STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525382	A. Building B. Wing	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Camillus Health Center	10101 W Wisconsin Ave Wauwatosa, WI 53226

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 2 (R1 and R2) of 2 residents with allegations of abuse and injuries of unknown origin were reported to the state agency and one or more law enforcement entities.* On 6/13/25, R1's daughter Companion-K allegedly overheard Certified Nursing Assistant (CNA)-I verbally abusing R1 when providing cares to R1. The facility did not report this allegation of abuse to law enforcement. * On 6/13/25, the facility was informed by R2's wife of bruising and swelling of unknown origin with R2's right foot. R2 had an X-RAY of R2's foot on 6/14/25, which showed a fracture of the 5th metatarsal in R2's right foot. The Registered Nurse (RN) Supervisor did not notify the Nursing Home Administrator (NHA)-A of the injury with fracture until 6/16/25. The facility did not report this significant injury of unknown origin within 24 hours to the State Agency as required.Findings include:The facility's policy titled, Abuse, Neglect, Mistreatment and Misappropriation of Resident Property, dated 7/26/18, and last updated 4/29/21, documents:*Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation of an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. Abuse includes verbal abuse, sexual abuse, physical abuse and mental abuse, including abuse facilitated or enabled through the use of technology.*Injuries of unknown origin: any injuries should be classified as an injury of unknown source when both of the following conditions are met:The source of the injury was not observed by any person or the source of the injury could not be explained by the resident;The injury is suspicious because of the extent of the injury for the location of the injury (example, the injury is located in an area not vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.*Immediately: means as soon as possible, but ought not to exceed 24 hours after discovery of the incident. Federal requirements under 42 CFR state that if the events that caused the allegation involve abuse or result in serious bodily injury, nursing homes must report the violation to the administrator of the facility and Wisconsin Division of Quality Assurance (DQA) no later than two hours after the allegation is made.*All other allegations that do not involve abuse and do not result in serious bodily injury must be reported no later than 24 hours after the allegation is made. In addition, nursing homes must report to DQA and law enforcement any reasonable suspicion of a crime against any individual who is the resident of, or is receiving care from, the facility. Immediately for the purposes of reporting a crime resulting in serious bodily injury means covered individual shall report immediately, but not more than two hours after forming the suspicion.*Internal reporting:Employees must always report any allegations of or witnessed abuse or suspicion of abuse immediately to the administrator. *Law enforcement:All reports of suspected crime and/or alleged sexual abuse must be immediately reported to local law enforcement to be investigated. R1 was admitted to the facility on [DATE] with diagnoses that include cerebral infarction (a condition where blood flow to part of the brain is blocked, causing brain tissue to die due to lack of oxygen and nutrients), muscle weakness, cognitive deficit (a condition where there are difficulties with thinking abilities, including memory, learning, problem solving, and decision making), aphasia (a disorder that affects the ability to communicate), Transient Ischemic Attack (TIA) (a temporary blockage of blood flow to the brain often referred to as a stroke), and falls. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's admission Minimum Data Set (MDS) completed on 6/15/25, documents that R1 has impairment to both upper extremities and requires partial/moderate assistance with bathing and rolling left to right. R1 is dependent on staff for toileting, dressing, and transfers. R1 is frequently incontinent of bowel and bladder. R1 was documented as having a Brief Interview for Mental Status (BIMS) score of 5, indicating that R1has severe cognitive impairment.On 7/7/25, at 10:11 AM, Surveyor reviewed the facility self-report which documents the following:*On the afternoon of Friday, 6/13/25, Companion-K reported to R1's daughter, Companion-K was walking down the hall to see R1, when Companion-K observed CNA-I close R1's door to provide cares. Companion-K waited in the hallway to give CNA-I time to complete cares. Companion-K could hear through the door, CNA-I with a stern and demanding voice when talking to R1 during cares. Companion-K heard CNA-I tell R1 to stop crying, calm down, and R1 was getting up and to stay focused and pay attention. After listening for several minutes outside the door to the struggle and to the point of R1 going into hysterics, Companion-K knocked on the door. Companion-K walked into R1's room and observed CNA-I yanking R1's shirt off. R1 was tearful, upset, and anxious.*R1's daughter notified Director of Nursing (DON)-B of the allegation of abuse on 6/13/25. DON-B started an investigation immediately.*Initial self-report was submitted to the state agency on 6/13/25, at 2:50 PM. *A 5-day self-report was submitted to the state agency on 6/20/25, at 2:27 PM.*Resident interviews were obtained and reviewed.*Staff interviews were obtained and reviewed.*Resident (R1) interview/statement was obtained and reviewed.*DON-B interviewed R1's roommate, who did not recall the incident on 6/13/25.*R1's Electronic Medical Record (EMR) documents skin and pain assessments were completed on 6/13/25.Surveyor notes the facility did not contact law enforcement.On 7/8/25, at 8:54 AM, Surveyor attempted to contact Companion-K.On 7/7/25, at 12:16 PM, Surveyor interviewed Physical Therapy Assistant (PTA)-J who stated R1 has cognitive changes, confusion, and has a hard time remembering things at times. PTA-J states she entered R1's room on 6/13/25, about 20-30 minutes after the alleged abuse on 6/13/25, with CNA-I, and observed R1 visibly upset and crying. PTA-J states Companion-K notified PTA-J that CNA-I was verbally abusive with R1 and made R1 cry. Companion-K notified PTA-J that she requested to speak with a supervisor regarding the incident with CNA-I. PTA-J states nobody should treat people like that and didn't think CNA-I was very kind when talking with R1. PTA-J states R1 and Companion-K we're both visibly upset about what happened, with Companion-K stating she couldn't believe CNA-I could act like that with someone.On 7/7/25, at 2:40 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and DON-B who stated Companion-K is not an employee with the facility and is a friend/companion to R1. DON-B states Companion-K asked facility staff to speak with a supervisor at the time of the incident on 6/13/25, but never clarified with facility staff what she wanted to speak with the supervisor about. DON-B indicated that Companion-K contacted R1's daughter regarding the alleged abuse on 6/13/25, and R1's daughter contacted DON-B with allegations of abuse witnessed by Companion-K on 6/13/25. DON-B states she immediately started the investigation. NHA-A states R1 was monitored for possible negative side effects and/or psychiatric concerns related to the allegations of abuse on 6/13/25. Surveyor asked NHA-A if the facility had contacted law enforcement with the allegations of abuse on 6/13/25. NHA-A replied no, the facility did not contact law enforcement due to the facility had not substantiated the allegations at that time and the facility was still investigating. NHA-A then stated R1 had no visible injuries and no adverse effects when DON-B interviewed R1. NHA-A stated we didn't feel it was deliberate by CNA-I. Surveyor notified NHA-A and DON-B of concerns with the facility not contacting law enforcement with allegations of abuse that occurred with R1 on 6/13/25. NHA-A and DON-B acknowledged the concern. Surveyor requested additional information if available. No additional information was provided. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.) R2 was admitted to the facility on [DATE] with diagnosis that included, Traumatic Subdural Hemorrhage without loss of consciousness (brain bleed), Cognitive Communication Deficit, and Dementia.R2's MDS (Minimum Data Set) assessment with an assessment reference date of 6/8/25 documents that R2 has short and long term memory problems. R2's Nursing Note dated 6/13/25, at 7:30 PM, documents: Wife reported that she took off his socks and saw Lg (large) bruising on Rt foot, measures 10 x 12 cm. Foot also has some swelling. And the Resident does c/o pain but not able to rate pain. The wife said that she sees staff & also his personal caregiver that was here today not using foot pedals when pushing him in wc. Said she thinks that is the reason he has the bruise. This Res is also very demented, agitated daily, extremely uncooperative and difficult to redirect as he doesn't seem to understand anymore. He is a high fall risk & requires close supervision, but frequently after staff helps him to bed, he will be up walking around in his room. Sometimes staff will find him walking in hallway or into other Resident rooms.R2's Nursing Note dated, 6/13/25, at 7:54 PM, documents: Found bruises on his right foot, slightly swollen and tender to touch and says ouch. he had falls couple times and self-transferring and propels in w/c. spouse is aware and NP (nurse practitioner) is updated and NOR x-ray to right foot x 2 view d/t bruising/swelling and pain. Call placed to (name x-ray company) and scheduled for tomorrow. Icing as needed and elevate the legs.R2's Nursing Note dated, 6/14/25, at 3:23 PM, documents:{name} imaging at facility for XRAY. Resident tolerated well. Awaiting results.R2's Physician's Note. dated, 6/14/25, at 11:42 PM, documents: Date of Service: 06/14/2025 11:14 PM CT. Details: Nurse Name: Registered Nurse (RN)-E. Patient Name: R2. Primary Chief Complaint: Radiology review: abnormal results and/or requiring provider assessment. History Present Illness: x-ray right foot showed acute fracture of the 5th metatarsal Review of Systems: ROS as per HPI, all other systems reviewed and are negative MH and SH : Reviewed PMH, SH and Medications Source of verification for all history : Per nurse and/or patient: Vital Signs : T: 97.1 (°F). HR: 60 (bpm). BP Sys: 123 (mm/Hg). /Dia: 68 (mm/Hg). RR: 1 (rpm) SpO2: 94 (%) Sp02 Levels: Room Air. Physical Exam: Exam findings per nurse and video observation Physical Exam - Notes: not in distress. Diagnosis, Assessment/Plan: M79671 - Pain in right foot (Primary) acute fracture of the 5th metatarsal. Condition is stable. Orders: obtain Orthopedic consult. Notify a clinician of any change in condition. Disposition: Stay at Facility. Technology Used: Audio and video with patient and nurse present. Statement of Medical Necessity: Yes. Consent for telemedicine/virtual visit obtained from patient/POA: YesOn 7/7/25, at 12:52 PM, Surveyor interviewed NHA-A and Director of Nursing (DON)-B. Surveyor asked how NHA-A knows when and where to report a significant Injury of unknown origin or abuse allegations to the state agency and police. NHA-A informed Surveyor that NHA-A had a flow chart that informed NHA-A what to report and when to report significant injuries of unknown origin and to whom. NHA-A informed Surveyor if there is a severe or significant injury of unknown origin NHA-A will report that to the state agency right away. Surveyor asked NHA-A why the delay in reporting R2's injury to the state agency from 6/14/25 when the fracture was confirmed until 6/16/25. NHA-A informed Surveyor that the night shift supervisor RN-E did not inform NHA-A of the fracture until 6/16/25. NHA-A informed Surveyor the wife reported the incident on 6/13/25 and the x-ray results came back 6/14/25 on Saturday evening at 11:17 PM which likely caused the delay in reporting to NHA-A. NHA-A acknowledged it was an error not reporting the fracture until Monday 6/16/25 by RN-E to the NHA-A. NHA-A believed the delay was because of the late X-Ray results on 6/14/25. NHA-A informed Surveyor that NHA-A did a plan of correction and educated RN-E on 6/16/25 the need to immediately report significant injuries of unknown origins to administration. NHA-A informed Surveyor that NHA-A started to educate the rest of the staff on 6/16/25 on reporting significant injuries of unknown origin to NHA-A immediately. NHA-A provided surveyors with the completed education provided to staff on reporting injuries of unknown origin. On 7/7/25, at 03:41 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-D. Surveyor asked LPN-D to describe what LPN-D observed on 6/13/25 when R2's injury of unknown origin was discovered on R2's right foot. LPN-D informed Surveyor that LPN-D had entered R2's room and R2's spouse was holding onto R2's socks. LPN-D informed Surveyor that LPN-D assessed R2's bruised and swollen foot. LPN-D informed Surveyor that after speaking with R2's wife, LPN-D or R2's wife didn't know how the injury to R2's right foot occurred. Surveyor asked LPN-D if LPN-D reported the injury. LPN-D informed Surveyor that LPN-D reported the injury to Registered Nurse (RN)-C.On 7/7/25, at 03:41 PM, NHA-A came in to speak to Surveyors. NHA-A informed Surveyors that NHA-A admitted that the algorithm that NHA-A uses does lead NHA-A to call the police for

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No additional information was provided by the facility.