if wheel locks are engaged, is that considered a restraint. DON B indicates, yes. Surveyor asked DON B if R67 can unlock his wheels. DON B indicates she is unsure and would have to look at R67.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avina of Pewaukee	N26 W23977 Watertown Rd. Waukesha, WI 53188

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Example 4 R46 admitted to the facility on [DATE] with diagnoses including anxiety. R46's physician orders, dated 6/5/25, include Lorazepam 0.5 mg every 6 hours as needed . for 6 months. Monitor for s/s (signs and symptoms) of anxiety; update MD/NP (Medical Doctor/Nurse Practitioner) for worsening symptoms. R46's Certified Nursing Assistant (CNA) Kardex (CNA care plan), printed 6/5/25, does not include monitoring or interventions related to R46's anxiety. R46's comprehensive care plan, printed 6/5/25, states in full, for R46's anxiety disorder: Focus: The resident has an active order for anti-anxiety medication(s) use anxiety disorder Goal: The resident will be free from discomfort or adverse reactions related to anti-anxiety therapy through the review date. Interventions: Administer Anti-anxiety medications as ordered by physician. Monitor/document/report PRN (As Needed) any adverse reactions to anti-anxiety therapy: Drowsiness, lack of energy, clumsiness, slow reflexed, Sslurred [sic] speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgement, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision. Unexpected side effects: Mania, hostility, rage, aggressive or impulsive behavior, hallucinati [sic] On 6/5/25 at 3:10 PM, Surveyor interviewed CNA F regarding R46's anxiety. CNA F indicated behaviors and interventions for residents are located on the CNA Kardex and on the computer in the electronic health record. CNA F indicated R46 has anxiety. CNA F indicated R46 won't sit still, won't stay in her room, fidgets a lot and will jump from task to task when she is feeling anxious. Of note, these behaviors are not listed in R46's comprehensive care plan or on the CNA Kardex and there are no interventions listed. On 6/5/25 at 2:22 PM, Surveyor interviewed MT FF (Medication Tech; a CNA that can administer medications) regarding residents with behaviors of anxiety. MT FF stated he gives PRN (As needed) medication for agitation and restlessness. Example 5 R57 admitted to the facility on [DATE] with diagnoses including dementia with agitation and aphasia (a language disorder that affects a person's ability to communicate). R57's physician orders, printed on 6/5/25, includes Quetiapine Fumarate 25 mg at bedtime for dementia related agitation (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R57's CNA Kardex, printed 6/5/25, does not include monitoring or interventions for R57's agitation. R57's comprehensive care plan does not include monitoring or tracking of R57's agitation. On 6/5/25 at 2:22 PM, Surveyor interviewed SW CC (Social Worker) regarding R57's agitation. SW CC indicated R57 has a hard time getting the words out when she tries to speak and becomes frustrated. SW CC was unable to elaborate what behaviors R57 exhibited when becoming agitated. On 6/5/25 at 2:28 PM, Surveyor interviewed CNA Q regarding R57's agitation. CNA Q indicated R57 can become agitated and will throw things at staff and when in bed will hang the top half of her body off the bed. Of note, R57's comprehensive care plan and CNA Kardex does not include these behaviors that R57 exhibits when becoming agitated. Based on record review and interview, the facility must ensure each resident is free from unnecessary drugs as evidenced by completing adequate drug monitoring for 5 of 5 residents (R16, R38, R7, R57, and R46) reviewed for unnecessary medication reviews. The facility is not monitoring resident-specific targeted behaviors for R16's psychotropic medication use. There is no evidence the facility is tracking targeted behaviors to assess the therapeutic effects of the psychotropic medications and ensure R16 is receiving the desired benefits and lowest possible dose. R16 has no nonpharmacological interventions documented to use when displaying targeted behaviors. R38 does not have nonpharmacological interventions documented in her plan care. R7 does not have nonpharmacological interventions documented in her plan care. R46 does not have resident-specific targeted behavior monitoring or nonpharmacological interventions. R57 does not have resident-specific targeted behavior monitoring or nonpharmacological interventions. This is evidenced by: Facility policy titled Baseline Care Plan, dated 2/1/25, states in part: Policy: The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care . Policy Explanation and Compliance Guidance: 2.b. Interventions shall be initiated that address the resident's current needs including: . ii. Any identified needs for supervision, behavioral interventions, and assistance with activities of daily living . (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility policy titled Use of Psychotropic Medication(s), dated 2/1/25, states in part: Policy: It is the intent of this policy to ensure that residents only receive psychotropic medications when other nonpharmacological interventions are clinically contraindicated . Policy Explanations and Compliance Guidance: 1. A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include but are not limited to the following categories: antipsychotics, antidepressants, anti-anxiety, and hypnotics . 5. The indications for initiating, maintaining, or discontinuing medications, as well as the use of nonpharmacological approaches, will be determined by evaluating the resident's physical, behavioral, mental, psychosocial signs and symptoms in order to identify and rule out any underlying medical conditions, including the assessment of relative benefits and risks, and the preferences and goals for treatment. 6. Nonpharmacological approaches must be attempted, unless clinically contraindicated, to minimize the need for psychotropic medications, use the lowest dose, or discontinue the medications. 7. The resident's medical record shall include documentation of this evaluation and the rationale for chosen treatment options . Example 1 R16 was admitted on [DATE] with diagnoses that include Other Recurrent Depressive Disorders, Generalized Anxiety Disorder, Insomnia due to Other Mental Disorder, Depression unspecified, anxiety disorder unspecified, and Insomnia unspecified. R16's Physician Orders include, in part: --buPROPion HCl ER (XL) Oral Tablet Extended Release 24 Hour 150 MG (Bupropion HCl) Give 1 tablet by mouth one time a day for Depression Document if resident voicing feeling sad/lonely. Start Date: 7/11/24. --busPIRone HCl Oral Tablet 15 MG (Buspirone HCl) Give 1 tablet by mouth two times a day for Anxiety Document if resident is having s/s (signs/symptoms) of anxiety. Start Date: 7/11/24. --Venlafaxine HCl ER Oral Capsule Extended Release 24 Hour 75 MG (Venlafaxine HCl) Give 3 capsule by mouth one time a day for Depression Document if resident voicing feeling sad/lonely. Start Date: 7/12/24. R16's Care Plan dated 7/12/24, states in part: --Focus: The resident has a mood problem r/t (related to) depression, insomnia due to other mental disorder, Generalized anxiety, and other recurrent depressive disorders. --Goal: The resident will have happier mood state with no s/x (symptoms) of depression through the review date. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--Intervention: Administer medications as ordered. Resident takes Effexor and Wellbutrin as current to for depression. Resident takes Buspar for anxiety. Monitor/document for side effects and effectiveness. Intervention: Administer sleep aid (melatonin) as ordered by NP/MD (Nurse Practitioner/Medical Director). --Intervention: Resident aware of psych and talk therapy services but not interested at this time. Of note: R16's Certified Nursing Assistant (CNA) Care Kardex, printed 6/5/25, does not include targeted behavior monitoring related to R16's depression or anxiety or nonpharmacological interventions when R16 displays targeted behaviors. On 6/5/25 at 2:33 PM, Surveyor interviewed CNA Q (Certified Nursing Assistant) regarding R16's depression and anxiety. CNA Q indicated that R16 does not have much anxiety but that she does have depression. CNA Q stated that R16 sometimes gets down about her past and how she wishes she could be out in the world instead of in the facility. Surveyor asked CNA Q what interventions were in place when R16 was feeling depressed. CNA Q stated that she tries to bring her to activities because she likes to talk to her friends and that gets her feeling better. Surveyor asked CNA Q if she charts in the electronic medical record when R16 is feeling anxious or depressed. CNA Q indicated that she will just let the nurse know. Surveyor asked CNA Q if she is aware of any behavior monitoring for R16 or if she had received any education on behavior or psychotropic medication monitoring for R16 or other residents. CNA Q stated she is not aware of behavior monitoring for R16 and has never received training on that. On 6/5/25 at 2:36 PM, Surveyor interviewed MT FF (Medication Technician) regarding how he would monitor the effectiveness of R16's medication for her anxiety and depression. MT FF stated that for R16 he would be monitoring for a loss of consciousness. Surveyor asked MT FF what he would do if R16 displayed signs of anxiety or depression. MT FF stated that he would give a PRN (as needed) medication such as lorazepam. MT FF stated he has never seen R16 depressed. Example 2 R38 was admitted to the facility on [DATE] with diagnoses that include, in part, Unspecified Dementia, unspecified severity, with other behavioral disturbance, Major Depressive Disorder, recurrent, unspecified, adjustment disorder with depressed mood, and anxiety disorder, unspecified. R38's Physician Orders include, in part: --Fluoxetine HCl Oral Capsule 20 MG (Fluoxetine HCl) Give 1 capsule by mouth one time a day for depression monitor for depression: update MD/NP for worsening symptoms. Start Date: 2/21/25. R38's Care Plan dated 7/12/24, states in part: --Focus: The resident has an active order for antidepressant medication for Depression and adjustment disorder with depressed mood. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--Goal: The resident will be free from discomfort or adverse reactions related to antidepressant therapy through the review date. --Intervention: Administer ANTIDEPRESSANT medications as ordered by physician. --Intervention: Educate the resident/family/caregivers about risks, benefits and the side effects and/or toxic symptoms. --Intervention: Monitor/document/report PRN adverse reactions to ANTIDEPRESSANT therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL (activities of daily living) ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance probs (problems), movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia; appetite loss, wt. (weight) loss, n/v (nausea/vomiting), dry mouth, dry eyes. --Focus: The resident has an active order for anti-anxiety medication for anxiety disorder --Goal: The resident will be free from discomfort or adverse reactions related to anti-anxiety therapy through the review date. --Intervention: Administer ANTI-ANXIETY medications as ordered by physician. --Intervention: Monitor for S/S of patient hoarding items or statements that she is feeling anxious. --Intervention: Monitor the resident for safety. The resident is taking ANTI-ANXIETY meds which are associated with an increased risk of confusion, amnesia, loss of balance, and cognitive impairment that looks like dementia and increases risk of falls, broken hips and legs --Intervention: Monitor/document /report PRN any adverse reactions to ANTI-ANXIETY therapy: Drowsiness, lack of energy, clumsiness, slow reflexes, Sslurred (sic) speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgment, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision. UNEXPECTED SIDE EFFECTS: Mania, hostility, rage, aggressive or impulsive behavior, hallucinati (sic). --Intervention: Monitor/record occurrence for target behavior symptoms Reports of anxiety/restlessness, Resistive to cares and document per facility protocol. --Focus: The resident has a mood problem r/t diagnosis of depression, anxiety --Goal: The resident will have improved mood state (happier, calmer appearance, no s/sx of depression, anxiety or sadness) through the review date. --Intervention: Administer medications as ordered. --Intervention: Monitor/document for side effects and effectiveness (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--Intervention: Assist the resident, family, caregivers to identify strengths, positive coping skills and reinforce these . Behavioral health consults as needed (psycho-geriatric team, psychiatrist etc.) R38's CNA Care Kardex, printed 6/5/25, states, in part: monitor for s/s (signs and symptoms) of patient hoarding items or statements that she is feeling anxious . Monitor/document/report PRN (as needed) adverse reactions to ANTIDEPRESSANT therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL (activities of daily living) ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance probs (problems), movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia; appetite loss, wt. (weight) loss, n/v (nausea/vomiting), dry mouth, dry eyes . On 6/5/25 at 2:23 PM, Surveyor interviewed LPN O (Licensed Practical Nurse) regarding R38's anxiety and depression. LPN O stated that R38 is a very outgoing person, so they monitor if she is staying in her room or staying in bed. Surveyor asked LPN O how R38's anxiety is displayed. LPN O stated that R38 will ask repetitive questions, such as she likes to get her medications at a certain, routine time. LPN O stated that R38 will constantly come up to her and ask about her medications, even 20 minutes before the one-hour administration window. LPN O indicated that R38 is like that every time she works with her. Surveyor asked LPN O what nonpharmacological interventions work for R38's anxiety and depression. LPN O stated that going outside helps R38 and that she enjoys feeding the birds. Surveyor asked LPN O where R38's anxiety and depression monitoring were being documented. LPN O stated that they would enter a progress note into the electronic medical record if R38 was having those behaviors or not, but since R38 has these anxious behaviors daily, they were not documenting on that. Of note, R38's comprehensive care plan does not include these resident specific behaviors that R38 exhibits when anxious, nor are the nonpharmacological interventions included anywhere in R38's medical record. Example 3 R7 was admitted to the facility on [DATE] with diagnoses that include, in part: Alzheimer's Disease unspecified, Unspecified Dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, Insomnia due to other mental disorder, and Major depressive disorder, recurrent, mild. R7's Physician Orders include, in part: --Abilify Oral Tablet 2 MG (Aripiprazole) Give 2 tablet by mouth in the morning for dementia with agitation 4mg; monitor for s/s of agitation, notify NP/MD. Start Date: 5/9/25. --Trazodone HCl Oral Tablet 50 MG (Trazodone HCl) Give 25 mg by mouth at bedtime for insomnia. Start Date: 12/3/24. R7's Care Plan, dated 11/22/19, includes, in part: (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--Focus: The resident has impaired cognitive function/dementia or impaired thought processes r/t Dementia and Parkinson's. --Goal: The resident will be able to communicate basic needs on a daily basis through the review date. --Intervention: Administer medications as ordered. Monitor/document for side effects and effectiveness. --Intervention: Communicate with the resident/family/caregivers regarding resident's capabilities and needs --Intervention: Cue, reorient and supervise as needed --Intervention: Keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. --Intervention: Monitor for s/s of agitation; Notify NP/MD --Intervention: Monitor/document/report PRN any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. --Intervention: Present just one thought, idea, question or command at a time. --Focus: The resident has depression. --Goal: The resident will exhibit indicators of depression, anxiety or sad mood less than daily by review date. --Goal: The resident will remain free of s/sx of distress, symptoms of depression, anxiety or sad mood by/through review date --Intervention: Administer medications as ordered. Monitor/document for side effects and effectiveness --Intervention: Monitor/document/report PRN any risk for harm to self: suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgment or safety awareness --Intervention: Monitor/document/report PRN any s/sx of depression, including hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing, negative statements, repetitive anxious or health-related complaints, tearfulness. making comments of not wanting to be alive anymore. resident voiced feeling sad and/or lonely each shift, refusing to get out of bed, refusing medications, or statements of wanting to die. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R7's CNA Care Kardex, printed 6/5/25, states, in part: Monitor for s/s of anxiety, tremor, seizure activity, and terminal restlessness . Monitor/document/report PRN any s/sx of depression, including hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing, negative statements, repetitive anxious or health-related complaints, tearfulness. making comments of not wanting to be alive anymore. resident voiced feeling sad and/or lonely each shift, refusing to get out of bed, refusing medications, or statements of wanting to die. On 6/5/25 at 2:29 PM, Surveyor interviewed LPN O regarding R7's anxiety and depression. LPN O stated that R7 tends to yell out a lot, he will cuss a lot, say inappropriate words to the staff, and calls them names. LPN O stated that R7 wants a Pepsi right away and when he finishes that one, he wants another one right away and if he doesn't get it, he starts yelling out. Surveyor asked LPN O what interventions work for R7 when he is agitated and yelling out. LPN O stated that they let him calm down give him space, and that he likes to have the TV on. Surveyor asked LPN O how often R7 was having these behaviors. LPN O stated pretty much every day because he has some memory issues too. LPN O indicated that R7 will yell out to get in the chair and then 2 minutes later he will yell out to go back to bed. Surveyor asked LPN O where R7's anxiety and depression monitoring were being documented. LPN O stated that they would enter a progress note into the electronic medical record, but because R7 has these anxious behaviors daily, they were not documenting on that. Of note, R7's comprehensive care plan does not include these behaviors that R7 exhibits when anxious, nor are there nonpharmacological interventions included anywhere in R7's medical record. On 6/5/25 at 2:55 PM, Surveyor interviewed NHA A (Nursing Home Administrator) regarding personalized interventions and monitoring of resident behaviors. Surveyor asked NHA A whether specific behaviors that residents have should be included in their plan of care. NHA A stated it depended on a case-by-case basis. Surveyor asked NHA A whether a resident's specific behaviors should be monitored and documented in the electronic health record. NHA A stated that if a resident exhibits any behaviors, the nurse should put in a progress note. Surveyor asked NHA A if the care plans should be resident specific. NHA A indicated yes, on a case-by-case basis.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not provide an ongoing program of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident this affected 4 of 23 Residents (R57, R46, R67, and R56) reviewed for activities. Surveyor observed R57, who needs assistance to/from structured leisure activities, not being provided activities. The facility failed to ensure R46's activity care plan is meaningful, personalized, and had measurable goals. R56's Comprehensive Care Plan does not contain an activities care plan. R67's Comprehensive Care Plan does not actually list any Resident specific preferred activities. Evidenced by: The facility policy, Activities, dated 2/1/25, states, in part; .It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. Facility sponsored group, individual, and independent activities will be designed to meet the interests of each resident, as well as support their physical, mental, and psychosocial well-being. Activities will encourage both independence and interaction within the community .2. Activities will be designed with the intent to: a. Enhance the resident's sense of well-being, belonging, and usefulness. b. Create opportunities for each resident to have a meaningful life. c. Promote or enhance physical activity. d. Promote or enhance cognition. e. Promote or enhance emotional health. f. Promote self-esteem, dignity, pleasure, comfort, education, creativity, success and independence. g. Reflect resident's interest and age. h. Reflect cultural and religious interests of the residents. i. Reflect choices of the residents . Example 1: R57 was admitted to the facility on [DATE] with a diagnoses including dementia with agitation, respiratory failure, kidney disease, depression and cognitive communication deficit. R57's most recent Minimum Data Set (MDS) dated [DATE] indicates R57 has a Brief Interview for Mental Status (BIMS) score of 01 which indicates R57 is severely cognitively delayed. R57 has an activated power of attorney. R57's Comprehensive Care Plan, states, in part; .ACTIVITIES: The resident's activity involvement is limited as a result of: cognitive impairment secondary to Alzheimer's disease or a related dementia .The resident will be invited to all activities to observe or/and participate in appropriate activities .Provide activity programming consistent with physical and psychosocial abilities. This includes: energy level, cognitive functioning, medical condition and mood/behavior patterns . R57's activity participation documentation for April 2025-current, states, in part; .APRIL 2025: bingo 5x, music/entertainment 1x, movie/tv 1x, and dancing/exercise 1x. MAY 2025: movies/tv 7x, bingo 5x, exercise 1x, lobby/lounge 1x, 1:1 2x. JUNE 2025: bingo 1x, bible study 1x, 1:1 2x. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/2/25, Surveyor observed R57 sitting at table in broda chair with no activities, conversation, or stimulation offered. R57 sat in the same spot from 10:57 AM - 3:50 PM. Surveyor observed R57's head down at the table at 2:00 PM. On 6/3/25, Surveyor observed R57 from 10:23 AM - 12:23 PM, 1:00 PM - 3:30 PM sitting at a table in broda chair with no activities, conversation, or stimulation offered. On 6/4/25, Surveyor observed R57 sitting at table in broda chair with no activities offered. Surveyor observed on 6/4/25 at 1:39 PM activity staff discussing if R57 should go to bingo. LPN R (Licensed Practical Nurse) stated, She's literally been sitting here with nothing to do. She likes bingo. Surveyor observed activities staff assist R57 to bingo. This was the first activity Surveyor observed R57 being assisted to from 6/2/25-6/4/25. Example 2: R46 was admitted to the facility on [DATE] with a diagnoses including chronic respiratory failure, dementia, chronic pain, depression, anxiety, muscle weakness, abnormalities of gait and mobility, and cognitive communication deficit. R46 most recent Minimum Data Set (MDS) dated [DATE] indicates R46 has a Brief Interview for Mental Status (BIMS) of 14 indicating R46 is cognitively intact. R46's Comprehensive Care Plan, states, in part; .ACTIVITIES The resident is functioning at a reasonably independent level concerning leisure pursuits. The resident is alert, sufficiently oriented and coherent, able to express her needs. The resident currently engages in the following leisure/recreation pursuits: Television, movies. The resident will assist the activity department in planning the next month's program through the next review. Provide activity program consistent with physical and psychosocial abilities. Help the resident monitor energy level and recognize over-activity as well as under-activity. R46's activity participation documentation from April 2025-current, states, in part; .APRIL 2025: dancing/exercising 2x, music/entertainment 3x, bingo 1x, and discussion 1x. MAY 2025: electronics 2x, movies 3x, music 1x, nail care 2x, discussion 3x, exercise 1x, pet therapy 1x, and snack time 2x. JUNE 2025: electronics 2x, bingo 1x, and discussion 2x. On 6/4/25 at 1:12 PM, R46 came out of bedroom and stated, There is nothing to do. R46 indicated she would like more variety of activities. On 6/5/25 at 8:17 AM, AD T (Activity Director) indicated when a resident first comes to the facility she will complete activity assessment and then invite resident to scheduled activities. AD T indicated for the residents who are not able to verbally share what they enjoy doing and need more assistance in structuring their day staff will assist them to activities. AD T indicated she has been at the facility for a couple years, so she knows what the long term residents enjoy doing. AD T indicated they complete the activity care plan and document activity attendance and participation on their computer system. AD T provided Surveyor with an activity care plan and activity participation. (continued on next page)

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Avina of Pewaukee	N26 W23977 Watertown Rd. Waukesha, WI 53188

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/5/25 at 11:06 AM, AD T indicated she feels R57's activity care plan is personalized. Surveyor asked AD T if a new staff is reading R57's activity care plan can they tell what her activity goals are, activities she enjoys, and what is most important to her? AD T indicated staff can go down and talk to R57 and ask. AD T indicated R57 may get anxious at larger activity events. AD T indicated R57 enjoys bingo a lot. Surveyor and AD T reviewed R57's activity participation. Surveyor indicated if R57 doesn't enjoy larger group activities could an activity aide come to R57? AD T indicated activity staff could come to R57. AD T indicated understanding on creating a personalized activity care plan for residents. On 6/9/25 at 8:33 AM, NHA A (Nursing Home Administrator) indicated she would expect activity care plans to be personalized for each resident. NHA A indicated she would expect residents to be offered activities and activities tailored to residents needs and preferences. The facility failed to provide an ongoing program of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident. Example 3: R56 was admitted to the facility on [DATE] with diagnoses that include, in part: vascular dementia, dysphagia (difficulty swallowing), epilepsy (seizure disorder), muscle weakness (generalized), and abnormal posture. R56's most recent Minimum Data Set (MDS), with Assessment Reference Date (ARD) of 5/20/25 indicates R56 had a Brief Interview for Mental Status (BIMS) score of 6 out of 15, indicating severe cognitive impairment. R56's Comprehensive Care Plan states, in part: Focus: The resident has impaired cognitive function and impaired thought process r/t (related to) impaired decision making (cerebral Infarction (Stroke) and vascular dementia) Goal: The resident will be able to communicate basic needs on a daily basis through the review date Interventions: Ask yes/no questions in order to determine the resident's needs Communicate with the resident/family/caregivers regarding residents capabilities and needs Cue, reorient and supervise as needed (Of note: R56's Comprehensive Care Plan does not contain an activities care plan) R56's most recent activities evaluation, dated 5/18/25 states, in part that R56 currently participates in one to one activities with the beauty/barber activity, family and friend visits, movies, music, and religious services. The section titled, Leisure Routines and Other Preferences indicates R56 participates in 0-1 activities per week and 0-3 per month. In the section titled, Comments, it indicates the resident needs encouragement to attend activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor reviewed R56's activity participation from 4/11/25 to 6/5/25. During this time period, R56 participated in 14 self-directed activities labeled Movies/TV, 4 1:1 (one to one) activities labeled Manicure/Spa, and one group activity labeled, Conversation on 5/9/25. This equals 19 total activities over a span of 56 days. It is important to note the documentation does not state how long R56 participated in activities and if the resident enjoyed the activity. On 6/9/25 at 11:59 AM, Surveyor interviewed AD T (Activities Director). Surveyor asked AD T if she is aware of any of R56's activity preferences. AD T indicates R56 enjoys watching TV and getting her nails done, as well as occasionally liking to color. AD T also indicates R56 is very content to lay and watch TV. Surveyor asked AD T if she would expect to see these things on R56's care plan. AD T indicates she is not sure. R56's Comprehensive Care Plan does not contain an activities care plan Example 4: R67 was admitted to the facility on [DATE] with diagnoses that include: progressive supranuclear ophthalmoplegia (degenerative neurological disorder that affects movement, balance, and eye control), dementia with other behavioral disturbance, acute and chronic respiratory failure with hypoxia (low oxygen levels), and cognitive communication deficit. R67's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/12/25 indicates a Brief Interview for Mental Status (BIMS) score of 3 out of 15, indicating severe cognitive impairment. Section GG indicates R67 has impairment on both sides of his upper and lower extremities.R67 requires substantial/maximal assistance with toileting hygiene, showering/bathing, lower body dressing, and putting on/taking off footwear. Section GG also indicates R67 requires partial/moderate assistance with rolling left and right, moving from sitting to lying, and lying to sitting on the side of the bed. Additionally, R67 requires substantial/maximal assistance with moving from sitting to standing, transferring between a chair and a bed, transferring to a toilet, and transferring to a tub or shower. R67's Comprehensive Care Plan states, in part: Focus: The resident's activity involvement is limited as a result of: Cognitive impairment secondary to Alzheimer's disease or a related dementia. Goal: The resident will participate in staff initiated in-room as well as giving him rides around facility when requested activity 5 days per week through the next review. Interventions: Develop an activity plan centering around the resident's interest and history that take lifetime values, attitudes, leisure patterns and psychosocial well-being into consideration. (Of note: R67's Comprehensive Care Plan does not actually list any Resident specific preferred activities) (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R67's most recent Activities Evaluation, dated 3/7/25, indicates R67 likes to participate in Animal/Pets activities, family/friend visits, sports, and television activities. This evaluation also indicates R67 participates in zero activities per week and zero per month. R67's Activity Documentation shows that from 4/3/25 through 6/9/25, R67 participated in 14 self-directed activities labeled Movies/TV with one labeled Other/See Progress Note, 9 1:1 activities labeled Snack Time, Discussion/Current Events, and Movie/TV, and 6 group activities labeled, Conversation, Lobby/Lounge, Exercise/Fitness/Dancing, Exercise/Action Games, Dancing/Exercise, and Music/Entertainment. This totals to 29 activities over 68 days. On 6/9/25 at 11:59 AM, Surveyor interviewed AD T (Activities Director). Surveyor asked AD T if she is aware of any of R67's activity preferences. AD T indicates R67 likes to watch people on his pod, people watch, go for walks, and family visits. AD T also indicates R67 doesn't care to stick around for activities, but rather will start to roam around. Surveyor asked AD T if she would expect to see these things on R67's care plan. AD T indicates, the walking, roaming, and watching tv are on his care plan. Surveyor advised AD T that they are being told by staff that R67 likes listening and watching Elvis on the tablet. Surveyor asked AD T if she would expect that to be on R67's care plan. AD T indicated no because AD T is not aware of that so she cannot verify it.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff did not provide care and treatment in accordance with professional standards of practice for 3 of 3 supplemental residents (R11, R381, & R52). R11 experienced a fall with a change of condition in which there was a delay of assessment of R11's right hip fracture. R381 had a change of condition and did not have documented assessments through the course of antibiotic treatment. R52 had a change of condition and did not have documented assessments through the course of antibiotic treatment. This is evidenced by: Surveyor requested facility's Change of Condition Policy. DON B states the facility does not have a Change of Condition policy but does follow AMDA (American Medical Directors Association) guidelines. According to the AMDA Change of Condition guidelines, the resident should be assessed further for an acute change of condition for pain worsening in severity, duration, or occurring in a new location, new onset of pain associated with trauma, or new onset of pain greater than 4 on a 10-point scale. Examples provided for transferring a patient to the hospital without identifying the cause of the acute change of condition includes: fall with pain and other clinical features consistent with fractures. Example 1 R11 was admitted to the facility on [DATE], with diagnoses that include: absence epileptic syndrome (seizure disorder characterized by brief lapses of consciousness), type 2 diabetes, major depressive disorder, anxiety disorder, and unspecified lack of expected normal physiological development in childhood. R11's Significant Change Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 3/31/25 states R11 has a Brief Interview for Mental Status (BIMS) score of 8 out of 15, indicating moderate cognitive impairment. Section GG indicates R11 has impairment on one side of her lower extremities and requires substantial/maximal assistance for rolling left and right, sitting to lying, lying to sitting on side of bed, sitting to standing, chair to bed transfers, toilet transfers, and tub/shower transfers. Section GG also indicates walking 10 feet was not attempted due to a medical condition or safety concerns. R11's Physician Orders state, in part: ADMIT to [Provider Name] Hospice, dx (diagnosis): angiodysplasia (fragile blood vessels causing chronic gastric bleeding) of stomach and duodenum with bleeding. Order date: 3/17/25. Order status: Active. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Strict bedrest per [Provider Name] Hospice one time only for confusion/weakness until 3/23/25 23:59 (11:59 PM). Order start: 3/22/25. End date: 3/23/25. Order status: discontinued Lorazepam (Benzodiazepine) Oral Tablet 0.5 MG (milligrams) (Lorazepam) Give 0.5 tablet by mouth three times a day for Anxiety; EOL (End of Life) care for 6 months. Monitor/Document for s/s (signs and symptoms) of anxiety. Order start: 5/19/25. Order status: Active. Morphine Sulfate Oral Tablet 15 MG (Morphine Sulfate). Give 0.5 tablet by mouth two times a day for pain. Order start: 3/24/25. Order status: Active. R11's Comprehensive Care Plan states, in part: Focus: The resident is at risk for falls related to poor safety awareness, seizures, current medications and fall history. Date initiated: 11/14/24. Goal: The resident will be free of injury through the review date. Date initiated: 11/14/24. Target date: 6/22/25. Interventions: Ask for assistance when needing ice. Date initiated: 2/10/25. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Date initiated: 11/14/24. Broda chair for comfort. Date initiated: 2/12/25. Revision on: 3/31/25. Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Date initiated: 11/14/24. Ensure that the resident is wearing appropriate footwear. Date initiated: 11/14/24. Focus: The resident has pain and/or receiving pain medication, PRN (as needed) pain medications. Date initiated: 11/14/24. Goal: The resident will verbalize adequate relief of pain or ability to cope with incompletely relieved pain through the review date. Date initiated: 11/14/24. Target date: 6/22/25. Interventions: Monitor/record/report to Nurse resident complaints of pain or requests for pain treatment. Date initiated: 11/14/24. Resident's non-pharmacological pain relievers include: walking/change of scenery, music, tv, extra pillows, food/beverage, lollipop/lozenges. Date initiated: 11/14/24. (Of note: R11's Comprehensive Care Plan does not indicate a pain goal or providing PRNs as ordered). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R11's Medical Record indicates, in part: On 3/22/25 at 14:15 (2:15 PM), a Progress Note is written that states, in part: The resident was found on the floor near her wheelchair and a chair in the dining room. Resident was laying on her right side. Resident stated she tripped trying to get into the chair and denied hitting her head. Resident was evaluated and was fully conscious, hand grabs were equally strong bilaterally . Resident states her leg and arm were hurting her. Resident favored her right leg when walking and had full range of motion on all four extremities .The POA (Power of Attorney) . and [Provider Name] hospice and spoke with nurse [Nurse name and phone number]. On 3/22/25 at 15:07 (3:07 PM), R11 rated her pain a 5 out of 10. PRN Lorazepam and Morphine administered for treatment. No non-pharmacological interventions attempted. On 3/22/25 at 6:03 PM, a Nurse Progress Note was written by a Hospice nurse. This note states, in part: PRN visit completed due to fall today. Staff reported some pain to her right amd [sic] and right leg. She cannot pivot transfer with staff like before and has a lot of pain and weakness in her legs . Staff have been giving her pain and anxiety medication to help her get thru this. She is more confused . She is alert to self but not able to comprehend what is happening with her pain issues and now that she can't stand to pivot transfers to bathroom, she has become incontinent of urine and bowels . On 3/22/25 at 19:26 (7:26 PM), R11 reported her pain at a 4 out of 10. No non-pharmacological interventions or PRN pain medications administered at this time. On 3/22/25 at 20:07 (8:07 PM), R11 reported her pain at a 4 out of 10. No non-pharmacological interventions administered. Scheduled Lorazepam administered at HS (bedtime) and scheduled Morphine administered at 21:00 (9:00 PM). On 3/22/25 at 21:29 (9:29 PM), a Progress Note is written that states: Resident is post fall monitoring. This shift resident refused dinner and c/o (complained of) left hip pain. Resident was also very anxious and shaky, PRN Morphine and Lorazepam provided throughout shift. Resident range of motion was weak and resident was unable to transfer to bathroom as she usually does [sic]. [Provider Name] Hospice notified regarding changes and arrived at 1800 (6:00 PM), assessed resident and ordered strict bedrest. [sic] Order was given for one day. On 3/22/25 at 22:58 (10:58 PM), a Progress Note is written that states: Resident POA [Name] notified regarding changes and visited resident at 1730 (5:30 PM). (Of note: Following initial provider notification of the fall, the provider was not notified of changes of condition of the resident's pain, range of motion, and transfer status.) On 3/23/25 at 13:59 (1:59 PM), R11 reported her pain at a 0 out of 10. On 3/23/25 at 20:02, R11 reported her pain at a 6 out of 10. Scheduled Lorazepam administered at HS (bedtime) and scheduled Morphine administered at 21:00 (9:00 PM). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Of note: no nurse assessments or progress notes are written on 3/23/25. These are the only two times R11's pain was assessed on 3/23/25. No non-pharmacological interventions or PRN pain medications were administered on this date.) On 3/24/25 at 12:44 PM, a Progress Note is written that states, in part: Resident alert and responsive, most of her needs anticipated and met by staff. Resident f/u (follow up) fall . Resident received PRN Morphine x3 for pain management. Repositioned for comfort. Resident cont. (continues) on strict bed rest . (Of note: This is the first note that mentions non-pharmacological interventions being used to treat R11's pain). On 3/24/25 at 13:33 (1:33 PM), a Progress Note is written that states, in part: IDT (Interdisciplinary Team) met to review the resident's most recent fall and need for further intervention. Directly after the fall, Hospice staff did not recommend xray because the resident has a h/o (history of) right-sided pain. During this morning's discussion, a hospice order for bedrest d/t (due to) continued pain was noted. IDT determined that a bilateral 2-view hip xray would be appropriate to determine if there was a diagnostic reason for the resident's pain. Xray conclusion: acute, displaced right femoral neck fracture. POA, [Provider Name] Hospice, [Name] NP (Nurse Practitioner) notified . On 6/9/25 at 11:30 AM, Surveyor interviewed NP V (Nurse Practitioner). Surveyor asked NP V if she would expect to be notified of a change in range of motion. NP V indicates, yes. NP V also checked messaging application and found that the only notification her organization received was regarding the initial fall on 3/22/25, then nothing until 3/24/25. Surveyor asked NP V if she would expect to be notified of R11's range of motion going from normal to weak several hours after her fall. NP V indicates, yes. On 6/9/25 at 3:22 PM, Surveyor interviewed DON (Director of Nursing) B. Surveyor asked DON B what are some reasons she would expect staff to notify a physician for a change of condition. DON B indicates she would expect staff to notify a physician for falls, acute pain out of baseline, chest pain, and abnormal vital signs and labs. Surveyor asked DON B if she would expect staff to notify a physician for a change in range of motion following a fall. DON B indicates, yes. Surveyor asked DON B if she would expect staff to notify a physician for a change in transfer status following a fall. DON B indicates, yes. Surveyor referred to R11 sustaining a fall on 3/22/25 and several hours later, R11 had decreased range of motion and a change in transfer status. Surveyor asked DON B if she would expect staff to notify a physician in that situation. DON B indicates, at a minimum hospice should have been notified and hospice did assess R11 after the resident fell. Surveyor asked DON B how staff communicate between shifts regarding residents who have a change of condition. DON B indicates staff should be doing a verbal hand-off report, going through each resident, and if the resident falls, they should be put on the 24-hour board. Surveyor asked DON B, that on 3/23/25, no nursing assessments were performed and should a nursing assessment have been performed. DON B indicates, yes, and notes that the NP was updated on 3/24/25. Example 2 R381 admitted to the facility on [DATE] and has diagnosis that include: Alzheimer's Disease; calculus in bladder (solid mineral deposits that form in the bladder, usually caused when the bladder doesn't empty completely after urination); need for assistance with personal care. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R381's Progress Notes include: *4/22/25 11:00 AM: .Chief Complaint: Change of condition .R381 is being seen today for evaluation of a significant change in condition.Low -grade fever of 99.1. Administered 1g (gram) IM (intramuscular) Rocephin (antibiotic). Ordered stat (immediately) CBC, BMP, chest xray, UA CNS (Urinalysis and Culture and Sensitivity-urine test which detects the specific bacteria causing an infection and identifies what antibiotics are effective against the bacteria). *4/22/25 2:00 PM: Resident noted to be very lethargic (a state of being tired, sluggish, and lacking energy, often accompanied by a reduced level of mental alertness) throughout shift .Malodor (unpleasant smell) of urine noted .No success with straight cath (intermittent catheter; a thin tube used to drain urine from the bladder) with UA collection. After multiple tries resident strongly refused . *4/25/25 9:13 AM: .still seems to be showing signs of a potential infection or possible decline. NP (Nurse Practitioner) ordering labs and staff to attempt another UA. *4/28/25 9:30 AM: Critical lab results received, viewed by NP. NOR (new order received) to start Macrobid (antibiotic) 100 mg (milligrams) BID (twice a day) x (for) 5 days . *4/29/25 12:41 AM: Resident is on ABT (antibiotic) for UTI (urinary tract infection) .No adverse reaction noted. No complaints at this time. R381's Weights and Vitals Summary includes: *Temperature-4/25/25 5:38 PM 97.2 degrees Fahrenheit (F); 5/6/25 9:05 PM 97.6 degrees F. There are no documented temperatures between 4/25/25 and 5/6/25. *Pulse-4/25/25 5:38 PM 73 bpm (beats per minute); 5/6/25 9:05 PM 70 bpm. There are no documented pulses between 4/25/25 and 5/6/25. *Respiration-4/25/25 5:38 PM 17 breaths/min (breaths per minute); 4/29/25 3:16 PM 17 breaths/min; 5/6/25 9:05 PM 18 breaths/min. There are no documented respirations between 4/25/25 and 4/29/25 or between 4/29/25 and 5/6/25. *Blood Pressure-4/25/25 5:38 PM 145/54; 5/6/25 136/70. There are no documented blood pressures between 4/25/25 and 5/6/25. R381's April 2025 and May 2025 Medication Administration Record (MAR) state Nitrofurantion Macrocrystal Oral Capsule (Macrobid -- antibiotic) 100 mg Give 100 mg by mouth two times a day for UTI for 5 days. Start date: 4/28/25 On 6/3/25 at 4:18 PM, Surveyor interviewed NM AA (Nurse Manager) and asked about residents showing new signs and symptoms of infection. NM AA stated there is to be an initial assessment, including vital signs, and update to the RN (Registered Nurse) and report to the provider. Surveyor asked if there is any continued assessment. NM AA stated yes, assessment should be documented every shift, in the progress notes, through the duration of the antibiotic. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/4/25 at 1:02 PM, Surveyor interviewed IP/UM D (Infection Preventionist/Unit Manager) and asked how often residents should be assessed when on an antibiotic. IP/UM stated every shift. Surveyor asked if there was documentation of R381's assessments following start of antibiotic for UTI. IP/UM D stated no. Surveyor asked if there should be documentation of assessment for R381. IP/UM D stated there should be. On 6/5/25 at 8:01 AM, Surveyor interviewed DON B (Director of Nursing) and asked if an infection is a change of condition. DON B stated yes. Surveyor asked what is expected of the facility staff when a resident has a change of condition. DON B stated there should be assessment of the resident, on-going through duration of antibiotic treatment. Example 3 R52 was admitted to the facility on [DATE] and has diagnoses that include: Type 2 Diabetes Mellitus; elevated white blood cell count (leukocytosis: can indicate an infection, inflammation or other underlying medical conditions); need for assistance with personal cares. R52's Progress Notes include: *3/10/25 11:35 AM: received results from BMP (Basic Metabolic Panel-blood test), CBC (Complete Blood Count-blood test), WBC (White blood cells) elevated; Nurse Practitioner reviewed; n/o (new order) UA (urinalysis) with C&S (culture and sensitivity) *3/15/25 1:48 PM: .new order for Macrobid (antibiotic) 100 mg (milligrams) bid (twice a day) x (for) 7 days . *3/21/25 4:41 AM: resident on ABT (antibiotic) for UTI. No adverse reaction noted. No complaints at this time. *3/21/25 2:06 PM: resident is currently on ABT for UTI no adverse reaction noted this shift R52's March 2025 MAR states, in part: *Vital signs every Sunday and Thursday AM. Start date: 3/31/24 *Macrobid Oral Capsule 100mg Give one capsule by mouth two times a day for UTI for 7 days. Start date: 3/15/25 *Methanamine Hippurate oral tablet 1 GM (gram) Give one tablet by mouth two times a day for recurrent UTI with meals. Start date: 2/24/25 R52's Weights and Vitals Summary includes: *Blood Pressure-3/16/25 1:59 PM 137/63; 3/20/25 10:02 AM 137/71 *Temperature-3/16/25 1:59 PM 97.5 degrees Fahrenheit (F);; 3/20/25 10:02 AM 97.6 *Pulse-3/16/25 1:59 PM 64 bpm (beats per minute); 3/20/25 10:02 AM 76 bpm (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avina of Pewaukee	N26 W23977 Watertown Rd. Waukesha, WI 53188

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Respiration-3/16/25 1:59 PM 17 breaths per minute; 3/20/25 10:02 AM 18 breaths per minute On 6/3/25 at 4:18 PM, Surveyor interviewed NM AA (Nurse Manager) and asked about residents showing new signs and symptoms of infection. NM AA stated there is to be an initial assessment, including vital signs, and update to the RN (Registered Nurse) and report to the provider. Surveyor asked if there is any continued assessment. NM AA stated yes, assessment should be documented every shift, in the progress notes, through the duration of the antibiotic. On 6/4/25 at 1:02 PM, Surveyor interviewed IP/UM D (Infection Preventionist/Unit Manager) and asked how often residents should be assessed when on an antibiotic. IP/UM stated every shift. Surveyor asked if there was documentation of R52's each shift assessment following start of antibiotic for UTI. IP/UM D stated no. Surveyor asked if there should be documentation of these assessments for R52. IP/UM D stated there should be. On 6/5/25 at 8:01 AM, Surveyor interviewed DON B (Director of Nursing) and asked if an infection is a change of condition. DON B stated yes. Surveyor asked what is expected of the facility staff when a resident has a change of condition. DON B stated there should be assessment of the resident, on-going through duration of antibiotic treatment.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility did not ensure that a resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility for 1 of 3 (R33) residents reviewed for mobility/restorative programs. R33 was on a walking program this program this program was discontinued. R33 voiced frustration with not being in the walking program and wanting to walk. This is evidenced by: The facility's Screening and Restorative Policy, dated 3/4/24, states, in part: 1. Most new and readmissions will admit with therapy evaluation orders; however, for those that don't all new and readmissions should be screened to determine therapy needs.3. Restorative Program/Therapy to Nursing Communication form should be completed and dated.c. Give a copy of the Restorative Program/Therapy to Nursing Communication form to MDS (Minimum Data Set), DON (Director of Nursing) and/or Restorative Nurse. R33 was admitted to the facility on [DATE] and has diagnoses that include: polyneuropathy (a condition where many peripheral nerves are affected, leading to a variety of symptoms like numbness, tingling, and weakness); unilateral primary osteoarthritis, left knee (a degenerative joint disease caused by the breakdown of the protective tissue in joints, which leads to pain, stiffness, and limited range of motion), major depressive disorder (a mood disorder characterized by persistent low mood). R33's most recent MDS, with target date of 5/15/25, documented that R33 had a Brief Interview for Mental Status (BIMS) score of 14, indicating that R33 is cognitively intact. R33's Therapy to Restorative Nursing Recommendations, dated 7/2/24, states, in part: Restorative recommendation: Walking: yes: Assist of one with gait belt and 2 wheeled walker with wheelchair follow up to 20 feet for ambulation program. R33's Physician Orders state, in part: Walking Program: Assist by 1 staff with 2 wheeled walker and wheelchair follow to walk up to 20 feet every day and evening shift for maintain mobility. Order status: discontinued. Order date 7/3/24 R33's Treatment Administration Record (TAR) for March 2025, states, in part: Walking program: Assist by 1 staff with 2 wheeled walker and wheelchair follow to walk up to 20 feet every day and evening shift for maintain mobility. Start date: 7/3/24 D/C (discontinue) date: 3/14/25. The TAR indicates that R33 accepted the walking program on 9 of 14-day shifts and 7 of 13 evening shifts in March 2025, prior to the program being discontinued. On 6/3/25 at 9:32 AM, Surveyor interviewed R33 during initial screening. R33 stated that R33 finished therapy and has a walker, but no one comes to help with walking. R33 stated that R33 has to take the wheelchair everywhere. I came here for rehab, so why am I not walking? I want to be walking, if I don't walk, I won't be able to walk. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/9/25 at 10:07 AM, Surveyor interviewed CNA F (Certified Nursing Assistant) and asked about walking programs. CNA F stated that there were no residents on the unit with walking programs. CNA F indicated that information on a walking program would be in the resident's care plan. On 6/9/25 at 10:33 AM, Surveyor interviewed LPN E (Licensed Practical Nurse) and asked about walking programs. LPN E reviewed R33's chart and stated that R33 used to be on a program, but it is no longer listed on the TAR. On 6/9/25 at 10:23 AM, Surveyor interviewed PTA DD and asked about restorative programs. PTA DD stated that recommendations from therapy are written on a Therapy to Restorative Nursing Recommendations form and given to the unit manager for entry into the resident's chart. Surveyor asked if recommendations had been made for a walking program for R33. PTA DD stated PTA DD would review R33's chart for most recent recommendations and provided a document from 7/2/24 indicating recommendation of walking program of 20 feet every day and evening shift. On 6/9/25 at 11:00 AM, Surveyor interviewed IP/UM D (Infection Preventionist / Unit Manager) and asked about walking programs. IP/UM D stated that recommendations from therapy are reviewed and entered into the resident's TAR for nurses to document. Surveyor asked if R33 had a walking program. IP/UM D stated that there was a program started in July 2024 that had been discontinued in March 2025. IP/UM D indicated uncertainty as to reason for discontinuation as no documentation of rationale was noted. On 6/9/25 at 11:48 AM, Surveyor interviewed DON B (Director of Nursing) and asked about R33's walking program. DON B stated it seems like it should have continued; there is no documentation of why the program was discontinued.

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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** Example 2 R26 was admitted to the facility on [DATE] with diagnoses that include in part: Cerebral Palsy (a group of neurodevelopmental disorders that affect body movement and muscle coordination), Type II Diabetes, Spinal Stenosis, lumbar region with neurogenic claudication (A condition where the spinal canal narrows, compressing spinal nerves and causing leg pain, particularly when walking), Gastro-Esophageal Reflux, and other fatigue. R26's Most recent MDS (Minimum Data Set), with a target date of 3/20/25, indicates a BIMS (Brief Interview for Mental Status) score of 15, meaning R26 is cognitively intact. On 6/3/25 at 1:03 PM, during the record review portion of the initial pool process, surveyor was unable to locate all weights for trending weight loss or gain. On 6/4/25 at 7:30AM the facility provided the following list of weights for R26 from 1/1/25 to present: 1/1/25: 263 Lbs (Hoyer Scale) 3/21/25: 255 Lbs (Wheelchair) 4/9/25: 255 Lbs (Last weight obtained - refusal) R26's Comprehensive Care Plan, includes, in part: Focus: Alteration in nutritional status r/t (related to) hx (history) of DM (Diabetes Mellitus), obesity w/BMI >30 (Body Mass Index), decline in ADLs (Activities of Daily Living). Date Initiated: 12/18/23. Revision on: 12/18/24. Goal: Will tolerate diet as evidenced by no weight changes equal to or greater than 7.5% thru next care plan review. Date Initiated: 12/18/23. Revision on 3/19/25. Interventions: .Weigh resident every month or per MD/RD (Medical Doctor/Registered Dietician) order. Document and notify MD/RD of any significant weight changes. Date Initiated: 12/18/23. On 6/4/25 at 9:20 AM during an interview with R26, he indicated he is weighed monthly and does not refuse his weights. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/4/25 at 8:05 AM, Surveyor interviewed CNA X (Certified Nursing Assistant) and asked what the process was for obtaining residents weights. CNA X indicated weights are obtained once a month unless they have a daily weight or they just want one that day. Surveyor asked CNA X how she knows if a resident is a daily weight. CNA X indicated it is usually on the care card and usually the nurse will give them a note with who needs weights. Surveyor asked CNA X what the process is if a resident refuses to get weighed. CNA X indicated they will ask at least twice and write refused in the chart and report to the nurse. Surveyor asked CNA X if there is anyone on the 300 unit that tends to refuse weights. CNA X did not indicate R26 refuses. Surveyor asked CNA X if there is anyone on the 300 unit that does not get weighed at all. CNA X indicated, no, everyone gets weighed. On 6/4/25 at 1:52 PM, Surveyor asked CNA X after she completes the weights where she takes the list. CNA X indicated it goes to the DON (Director of Nursing). On 6/4/25 at 1:03 PM, interviewed CNA Q and asked what the process was for obtaining weights. CNA Q indicated, normally at the beginning of the month we have a sheet that we put them all on. Surveyor asked CNA Q if she has ever known R26 to refuse his weight. CNA Q indicated she had but couldn't say how often and that she was asked to get his weight today. Surveyor asked CNA Q if she charts the weights in the computer. CNA Q indicated she does not and that the she gives the paper to the nurse when she is done. On 6/4/25 at 12:37 PM, Surveyor interviewed LPN Y (Licensed Practical Nurse) and asked what the overall process is for obtaining weights. LPN Y indicated on the first of the month they are supposed to get weights, usually they have certain aides that come in and do all that. Once they have them on the paper she is not sure who enters them. LPN Y indicated, if management asks for a specific weight from her, she will get the weights from the aides and then chart them in the computer under the weights/vitals tab. Surveyor asked LPN Y what she does if someone refuses to be weighed. LPN Y indicated she will go and ask again, she will give it two times, and then chart in a progress note the refusal. Surveyor reviewed R26's weights with LPN Y and LPN Y indicated that R26 should have monthly weights. LPN Y indicated the nurse manager had asked her to obtain R26's weight today because he had been refusing. Surveyor asked LPN Y if she was aware of him refusing before today or if any CNA's have come to her and told her he has refused. LPN Y indicated, no. Surveyor asked LPN Y if R26 had refused any of the weights should it be documented. LPN Y indicated, yes. Surveyor asked LPN Y if they don't have those weights how they would know if R26 had lost weight. LPN Y indicated, right, there is nothing to compare it to. On 6/4/25 at 1:49 PM, Surveyor interviewed LPN Y and asked who checks that weights are complete and compares to past weights for variances. LPN Y indicated she did not know for sure. Usually, she finds the list of who needs weights on her cart and then gives it to the aides and then she does not know what happens to it. LPN Y indicated she would think it would be the DON but does not know for sure. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/9/25 at 10:26 AM, Surveyor interviewed LPN Z and asked what the process is for obtaining monthly weights. LPN Z indicated the list is found on med cart for the pod and she will communicate with her aides and give them the list of weights. The aide will tell her if she wasn't able to get one and will highlight the ones they did get and not the ones they couldn't. The highlighted ones, the aide documents in the computer. Surveyor asked LPN Z how she ensures the weights the aide could not get are completed. LPN Z indicated once they tell her what the reason was for not getting it, she may try again later. Otherwise, she will pass it on to the next nurse if they still don't have the weights. LPN Z indicated if they had two attempts on her shift then she would document refused for her shift and that they will try on 2nd shift and pass it on. On 6/4/25 at 2:22PM Surveyor interviewed NM AA (Nurse Manager) and asked what the process is for obtaining weights. NM AA indicated, if we need a weight we put the order in PCC and it will pop up on the MAR (Medication administration Record) for them to get the weight. NM AA indicated, in her role she will verbally tell them that she just put an order in for a weight and ask them to get the weight. For new admission they typically get weights for 3 days and then if they require additional monitoring for weights, based on the NP (Nurse Practitioner) we will put those orders in as well. Surveyor asked NM AA what the process is for residents who are no longer a new admit. NM AA indicated they get weekly weights. Surveyor asked NM AA if they do monthly weights on anyone. NM AA indicated they do. NM AA indicated, usually in the first two days of the month they will print out a huge list and there is usually a staff member that comes in to do just the weights. NM AA indicated everyone gets monthly weights. Surveyor asked if there is supposed to be an order for the monthly weight. NM AA indicated, no and that it is just a policy. Surveyor asked NM AA where refusals should be documented. NM AA indicated in a progress note. Surveyor asked NM AA what happens to the sheet that they document the monthly weights on after they are obtained. NM AA indicated she believes one of the nurses does the documentation. Surveyor asked NM AA if she knows who that is. NM AA indicated, anyone who is a licensed nurse can put the weights in. NM AA indicated that it is normally the CNA's that get the weights. Surveyor asked NM AA who the CNA's are trained to give the paper to after obtaining the weights. NM AA indicated any nurse. Surveyor asked NM AA who prints the weight list. NM AA indicated NHA A (Nursing Home administrator) or DON B (Director of Nursing) would print the list and distribute to a staff member to get the weights and then any nurse can put the weights in. Surveyor asked NM AA if she is the NM for the 300 pod and she indicated yes. Surveyor asked NM AA how often R26 should be having his weight done. NM AA indicated monthly. Surveyor asked NM AA if they are being done monthly. NM AA indicated, it looks like they are not done monthly, he had weights 1/1/25, 3/21/25, 4/9/25, and 6/4/25. NM AA indicated there may be some notes regarding refusals and she will look for these. Surveyor asked NM AA if R26 refuses should that be documented in the progress notes. NM AA indicated, yes. Surveyor asked NM AA if there are not monthly weights how they are able to determine if he meets a significant weight loss. NM AA indicated they would look at his food intake and see if they are seeing a trend in his appetite and then also encourage him to get the weight as well. NM AA indicated, she would say nutritional intake. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/4/25 at 3:44 PM, Surveyor interviewed RD S (Registered Dietician) and asked what her expectation is on weights and how often they should be completed. RD S indicated they should be done monthly. New admissions should be done on admission and then weekly weights x 4 and then monthly, unless the provider wants something different. Surveyor asked RD S if those weights are utilized for calculating significant weight loss. RD S indicated, yes. Surveyor asked RD S what she does if she looks at the weights and not all the monthly weights are present. RD S indicated she prints a report out of [PCC] the electronic medical record program monthly and she also looks weekly for weights. If there is something that looks really questionable for accuracy she will reach out to the facility and ask for a re-weight. If she notes there are weights missing, she will let the facility know because they may have them written down somewhere. RD S indicated when she does have a good amount of weights, she does chart any significant weight changes. Surveyor asked RD S if she keeps the documents where she notes missing weights on residents. RD S showed surveyor an email that was sent to the facility from 5/14 that contained a list of residents she indicated still needed weights for May at that time. There are 31 resident names on this list and R26 is one of them. Surveyor asked RD S how she finds out if they obtained the missing weights. RD S indicated she will go into the electronic medical record and look and then update the paper she keeps and sends and updated email every week if she doesn't get the weight from the facility. Surveyor asked RD S if she puts in a note saying she reviewed them in the computer. RD S indicated she does not unless there is a quarterly note that pops up. RD S indicated she does send a monthly report to the facility and to the NP (Nurse Practitioner) with significant weight changes and the information for 1, 3 and 6 months. RD S indicated if they have a significant weight change, I do put in a progress note, but just reviewing a weight is a standard of care. Surveyor reviewed the weights documented for R26. RD S indicated that the April 9th weight is not an actual weight, it is showing that there was a refusal and so it pulls in the weight from the month before so that is why March and April weights are the same. Surveyor asked RD S without all of the monthly weights on R26 how does she know if there was a significant weight change. RD S indicated, we don't. Surveyor asked RD S if she is looking at a resident for a quarterly note and doesn't have all the monthly weights how can they calculate if the resident has had a significant weight change. RD S indicated, we can't. After the interview RD S provided surveyor with the emails from 5/14/25 and 5/21/25 she sent to the facility indicating missing May weights. The 5/21/25 email contained 29 names for residents still missing May weights and 9 residents indicated as recent admits still needing facility weights. Of note, R26 is noted on both email lists. On 6/4/25 Surveyor interviewed NM AA who indicated she did not find any refusals for R26 and that she asked the DON to look as well. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/9/25 at 12:34 PM, Surveyor interviewed DON B (Director of Nursing) and asked what the process is for monthly weights. DON B indicated she sends out a text blast reminding the nurses and CNA's that monthly weights are needed. DON B indicated she will send these out a couple times during the first week of the month. DON B indicated whoever has not been done they will print off the weight sheet and it goes to the floor staff and then when it is done they return it to her or the NHA (Nursing Home Administrator) and whoever gets the sheet back enters the weights into [PCC] the electronic medical record. Surveyor asked DON B what happens if a resident refuses a weight. DON B indicated, under the weights and vitals, when you go to put in the weight, it will say last weight obtained-refusal and you just put in the last weight that was completed. Surveyor clarified with DON B in this instance the weight under the refusal is not the current days weight. DON B indicated that was correct. Surveyor clarified with DON B that herself and NHA A are responsible for putting the weights into the electronic medical record. DON B indicated yes, and that she does know the nurse will sometimes do it as well, but she would still make sure it got done. Surveyor asked DON B if the weights under the weights/vitals tab are the weights being used for monitoring weight loss and DON B indicated that was correct. Surveyor asked DON B if she would expect all the weights to be documented. DON B indicated, yes, whether we obtained the weight, or they refused. Surveyor reviewed with DON B, R26's weights, noted that not every months weight was documented, only 1 refusal was documented, and that NM AA indicated she was not able to find any other documentation of refusals. Surveyor asked DON B, without having all the monthly weights how they would know if R26 had a weight gain or loss. DON B indicated; we would essentially need the weights from month to month to trend it. Based on observation, interview, and record review, the facility did not consistently monitor weights and ensure interventions were in place as per physician order for 4 of 7 Residents (R46, R26, R433, and R56) reviewed for nutrition maintenance. R46 experienced significant weight loss. R46's meal ticket and care plan does not include resident likes and dislikes. R46 indicated staff do not offer substitutes if resident eats 50% or less of meal as stated in care plan. The facility did not implement weekly weights until 6/6/25 after family requested it, despite R46 significant weight loss. R26 and R433 did not have consistent documentation of weights so that tracking and trending of weight loss/gain could be completed. R433 did not have a weight completed upon admission. R56 had significant weight loss. Evidenced by: The facility policy, Weight Monitoring, dated 2/1/25, states, in part; .Based on the resident's comprehensive assessment, the facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise .4. Interventions will be identified, implemented, monitored and modified, consistent with the resident's assessed needs, choices, preferences, goals and current professional standards to maintain acceptable parameters of nutritional status .5. A weight monitoring schedule will be developed upon admission for all residents .6. Weight Analysis: .5% change in weight in 1 month .7.5% change in weight in 3 months .10% change in weight in 6 months .The physician should be informed of a significant change in weight and may order nutritional interventions . (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy, Meal Identification and Preference Cards/Tickets, states, in part; .The permanent meal ID card/ticket should include the name of the individual, diet order, beverage preferences, food dislikes and any other applicable diet information The facility policy, Nutritional Management, dated 2/1/25, states, in part; .The resident's goals and preferences regarding nutrition will be reflected in the resident's plan of care .Monitoring/revision: Monitoring of the resident's condition and care plan interventions will occur on an ongoing basis .Interviewing the resident and/or resident representative to determine if their personal goals and preferences are being met . Directly observing the resident .Evaluating the care plan to determine if current interventions are being implemented and are effective . Example 1 R46 was admitted to the facility on [DATE] with a diagnoses including chronic respiratory failure, dementia, chronic pain, depression, anxiety, osteoarthritis, muscle weakness, dysphagia, abnormalities of gait and mobility, severe protein-calorie malnutrition, and cognitive communication deficit. R46 most recent MDS (Minimum Data Set) dated 3/13/25 indicates R46 has a BIMS (Brief Interview for Mental Status) of 14 indicating R46 is cognitively intact. R46's weights state, in part; .3/8/25 99.2lbs .3/9/25 99lbs .3/12/25 91.8lbs .4/2/25 91.1lbs .4/15/25 93lbs . 5/16/25 86lbs .6/4/25 86.5lbs . It is important to note from 3/9/25 to 5/16/25 R46 experienced a 13.13% weight loss indicating severe weight loss. R46's Comprehensive Care Plan, states, in part; .Alteration in nutritional status r/t dysphagia requiring mech altered diet, cognitive deficits, decline in ADL's, severe COPD, underweight status, malnutrition 3/14/25 . Allow adequate time for the resident to consume food served 3/7/25. Encourage resident to drink fluids during meals and medication pass 3/14/25. Monitor for s/s of aspiration or any difficulty with swallowing 3/14/25. Monitor for s/s of dehydration: decreased output, dark urine, dry mucous membrane, low grade temp, cognitive changes, poor skin turgor 3/14/25. Monitor resident during meals to provide assistance and encouragement 3/14/25. Offer a substitute if less than 50% of the meal is consumed 3/14/25. Pertinent nutritional labs per MD order 3/14/25. Provide house shake with breakfast and dinner 3/7/25. Serve the resident's diet as ordered 3/14/25. Weigh resident every month or per MD/RD order. Document and notify MD/RD of any significant weight changes 3/14/25 . R46's orders, state, in part; .General diet regular texture, regular thin liquids for high protein and high calorie start date 4/23/25 .House shakes with meals for meals start date 4/10/25 .weekly weights every day shift every Fri for protein malnutrition start date 6/6/25 . It is important to note weekly weights did not start until 6/6/25. R46's meal tickets state, in part; .Breakfast: General Regular Vanilla House shake 1 serving .Likes: rice Krispies. Dislikes: BLANK. Other: BLANK. Lunch: General Regular Vanilla House Shake 1 serving .Likes: BLANK. Dislikes: BLANK. Other: BLANK. Supper: General Regular Vanilla House Shake 1 serving .Likes: BLANK. Dislikes: BLANK. Other: BLANK . (continued on next page)

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Avina of Pewaukee	N26 W23977 Watertown Rd. Waukesha, WI 53188

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/2/25 at 11:07 AM, R46 indicated that she feels the food is terrible at the facility. R46 indicated she drinks ensure and likes them. Surveyor saw R46's breakfast tray still in bedroom. R46 indicated she did not like what was for breakfast and showed Surveyor that she didn't eat any of it. R46 indicated she drank the ensure. R46 indicated she has told staff that she thinks the food is terrible and they agree with her. R46 indicated she was not offered anything else to eat since she didn't eat breakfast. R46 indicated she does not remember anyone sitting down with her and discussing likes and dislikes. On 6/4/25 at 1:59PM, Registered Dietician S (RD) indicated she is at the facility once a week. RD S indicated she reviews weights weekly and will notify management team if there are weights missing. RD S indicated she will order supplements and make suggestions if a resident is losing weight. RD S indicated she will look at underlying reasons on why someone may be losing weight and then will figure out what intervention is appropriate. RD S indicated the Dietary Manager or Assistant Dietary Manager will meet with the resident and discuss likes and dislikes. RD S indicated the kitchen will then update the resident meal tickets. RD S indicated RD S will update meal tickets as well if RD S is the one ordering a supplement. RD S indicated R46's weight loss has been an ongoing discussion with everyone on the team. RD S indicated she has talked to family multiple times regarding weight loss and interventions. RD S indicated R46 has declined a feeding tube, medication to increase appetite, and appointments. RD S indicated it's a balancing act of how much the weight loss is due to R46's disease process. RDS indicated R46 recently had a care conference meeting and R46's sister asked why the facility wasn't weighing her more often, so they are starting to do weekly weights. On 6/4/25 at 2:28 PM, Assistant Dietary Manager I (ADM) indicated the kitchen staff will meet with new residents to discuss likes/dislikes, and this will then go on the resident meal tickets. On 6/9/25 at 2:28 PM, Nurse Practitioner V (NP) indicated R46, and her weight loss has been tricky. R46 has refused interventions. R46 has been adamant through this that she wants a more comfort care approach and her sister, who is not the power of attorney, disagrees. NP V indicated they recently had a care conference meeting to get everyone on the same page. NP V indicated she educated family what palliative care/hospice and failure to thrive means. NP V indicated it is not that R46 doesn't want to eat but rather she is trying and working so hard to breathe. NP V indicated R46 sees multiple doctors and has declined some appointments. NP V indicated R46 does refuse some foods, and she had granola bars in her room for a snack. NP V indicated R46 just decided she didn't want the bars anymore. NP V indicated the facility is doing many different things to support R46 with her nutritional needs. NP V indicated the Registered Dietician has talked to resident and family and R46's diet changed because she did not like the ground meat. NP V indicated she would assume staff talked to R46 about her likes and dislikes, resident should have been weighed weekly and NP thought she was being weighed more frequently. NP V indicated she would expect likes/dislikes to be on meal ticket. NP V indicated if it is care planned to offer substitute if resident eats 50% or less NP V would think it should be offered, but Director of Nursing would be able to speak more on that. On 6/9/25 at 3:55 PM, Director of Nursing B (DON) indicated a resident's likes/dislikes should be on the resident meal tickets. DON B indicated weekly weights did not start for R46 until 5/30/25. DON B indicated if it is care planned that the resident is offered a substitute if they eat 50% or less, the meal ticket would be a good place to put that so that intervention occurs, and staff know to offer. DON B indicated understanding of the above concerns. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility did not consistently monitor weights and ensure interventions were in place as per physician order for nutrition maintenance. Example 4 R56 was admitted to the facility on [DATE] with diagnoses that include, in part: vascular dementia, dysphagia (difficulty swallowing), epilepsy (seizure disorder), muscle weakness (generalized), and abnormal posture. R56's most recent Minimum Data Set (MDS), with Assessment Reference Date (ARD) of 5/20/25 indicates R56 had a Brief Interview for Mental Status (BIMS) score of 6 out of 15, indicating severe cognitive impairment. Section GG indicates R56 has impairment on both sides of her upper and lower extremities, requires supervision or touching assistance for eating, and is dependent on staff for rolling left and right, chair or bed to chair transfers, and tub/shower transfers. R56's Physician Orders state, in part: General diet Regular texture, Regular (Thin Liquids) consistency. Start date: 12/3/24. Order status: Active R56's Comprehensive Care Plan indicates, in part: Focus: The resident has nutritional problem or potential nutritional problem of etoh (Ethanol-Alcohol) use, CVA (Cerebrovascular accident-stroke) and receives a general regular diet. Goal: The resident will maintain adequate nutritional status as evidenced by maintain weight with no significant changes, no s/sx (signs or symptoms) of malnutrition, and consuming at least 75% of at least 2 meals daily through the review date. Interventions: Administer medications as ordered. Monitor/Document for side effects and effectiveness. Develop an activity program that includes exercise, mobility. Offer activities of choice to help divert attention from food. Monitor/document/report PRN (as needed) any s/sx of dysphagia (difficulty swallowing): Pocketing, Choking, Coughing, Drooling, holding food in mouth, several attempts at swallowing, Refusing to eat, Appears concerned during meals. Monitor/record/report to MD (Medical Doctor) PRN s/sx of malnutrition: Emaciation (Cachexia), muscle wasting, significant weight loss: 3lbs in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months. Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Provide and serve diet as ordered. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RD (Registered Dietician) to evaluate and make diet change recommendations PRN. R56's Weight Documentation indicates: 3/13/25: 142.8 lbs. 5/23/25: 130.2 lbs. (Of note: No weight was assessed after 5/23/25. This documentation indicates R56 sustained a 8.82% weight loss over 2 months and 11 days. R56's Comprehensive Care Plan identifies this as significant weight loss. Additionally, no weight was recorded for the month of April.). On 6/5/25 at 10:30 AM, Surveyor interviewed NP V (Nurse Practitioner). Surveyor asked NP V if R56 was at risk for impaired nutritional status. NP V indicates yes and elaborates that due to the recent removal of R56's PEG tube and her seizure disorder, NP V expects R56 to have some weight fluctuation. Surveyor asked NP V, if she would have expected to have been notified of a R56's significant weight loss from 3/13/25 to 5/23/25. NP V indicates, yes. Surveyor asked NP V if there were any interventions or changes she would have made had she known about this weight loss. NP V indicates she would request a re-weigh to ensure accuracy of the weight. Surveyor asked NP V how often she expects R56 to be weighed. NP V indicates that she believes R56 is being weighed weekly. On 6/9/25 at 2:03 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B how often residents should be weighed. DON B indicates, monthly. Surveyor asked DON B what the process is for notifying a provider of a weight change. DON B indicates that once weights are recorded, the Registered Dietician reviews them and will email the NP V regarding weight changes. Surveyor asked DON B if she would expect a weight change of 8.82% in less than 3 months be reported to the physician. DON B indicates, yes. The facility failed to weigh R56 at least monthly and notify a physician of a significant weight loss of 8.82% in less than 3 months. Example 3 R433 was admitted to the facility on [DATE] with diagnoses that include in part: Chronic Diastolic (Congestive) Heart Failure (condition where the left ventricle of the heart becomes stiff and cannot fill properly), Hypertensive heart (heart condition caused by high blood pressure) and stage 1 through stage 4 chronic kidney disease (condition where kidneys are damaged and cannott filter blood), or unspecified chronic kidney disease, and malignant neoplasm of colon and rectum (colorectal cancer). R433's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 5/20/25 indicates R433's cognition is intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15. On 6/5/25 at 3:46 PM, the facility provided the following list of weights for R433 from 5/13/25 (admission date) to present: 5/23/25: 126 Lbs (pounds)(Wheelchair) R433's Care Plan, printed on 6/5/25, includes in part: (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Focus: Alteration in nutritional status r/t (related to) a therapeutic diet for CHF (chronic heart failure) & CKD4 (stage 4 chronic kidney disease), increased needs d/t (due to) new colorectal CA (cancer), potential for constipation w/large rectal mass, hx (history) proteinuria, daily ETOH (alcohol abuse), anemia, PAD (peripheral artery disease) Goal: Will tolerate therapeutic diet as evidence [sic] by o [sic] weight changes equal to or greater than 7.5% thru next care plan review. Interventions: .Weigh resident every month or per MD/RD (Medical Doctor/Registered Dietician) order. Document and notify MD/RD of any significant weight changes. Surveyor reviewed R433's After Visit Summary from the hospital dated 5/13/25. Discharge instructions include in part: Weight Monitoring - Weigh yourself every day. Use the same scale, at the same time of the day, and in the same kind of clothes. An unexpected weight gain can mean that your heart failure is worsening. (Of note: R433's care plan does not match R433's discharge instructions from the hospital as R433 is not being weighed daily.) On 6/4/25 at 4:37 PM, Surveyor interviewed RD S (Registered Dietitian). RD S completed a nutritional assessment for R433 on 5/20/25. R433 scored an 8 on the assessment, meaning she could be at risk for malnutrition. RD S indicated if R433 had scored a 7 or less, she would reach out to a nurse practitioner for review. Surveyor asked how R433's weight is being monitored. RD S indicated that a facility weight should have been entered upon admission. RD S had to reach out for a facility weight since there had not been one to compare with the hospital weight when she completed R433's nutritional assessment. Surveyor asked if RD S would expect R433 to have daily weights taken. RD S indicated weights would be taken at standard intervals, unless otherwise ordered. RD S indicated this is typically weekly weights for four weeks then monthly weights. Surveyor asked RD S if she thinks R433 is meeting her fluid and nutritional needs. RD S indicated R433 was not meeting needs as of 5/20, so she added a supplement and asked to work with her on preferred snacks. RD S indicated weight reviews are done weekly or monthly and she would review R433's status whenever the next weight happens to be charted. Facility staff were not weighing R433 per discharge orders.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure appropriate staffing to maintain residents highest practicable, physical, mental and psychosocial well-being. This affected 2 of 2 sampled residents (R47 and R24) and 1 of 1 supplemental residents (R29) reviewed for staffing. This has the potential to affect more than a limited number of residents residing in the home. Resident's voiced concerns regarding long call light wait times. Observations were made of no staff on the 200 hall for 45 minutes. Surveyor observed 45-minute call light wait time. Evidenced by: The facility policy, Call Lights: Accessibility and Timely Response, dated 2/1/25, states, in part; .The purpose of this policy is to assure the facility is adequately equipped with a call light at each resident's bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response .10. All staff members who see or hear an activated call light are responsible for responding . Example 1 R24 was admitted to the facility on [DATE]. R24 most recent MDS (Minimum Data Set) dated 5/7/25 indicates R24 has a BIMS (Brief Interview for Mental Status) of 15 indicating R24 is cognitively intact. On 6/2/25 at 11:50AM, R24 indicated there would be enough staff on shift if all staff did their job. R24 indicated she sees staff sitting on their phones and most of them are just concerned about taking a cigarette break. R24 indicated she sees it all the time that staff are just talking amongst each other and not answering call lights. R24 indicated this has been reported and it is an ongoing concern. Example 2 R29 was admitted to the facility on [DATE] with a diagnoses including panic disorder, weakness, abnormalities of gait and mobility, and need for assistance with personal care. R29's most recent MDS (Minimum Data Set) dated 5/13/25 indicates R29 has a BIMS (Brief Interview for Mental Status) of 14 indicating R29 is cognitively intact. On 6/3/25 at 2:30PM, R29 indicated she was frustrated. R29 indicated her call light has been on for 30 minutes so far. R29 indicated her stomach hurts, and she wants to lay down. R29 indicated this happens a lot, especially in the afternoons at shift change. R29 indicated this concern has been reported and continues being an issue. Surveyor observed no staff present throughout 200 hallway. Surveyor observed staff answer call light at 3:15PM. R29 indicated it makes her feel very angry when she has to wait this long for staff assistance. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Example 3 On 6/3/25 at 2:45PM, R47 indicated call light wait times are a concern and this is an ongoing issue. R47 indicated long call light wait times often are an issue during shift change. R47 indicated this concern has been shared with the facility. On 6/3/25 at 3:00PM, Licensed Practical Nurse M (LPN) indicated 8-10 minutes is an appropriate time for call lights to be answered. LPN M indicated long call light wait times are an issue and this happens a lot. There are times that they can't find the Certified Nursing Assistant (CNA) to assist the residents. LPN M indicated CNA's are split between two pods so the CNA might be assisting someone down a different hallway and can't see that the call light is on. On 6/3/25 at 3:11PM, Certified Nursing Assistant L (CNA) indicated she is responsible for 200 and 300 pods today. CNA L indicated she was assisting another resident with a shower and that someone should have been available to assist with the call lights. CNA L indicated she tries to answer call lights immediately within 2-3 minutes. CNA L indicated she usually reports to the nurse if she is going to be busy so the nurse can assist with answering lights as well. Surveyor reviewed Resident Council Minutes provided by the facility, include, in part: March 31, 2025 .Call Light Times Too Long May 28, 2025 .Resident Call Not Answered in Timely Fashion On 6/9/25 at 8:33AM, Nursing Home Administrator A (NHA) indicated she would expect call lights to be answered timely. NHA A indicated 10-15 minutes is an acceptable wait time and it may vary a bit depending on staff assisting other residents.

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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 all drugs and biologicals used in the facility were stored in accordance with currently accepted professional principles for 4 of 5 supplemental residents (R14, R15, R25,and R35), 3 of 6 medication carts, and 1 of 2 medication storage rooms. R14's eye drops were not dated with an open date. R15's eye drops were not dated with an open date and were not stored in the refrigerator. R25's Anbesol has no expiration date. R35's eye drops were past the discard date. The facility's 200-hallway medication cart had a loose pill in the top drawer and unlabeled medication. The facility's 300-hallway medication cart had loose pills in the top drawer and expired stock medication. The facility's 600-hallway medication cart had unlabeled insulin in the top drawer. The facility's medication room had undated tuberculin (TB) testing solution open and undated and missing refrigerator temperatures in the vaccine storage refrigerator. This is evidenced by: The facility's policy titled Medication Storage in the Facility, revised 1/18, includes the following: Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. C. All medications dispensed by the pharmacy are stored in the container with the pharmacy label. E. Except for those requiring refrigeration or freezing, medications intended for internal use are stored in a medication cart . H. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal. F. The facility should check the refrigerator or freezer in which vaccines are stored, at least two times a day, per CDC Guidelines. D. 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. The expiration date of a vial or container will be [30] [sic] days unless the manufacturer recommends another date or regulations/guidelines require different dating . G. All expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining. Example 1 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/5/25 at 10:39 AM, Surveyor observed the 300-hallway medication cart with LPN Z (Licensed Practical Nurse). R14's refresh tears (artificial tears) were in the medication cart. R14's refresh tears did not have an open date on the bottle. Surveyor interviewed LPN Z regarding R14's refresh tears. LPN Z indicated she was unsure when R14's refresh tears were opened. LPN Z indicated R14's refresh tears should have an open date on them. Example 2 On 6/5/25 at 10:25 AM, Surveyor observed the 200-hallway medication cart with LPN R. R15's Azopt eye drops were in the medication cart. R15's Azopt eye drops did not have an open date or expired date. R15's Azopt eye drops had a sticker that indicated to discard after 28 days on it. R15's Latanoprost eye drops were in the medication cart. R15's Latanoprost eye drops had stickers on the bottle that stated refrigerate and discard after 28 days. R15's Latanoprost eye drops did not have an open date. Surveyor interviewed LPN R regarding R15's eye drops. LPN R indicated she was not sure when R15's eye drops were opened and therefore did not know when the eye drops should be discarded. LPN R indicated R15's Latanoprost eye drops should have been refrigerated and were not. Example 3 On 6/5/25 at 10:49 AM, Surveyor observed the 600-hallway medication cart with LPN EE. R25 had a bottle of Anbesol liquid oral pain relief. R25's Anbesol bottle's expiration date was rubbed off. Surveyor interviewed LPN EE regarding R25's Anbesol expiration date. LPN EE indicated she was unable to determine the expiration date and therefore did not know if the medication was expired. Example 4 On 6/5/25 at 10:25 AM, Surveyor observed the 200-hallway medication cart with LPN R. R35's artificial tears were in the top drawer. R35's artificial tears had a date of 3/28/25 written on it and a sticker indicating to discard after 28 days. Surveyor interviewed LPN R regarding the date. LPN R indicated she would guess that the date was the date opened but could not be sure if it was the open date or the expired date. LPN R indicated either way, the bottle was beyond 28 days and should have been removed from the cart and disposed of. Example 5 On 6/5/25 at 10:25 AM, Surveyor observed the 200-hallway medication cart with LPN R. Surveyor observed a loose white pill in the top drawer and an open bottle of artificial tears unlabeled. Surveyor interviewed LPN R regarding the observation. LPN R indicated she was unsure what the white pill was and did not know who the unlabeled artificial tears belonged to. LPN R indicated loose pills should not be in the medication cart and all medications should be labeled. Example 6 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/5/25 at 10:39 AM, Surveyor observed the 300-hallway medication cart with LPN Z. Surveyor observed 16 loose pills in the top drawer of the medication cart and a bottle of vitamin B12 with an expiration date of 5/25. Surveyor interviewed LPN Z regarding the observation. LPN Z indicated she is not sure what the loose pills were and started to remove them from the cart to dispose of. LPN Z indicated loose pills should not be in the medication cart. LPN Z indicated the vitamin B12 was expired and should not be on the cart. Example 7 On 6/5/25 at 10:49 AM, Surveyor observed the 600-hallway medication cart with LPN EE. Surveyor observed an insulin Lispro pen in the top drawer. There was no cap on the insulin pen and there was no label to indicate who the medication belonged to. LPN EE indicated she does not know who the insulin Lispro pen belongs to. LPN EE indicated insulin pens should have a cap on them when not in use and the insulin pen should have been labeled with a resident's name and an open date. Example 8 On 6/5/25 at 10:56 AM, Surveyor observed the medication room with DON B (Director of Nursing). Surveyor observed the refrigerator that contained TB (tuberculin) testing solutions and vaccinations. Surveyor observed 3 open bottles of TB testing solution without an open date. Surveyor observed the vaccine refrigerator temperature logs for April, May, and June. The temperature logs have one slot per day to record the temperatures 4/14/25, 5/7/25, 5/11/25, 5/12/25, 5/15/25, 5/26/25, and 6/4/25 does not have a recorded temperature for the day. On 6/5/25 at 11:00 AM, Surveyor interviewed DON B regarding observations made of the medication carts and medication room. DON B indicated loose pills should not be in the cart, medications should be dated when opened, medications should be labeled, expired medications should not be left in the medication carts, medications labeled refrigerate should be in the refrigerator, and the vaccine refrigerator temperature log should be completed per the policy.

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	525646	A. Building B. Wing	06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avina of Pewaukee	N26 W23977 Watertown Rd. Waukesha, WI 53188

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Example 4 On 6/3/25 at 8:25AM Surveyor interviewed R53 as part of the initial screening process. R53 indicated the hot food is not always hot. R53 indicated the french fries are usually cool, sometimes potato dishes and wedges are almost raw, and noodles are not hot enough. R53 indicated this happens 1 to 2 times a week. Based on observation, interview, and record review, the facility did not ensure that food was palatable and at a safe and appetizing temperature for 4 of 15 residents (R46, R24, R53 and R12) who had specific complaints about food quality and serving temperature and 1 of 1 test trays were unpalatable. Residents voiced concerns about hot foods being served cold. Surveyor observed hot foods not hot and cold foods not cold on 1 of 1 test trays. Evidenced by: The facility policy, Food Temperature, no date, states, in part; .1. All hot food items must be cooked to appropriate internal temperatures, held and served at a temperature of at least 135F .2. All cold food items must be stored and served at a temperature of 41F or below . Example 1 R46 was admitted to the facility on [DATE] with a diagnoses including chronic respiratory failure, dementia, chronic pain, depression, anxiety, muscle weakness, dysphagia, abnormalities of gait and mobility, severe protein-calorie malnutrition, and cognitive communication deficit. R46 most recent MDS (Minimum Data Set) dated 3/13/25 indicates R46 has a BIMS (Brief Interview for Mental Status) score of 14 which indicates R46 is cognitively intact. On 6/2/25 at 11:07AM, R46 indicated the food at the facility is terrible. R46 indicated she has reported this concern to staff, and they agree. R46 indicated the breakfast this morning was not good, and she was not offered anything else. R46 showed Surveyor breakfast tray. R46 drank ensure, but no other food was consumed. Example 2 R24 was admitted to the facility on [DATE]. R24's most recent MDS (Minimum Data Set) dated 5/7/25 indicates R24 has a BIMS (Brief Interview for Mental Status) score of 15 which indicates R24 is cognitively intact. On 6/3/25 at 11:50AM, R24 indicated the food is often served cold. R24 indicated the 200 hallway is usually the last to be served so their food is always cold. Example 3 (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/3/25 at 12:38PM, Surveyor observed trays delivered to 200 hallway. At 12:53PM Surveyor requested last tray to be delivered. The following was noted; .meat and gravy 110.9F, carrots 104F, potatoes 106.5, and milk 42.9F. Example 5 R12 was admitted to the facility on [DATE] with diagnoses that include: spinal stenosis, lumbar region with neurogenic claudication (narrowing of spinal canal in lower back causing pain), congestive heart failure (heart fails to adequalety pump blood to oxygenate the body), and chronic obstructive pulmonary disease (disease that damages lung tissue causing difficulty breathing). R12's Quarterly Minimum Data Set (MDS), with Assessment Reference Date (ARD) 4/16/25, indicates R12 has a Brief Interview for Mental Status score of 14 out of 15, indicating that R12 is cognitively intact. On 6/2/25 at 11:44 AM, Surveyor interviewed R12. R12 stated to Surveyor that the food she receives is always cold. R12 also stated that she recently had scallop potatoes, which actually came hot, and she could taste the difference in how much better tasting it was when it was served hot. On 6/4/25 at 2:28PM, Assistant Dietary Manager I (ADM) indicated hot foods should be served hot and cold foods served cold. ADM I indicated foods should be palatable and served at appropriate temperatures to residents. On 6/9/25 at 8:33AM, Nursing Home Administrator A (NHA) indicated hot foods should be served hot and cold foods be served cold. NHA A indicated understanding of above concern. The facility failed to ensure that food was palatable and served at a safe and appetizing temperature.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility did not ensure garbage and refuse was disposed of properly. This has the ability to affect all 87 residents who reside at the facility. Garbage and litter was found near the facility's main dumpster area. Evidenced by: The facility policy, Disposal of Garbage and Refuse, dated 2/1/25, states, in part; .7. Refuse containers and dumpsters kept outside the facility shall be designed and constructed to have lids, doors, or covers. Containers and dumpsters shall be kept covered when not being loaded. Surrounding area shall be kept clean so that accumulation of debris and insect/rodent attractions are minimized. On 6/2/25 at 10:21AM, During initial kitchen tour, Surveyor observed facility dumpsters. Surveyor observed multiple used gloves and pieces of garbage outside the dumpsters. Surveyor observed the dumpster lids to be left open. Assistant Dietary Manager I (ADM) indicated she is not sure who is responsible for picking up the garbage, but can find out. On 6/3/25 at 9:45AM, Maintenance Director H (MD) indicated maintenance is responsible for picking up the area outside the dumpsters. MD H indicated maintenance tries to get out there daily to pick up garbage. MD H indicated the dumpster lids should be closed when not in use. On 6/9/25 at 8:33AM, Nursing Home Administrator A (NHA) indicated the dumpster lids should be closed when not in use and outside area free of garbage. The facility did not ensure garbage and refuse was disposed of properly.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. Based on interview and record review that facility did not ensure that residents acknowledge the understanding of an arbitration agreement and that they have just 30 days to rescind the arbitration agreement if they so choose after it is signed, this affected 1 of 1 sampled resident's (R73) and 1 of 2 supplemental residents (R430) reviewed for arbitration. R430 signed an arbitration agreement 5/29/25, R430 was not able to articulate understanding of the arbitration agreement and did not understand she had 30 days to change her mind. R73 signed an arbitration agreement 3/12/25, she did not know she only had 30 days to change her mind. This is evidenced by: The Facilities Policy and Procedure entitled Binding Arbitration Agreements dated 2/1/25, does not speak to the process of signing the document or the 30-day window to rescind. Example 1 R430 signed arbitration agreement on 5/29/25, the day following her admission to the facility. On 6/4/25 at 12:40 PM, Surveyor asked R430 (and her daughter who was present in room) if she could explain what a binding arbitration agreement is, R430 said she doesn't remember hearing about an arbitration agreement at all. Surveyor explained what it is R430 stated she does not recall this being discussed with her despite the fact the document was signed. R430 did not understand the agreement nor did R430 acknowledge the right to rescind the arbitration within 30 days of signature. Of note, the facility's arbitration agreement was signed and does acknowledge the 30-day ability to rescind however R430 did not have an understanding of this documentation. The facility must ensure the terms of the agreement are explained to the resident or his or her representative in a form and manner (including language) that he or she understands and inform the resident or representative they have the right to rescind or terminate the agreement within 30 calendar days of signing. Although this was in writing R430 did not have a clear understanding of this agreement. Example 2 R73 signed arbitration agreement on 3/12/25, the day following her admission to the facility. On 6/4/25 at 12:36 PM, Surveyor asked R73 if she could explain what a binding arbitration agreement is, R73 replied it's an agreement for settling concerns with an appointed advocate, not in court. Surveyor then asked R73 if she knew that she had 30 days to rescind this agreement, R73 stated I thought I could change my mind anytime. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Of note, the facility's arbitration agreement was signed and does acknowledge the 30-day ability to rescind however R73 did not understand the right to rescind or terminate the agreement within 30 calendar days of signing. Although this was in writing R73 was told by AC C (Admissions Coordinator) she could rescind the document at any time. On 6/4/25 at 12:48 PM, Surveyor interviewed AC C (Admissions Coordinator). Surveyor asked AC C how she presents the arbitration agreement to the residents, AC C said it is part of their admission contract, explain what it is, that it is optional, and that they can change their mind anytime. Surveyor asked AC C to explain how she presents what an arbitration agreement is about, AC C explained that she says it is a dispute resolution process for medical or financial concerns outside of court with a neutral mediator. Surveyor asked AC C when the arbitration agreements are signed, AC C said usually right away but they can take time to think about it. Surveyor asked AC C is she was aware that they only have 30 days from date signed to rescind, AC C said oh. Surveyor showed AC C where it says that in agreement and on the 2nd signature page for agreement. Of note, the Facilities admission Contract with the Arbitration Agreement in it is a total of 108 pages. On 6/5/25 at 1:01 PM, Surveyor interviewed NHA A (Nursing Home Administrator). Surveyor asked NHA A if she could tell me how AC C is explaining the arbitration agreements, NHA A replied in the event of wanting to sue the facility, this is optional to sign, a mediator is assigned, no court with this agreement, they can always change your mind. Surveyor asked NHA A is she knew when the arbitration agreements are signed typically, NHA A said with the admission contract. Surveyor asked NHA A if she knew if/when a resident could change their mind/rescind the agreement, NHA A said they can change their mind anytime. NHA A was not aware that once the Arbitration Agreement is signed that the resident only has 30 days to change their mind. The facility provided additional information however this did not change the deficient practice for this citation.