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	04/14/2025

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on record review and staff interview, the facility did not ensure all allegations involving potential abuse (R1) were thoroughly investigated for 1 of 4 reviewed facility reported incidents. *On 6/13/24, 2/21/25, and 3/5/25, the facility submitted facility reported incidents (FRI) involving R1 and allegations of R1 and sexual misconduct. All three FRIs were not thoroughly investigated by the facility. Findings Include: The facility's Abuse, Neglect, Mistreatment and Misappropriation of Resident Property updated 4/29/21 documents: .E. Investigation It is the policy of this facility that reports of abuse (mistreatment, neglect, or abuse, including injuries of unknown source, exploitation and misappropriation of property) are promptly and thoroughly investigated. Procedure: The investigation is the process used to try and determine what happened. The designated facility personnel will begin the investigation immediately. A root cause investigation and analysis will be completed. The information gathered is given to administration. a. Investigation of abuse: When an incident, allegation, or suspected incident of abuse is reported, the Administrator or designee will investigate the incident with the assistance of appropriate personnel. The investigation will include: i. Who was involved ii. Residents' statements a. For non-verbal Residents. cognitively impaired Residents or Residents who refuse to be interviewed, attempt to interview Resident first. If unable, observe Resident, complete an evaluation of Resident behavior, affect, and response to interaction, and document findings. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	iii. Resident's roommate statements if applicable iv. Involved staff and witness statements of events v. A description of the Resident's behavior and environment at the time of the incident vii. Observation of Resident and staff behaviors during the investigation viii. Environmental considerations if pertinent b. Investigation of injuries of unknown origin or suspicious injuries: must be immediately investigate to rule our abuse R1 was admitted to the facility on [DATE] with diagnoses of Unspecified Dementia (loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life), Unspecified Severity, With Other Behavioral Disturbance, Other Alzheimer's Disease(progressive disease that destroys memory and other important mental functions), Impulsiveness, Major Depressive Disorder(persistent feelings of sadness, hopelessness, and a loss of interest or pleasure in activities), Chronic Obstructive Pulmonary Disease(lung disease that block airflow and make it difficult to breathe), and Primary Generalized Osteoarthritis (breakdown of cartilage). R1 currently has an activated Health Care Power of Attorney (HCPOA). R1's Quarterly Minimum Data Set (MDS) completed 3/6/25 documents R1's Brief Interview for Mental Status(BIMS) score to be 7, indicating R1 is severely impaired for daily decision making. R1 has range of motion impairment on 1 side of lower extremity. R1 is dependent for dressing, mobility, and transfers. The facility submitted 3 facility reported incidents involving R1 and allegations of sexual misconduct directed at R1. Surveyor reviewed the documentation of the investigations. On 4/1/25, at 8:08 AM, Surveyor reviewed the 3 FRIs. On 6/13/24, reported at 12:48 AM, R1 stated that R1 was raped by 3 men on the way home from work. R1 described the 3 men having shaggy shoulder length hair and were wearing green scrubs. Surveyor notes that the facility did not obtain R1's roommate's statement (R24). 5 Resident statements were obtained with the same 3 questions asked: 1. Have you ever been treated roughly by a staff member? 2. Do you feel rushed by staff? 3. Has any staff member seemed frustrated with your or raised their voice at you? Surveyor notes the above 3 questions do not relate to the allegation of sexual abuse. On 2/21/25, reported at 3:17 AM, R1 reported an aide put a finger in R1's vagina causing pain. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8 Residents were interviewed with the same questions: 1. Have you ever been treated roughly by a staff member? 2. Do you feel rushed by staff? 3. Has any staff member seemed frustrated with your or raised their voice at you? R1's roommate (R24) was interviewed with the above questions but not specifically if R24 had heard or seen anything out of the ordinary in the room at the time of the allegation. On 3/5/25, reported at 12:59 AM, R1 reported a man came into R1's room, held R1 down by R1's shoulders, told R1 to lay still and quiet, and raped R1. Surveyor notes that the facility did not obtain R1's roommate's statement.(R24) 5 Residents interviewed with the same questions 1. Have you ever been treated roughly by a staff member? 2. Do you feel rushed by staff? 3. Has any staff member seemed frustrated with your or raised their voice at you? Surveyor notes the above 3 questions do not relate to the allegation of sexual abuse. The facility provided no documentation in the facility investigation of any men in the building before or during the time of the allegation. Surveyor requested the schedule from the facility for 3/5/25 and notes Registered Nurse (RN)-E was working and there is no statement from RN-E. Surveyor notes the facility reported the 3 allegations of sexual misconduct with in the regulatory reporting time-frame(within 2 hours) and on required reporting forms. Law enforcement was notified and responded. On 4/2/25, at 12:18 PM, Surveyor interviewed Director of Social Services (DSS)-P. Surveyor asked DSS-P what role DSS-P has when there is an abuse/neglect/or misappropriation allegation. DSS-P stated that DSS-P interviews 5 Residents. Surveyor asked why only 5 Residents? DSS-P stated DSS-P was told 5 is the sample. Surveyor asked if there is a roommate would DSS-P make it a point to interview the roommate. DSS-P stated that interviewing the roommate is not necessarily part of the process. DSS-P explained that it is 5 Residents, 1 from each unit to get a sample. That is part of the facility process. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/3/25, at 10:07 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON-B) in regards to the investigation of the 3 allegations of sexual misconduct involving R1. NHA-A stated that there is no defined process of who to talk to for the day as part of the investigation. NHA-A explained that a sample of staff from different departments statements are obtained with each investigation. NHA-A stated that there was nothing from all the departments that would initiate NHA-A to expand to other staff for more interviews. Surveyor asked why R1's roommate (R24) was not interviewed with the 6/13/24 and the 3/5/25 investigation. NHA-A stated that Resident statements are based on 25% of the census. Surveyor asked why RN-E's statement was not obtained for the 3/5/25 investigation where R1 reported an allegation of a male raping R1. NHA-A stated, Don't know why there is no interview. He is our only male and is sensitive to this. We would have talked to him. Surveyor shared that DSS-P informed Surveyor that DSS-P only obtains a sample of 5 Residents, 1 from each unit. NHA-A stated, That is correct. NHA-A would follow-up if there is a roommate to interview with an allegation of abuse or neglect to determine if the roommate saw or heard anything. Surveyor shared that R1's roommate (R24) was not interviewed for the 6/13/24 and the 3/5/25 investigation. NHA-A explained that it is a case by case investigation. Surveyor shared the concern that RN-E's statement as the only male for the 3/5/25 allegation was not obtained with the investigations and the Resident interviews is only 5 Residents, 1 from each unit with the same 3 questions that are not pertaining to R1's allegation of sexual abuse. Surveyor explained that it is a concern that a thorough investigation was not completed by the facility in regards to R1's 3 allegations of sexual abuse.

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47094 Based on observation, interview, and record review, the facility did not ensure residents received adequate supervision and assistive devices to prevent accidents for 2 of 6 residents (R291 and R24) reviewed for accidents. The deficient practice has the likelihood of affecting a pattern of residents at the facility has 14 residents who utilize lifts for transfers. * R291 had a care planned approach to use a Hoyer lift (a full body transfer lift that uses a sling to fully support the resident during the transfer) for transfers. R291's family brought in a sling they had purchased from an outside vendor. The facility did not ensure the sling was appropriate for R291's size/weight and also did not ensure the sling was appropriate to use with the Hoyer lift used in the facility. On 2/8/25, staff were transferring R291 with the Hoyer lift and the sling purchased by the family. R291 slid out of the sling and fell to the floor sustaining a subdural hematoma and laceration to the back of the head. R291 ultimately, was transported to the hospital and received 10 staples to the back of their head. R291 returned to the facility but was sent back to the hospital for additional care for their injuries. The facility did not have a system where residents were assessed to determine the correct size sling to safely transfer each resident. There was also no system in place to ensure slings were compatible with the lift(s) used in the facility. During the survey, staff were observed using random slings not assigned to the resident regardless of lift used or size of the individual resident to ensure safety. During interviews, facility staff were unaware of manufacturer's recommendations for specific use of slings and whether the sling being utilized for a transfer was safe for the resident to use. The facility's failure to assess each resident's individual needs and to provide appropriate slings for transfers created a finding of immediate jeopardy that began on 2/8/25. Surveyor notified Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B of the immediate jeopardy on 4/3/25 at 12:35 PM. The immediate jeopardy was removed on 4/4/25, however, the deficient practice continues at a scope and severity of a G (actual harm/isolated) based upon the additional example regarding R24. * Since R24's admission in May of 2024 R24 has had 11 falls in the facility. On 10/4/24 R24 fell when left unattended during personal hygiene in the bathroom when staff did not anticipated R24's needs when providing cares. R24 sustained multiple fractures of her ribs at this time. Prior to 10/4/24 R24 had an injury of unknown origin this involved a fracture of one rib that was discovered 3 days after an attempt to self transfer. The facility did not collect or analyze the details regarding each of R24's falls or attempts to self transfer to develop an individualized, comprehensive plan of care to prevent future falls. R24 was known to be incontinent upon admission and was known to be impulsive. The facility did not complete a voiding pattern to establish an incontinence plan to meet R24's individual needs. The facility did not review a plan to increase supervision of R24 despite staff input post fall sharing R24 needed increased supervision to prevent falls. Findings include: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1.) The facility policy titled Safe Resident Handling/Transfers with no implementation or revision date documents: It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines. Compliance Guidelines: 1. The interdisciplinary team (IDT) or designee will evaluate and assess each resident's individual mobility needs, taking into account other factors as well, such as weight and cognitive status. 6. The staff will inspect the equipment prior to use to ensure functionality and will alert maintenance or other designee if not functioning properly. 7. Damaged, broken, or improperly functioning lift equipment will not be used and tagged out according to facility policy. 8. The facility will ensure that there are appropriate amounts of varying sizes of slings to accommodate residents as per the manufacturer's instructions on proper sling sizing. 9. Ensure that the sling designed for the lift is utilized with that specific lift. Surveyor noted that each wing has two Hoyer style mechanical lifts: 1. EZ way smart lift which has a sling harness color coding system identifier on the lift that is indicates sling color by the resident's weight. 2. Direct Supply Atlas floor lift. Surveyor reviewed the manufacturer's/owner's manual for both brands of lifts and documented the following: 1. Per the EZ way smart lift operators' instruction: Safety notes: - Do not modify the sling design in any way. Please make sure the accessories used with each lift are appropriate for both the patient and the transferring situation. - EZ way slings are made specifically for EZ way smart lifts. For the safety of the patient and caregiver, only EZ way slings should be used with EZ way lifts. 2. Per Direct Supply Atlas Floor lift owner's manual: Operating guidelines: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Warning-only slings and accessories specifically designed for use with direct supply resident lifts should be used. Use of other manufacturers components or accessories may compromise the operation of this resident's lift. 1.) R291 was admitted to the facility on [DATE] and had diagnoses that include diastolic congestive heart failure, chronic kidney disease stage 3, chronic venous insufficiency, chronic pain syndrome, transient ischemic attacks and cerebral infarctions, and chronic obstructive pulmonary disease. R291's quarterly minimum data set (MDS) dated [DATE] indicated R291 had intact cognition with a Brief Interview for Mental Status (BIMS) score of 14 and the facility assessed R291 as needing maximal assist with 1 staff member for dressing, repositioning, and personal/toileting hygiene and dependent on 2 staff for transfers. R291 used continuous oxygen at 2 Liters via nasal cannula for shortness of breath and had a Do Not Resuscitate (DNR) order and an activated Power of Attorney. R291's self-care deficit care plan had the following intervention initiated on 3/4/24: -Transfer: EZ stand lift (a lift to help raise the resident to a standing position). On 2/4/25, R291 transitioned to Hospice care with diagnosis of: Chronic diastolic heart failure. R291's Risk for falls care plan was revised on 2/4/25 with the following intervention: -Change to Hoyer Transfer for change in condition. On 2/4/25, at 14:51 (2:51 PM) in the progress notes, nursing documented: Toileting Hoyer sling (typically a mesh sling with an opening to allow toileting without removing the sling) requested from hospice. On 2/5/25, Hospice brought in a toileting sling for the Hoyer lift to use for R291 per request when toileting because R291 did not want to use a bed pan. Surveyor noted that there is no indication of an assessment or revision to R291's care plan regarding what type/size of Hoyer lift sling R291 requires for transfers or that R291 has a different Hoyer lift sling to use for toileting that Hospice provided on 2/5/25. On 4/2/25 at 11:01 AM, Surveyor interviewed CNA-I who stated R291's family brought in a sling on 2/8/25 and asked CNA-I to use it for R291. CNA-I stated that CNA-A, CNA-C, and a nurse put the sling on R291. CNA-I stated that CNA-I was familiar with the sling having used it in other facilities. CNA-I stated the sling that was put on R291 had flaps that went around the legs so R291 could go into a sitting position. CNA-I stated that there was no teaching on how to use it, R291's family asked that CNA-I use it, so CNA-I did. CNA-I does not recall if CNA-I told oncoming shift about the sling or reported that R291's family had brought it in. CNA-I stated that normally they are not sure what kind of sling is needed and would normally grab the sling that was in the resident's room to use. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 2/8/2025 at 1630 (4:30 PM) in the progress notes RN-E documented at approximately 1500 (3:00PM) RN-E was called into (R291's) room due to a fall. Per staff, was a witnessed fall and (R291) slid off Hoyer sling during transfer and hit head at base of Hoyer lift legs. Moderate amount of blood noted at back of (R291's) head . hematoma noted at base of back of head and approximately a 1 cm laceration. Suggested (R291) go to the emergency room for evaluation, but resident and family/power of attorney (POA) declined, family at bedside. Medical doctor (MD) made aware and continue to monitor with neurological checks. It was documented that vital signs are at (R291's) baseline, noted that the bleeding had stopped, and (R291) did not lose consciousness and denied pain. Surveyor noted that R291 was prescribed Eliquis (an anticoagulant medication) 2.5 mg two times a day (BID) for atrial fibrillation at the time of the fall and had received the AM dose on 2/8/2025. R291 did not get the PM dose of Eliquis 2.5 mg. On 2/9/25 at 7:58 AM in the progress notes, nursing documented (R291) found lying in bed in large pool of blood originating from laceration to occipital area of head from fall on 2/8/25. Dressing reinforced, (R291) denied pain or discomfort. Nursing spoke with (R291's power of attorney) and agreed to send (R291) to the emergency room for further evaluation. It was documented that (R291) was alert and responding appropriately, vital signs documented: (Blood pressure-105/70, pulse-91, respirations-18, oxygenation at 95% with 2 L (liters)/oxygen, and (R291) denied headache, dizziness, or nausea. On 2/9/25 at 1800 (6:00PM), in the progress notes, nursing documented (R291) returned from emergency room . order to discontinue Eliquis . staples to be removed in 7-10 days. Surveyor reviewed R291's emergency room discharge summary dated 2/9/25 and noted the following: - Emergency medical specialists (EMS) arrived at the facility and obtained vitals; it was noted R291's Blood pressure had dropped to 88/58. - Upon arrival to the hospital, R291's blood pressure went up to 98/48, and the bleeding to the laceration had stopped. - CT (computed tomography) head results document left subdural hemorrhage measuring 5 mm (millimeter). - 3 cm (centimeter) laceration was repaired with 10 staples. - Kcentra (prothrombin complex concentrate) was given for reversal of R291's anticoagulant (Eliquis). - R291 and Family/POA did not want further interventions after closing laceration. - R291 returned back to facility with Hospice for comfort measures, and order to discontinue Eliquis. Surveyor notes that the AM Eliquis 2.5 mg dose was not documented as being given to R291 on 2/9/25. On 2/10/25 at 11:49 AM, in the progress notes is a Late Entry health status note: Created on 4/1/25 at 16:51 (4:51) by DON-B that documents: emergency room consult from 2/10/2025. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Facility staff noted (R291) had oozing from (R291's) posterior scalp . on EMS arrival to facility, (R291) was found to be hypoxic at 70% on 4L oxygen via nasal cannula. (R291) was placed on 15L oxygen via nonrebreather mask. Surveyor reviewed R291's emergency room discharge summary dated 2/10/25 and noted the following: - R291's vital signs in the emergency roiagnom on arrival were documented: blood pressure 167/127, pulse 116, respirations 25, oxygenation at 93% on 15L oxygen with nonrebreather mask. - R291 was noted to be in atrial fibrillation with rapid ventricular rate (irregular heart rhythm) - An additional staple was placed to R291's laceration for bleeding and bleeding stopped. - R291's lab work documented an elevated creatinine and potassium which was associated to the increased Lasix R291 was receiving. - Treatment was discussed with R291 and family/POA and wanted to return to facility on Hospice with comfort measures. emergency room physician discussed with R291 and family/ POA and understood that with increased oxygen demand and increase of Lasix may worsen R291's renal function and blood pressures. R291 and family/POA were agreeable and understood. - Order for Lasix increased to 60mg BID (twice daily) . - Discharge diagnoses: acute on chronic hypoxic respiratory failure, acute kidney injury, hypervolemia, and shortness of breath. On 2/13/25 at 00:39 (12:39 AM), in the progress notes nursing documented (R291) alert, slow to respond, but responds appropriately . oxygenation at 80% on 6L oxygen via nasal cannula, face mask applied, and oxygen increased to 6.5 L and oxygenation at 95% with no concerns of shortness of breath or dyspnea, occasional tracheal rattle . Head of bed elevated, lung sounds clear but diminished in the bases. (R291) denies discomfort or pain . Chronic bilateral lower extremity edema remains with feet elevated, continue to monitor. On 2/13/25 at 1400 (2:00 PM), in the progress notes, nursing documented (R291) change of condition (COC)/actively dying. morphine and Ativan started this morning and given throughout the day, (R291) yelling out help me and asking to help breathe.(R291) was lethargic most of day, 2 scopolamine patches put on and atropine drops for increased secretions . On 2/13/25 at 1720 (5:20 PM), in the progress notes, nursing documented (R291) had no vital signs detected. Family/POA at bedside. Surveyor reviewed the facility self-report that was submitted to the state agency on 2/10/25. The facility obtained family statements, and it was documented that R291's family brought a sling to the facility for staff to use for R291 when toileting. The sling was purchased through [name of company] online and was intended to have (R291) in a sitting position to assist in having a bowel movement. There is no indication this sling was assessed prior to use to ensure the safety of R291. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/1/25 at 9:40 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-D who stated CNA-D was not assigned to R291's unit on 2/8/25 but assisted CNA-C with the Hoyer transfer that resulted in R291's fall from the sling on 2/8/25. CNA-D stated that R291 was sitting in the recliner chair and wanted to be changed in bed and then put into electric wheelchair to go out of room. CNA-D stated the sling got hooked up to the Hoyer lift, the straps were crossed under R291's legs and when CNA-C started to raise R291 in the sling to move to R291's bed, CNA-D bent down to move a cord and at that time R291 was falling out and R291 fell on to the ground. CNA-C went to get help and CNA-D stayed with R291. CNA-D stated they were not sure how R291 fell out of the sling because the sling was still connected to the lift. Surveyor asked CNA-D how staff know what sling to use for a resident. CNA-D stated that R291 was already on a sling and was not on CNA-D's assignment 2/8/25 so assumed R291 was in the correct sling. CNA-D stated that CNA-D had not seen that kind of sling before, but figured it was R291's to use. CNA-D stated that they felt sling was put on correctly but was following CNA-C's guidance. On 4/1/25 at 1:15 PM, Surveyor interviewed CNA-C who stated they were called to the room by R291's family and asked if R291 could be changed and put into the electric wheelchair. CNA-C stated they got help from CNA-D and hooked R291's sling up to the lift. CNA-D got R291 off the recliner and started to move over to the bed when CNA-C noted R291 was sliding out of the sling. CNA-C stated they went to grab R291 but were too late and R291 fell on to the ground. Surveyor asked what sling CNA-C used for the transfer. CNA-C stated that R291 was already on a sling, so they used that one. CNA-C stated they had not seen the sling before, so CNA-D and CNA-C figured out how to hook it up to the lift. CNA-C stated that the sling had two straps and CNA-D, and CNA-C crisscrossed the straps under R291's legs and hooked them up to the lift. CNA-C stated CNA-D and CNA-C did not ask for help because R291 was already in the sling so figured it was R291's sling. On 4/1/25 at 2:29 PM, Surveyor interviewed RN Supervisor-E who stated they were called into R291's room because of a fall. RN Supervisor-E noted R291 on the floor and there was blood behind R291's head. R291 and the family did not want R291 to go to the hospital so after doing assessments and making appropriate phone calls, R291 was put back into R291's bed. RN Supervisor-E stated the sling that was under R291 was a sling RN Supervisor-E had not seen before, so staff got R291 a full body sling that was in R291's chair and lifted R291 off the floor with the lift. Surveyor asked where the sling R291 had in place came from. RN Supervisor-E did not know where the sling had come from, never saw the sling in the facility before, and did not get told in report that R291 had a different sling. On 4/1/25 at 3:36 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-F who stated LPN-F had just started shift when CNA-C came out of R291's room asking for assistance. LPN-F stated R291 was on the ground and noted bleeding on the head during RN Supervisor-E's assessment. LPN-F stated the sling that was under R291 was one LPN-F had never seen before. Staff removed the sling and put a full body sling under R291 before using the lift to transfer R291 into the bed. LPN-F stated that the sling R291 was using had a lot of flaps to it. LPN-F stated they were not sure when R291 received the sling or who provided it, but it was one LPN-F had never seen or used before. On 4/2/25 at 1:42 PM, Surveyor shared concerns with Nursing Home Administrator (NHA)-A and DON-B regarding staff using a sling on a mechanical lift that staff were not trained how to use or approved to use for R291 resulting in R291 falling out of the sling during a transfer and sustaining a laceration requiring 10 staples and a subdural hemorrhage. Surveyor shared that several staff members used the sling even though the staff had not seen it before and were not fully aware of the correct way to apply it to safely transfer R291 with the lift. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	OBSERVATIONS/CONCERNS REGARDING LIFTS/SLINGS DURING SURVEY Surveyor reviewed the Resident Care Cards for the East, North, and [NAME] wings. Each care card was labeled with columns that referenced resident needs that the staff could look at quickly for details regarding resident care. The columns were titled: - Room number and shower day. - Residents name. - Glasses or dentures. - Activities of daily living (ADLs) - Toileting. - Transfers/ambulation. - Comments. - Precautions. - Diet. Surveyor reviewed the Transfer/ambulation column for residents. Hoyer with assist of 2 was documented for some residents and other residents it was simply documented Hoyer with no level of staff assistance needed. Surveyor noted that there is no indication of what sling size, type of sling, or named lift (EZ way smart lift or a Direct Supply Atlas floor lift) that a resident should use or is assessed for. Surveyor noted that there are currently 14 out of 36 residents that have a transfer status indicating a Hoyer lift and would be at risk for staff not using an appropriate sling during transfers with a mechanical lift. On 4/1/25 at 9:40 AM, Surveyor interviewed CNA-D who stated all residents have their own slings in their room. CNA-D stated that if a sling is not in the room, then staff go to the supervisor and get a new sling. Surveyor asked CNA-D how staff know if the sling in the resident's room is the accurate sling for them or if they are already on a sling, how do staff confirm they are on the accurate sling. CNA-D stated that it is just assumed that it is the accurate sling because it was on the resident's side and the resident is already in a sling. Surveyor asked if the type of Hoyer sling (correct size, correct model) to be used for each individual resident is listed anywhere that staff could look at to confirm the accurate sling is used. CNA-D was not sure and stated they would go to the supervisor. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/1/25 at 1:15 PM, Surveyor interviewed CNA-C who stated all residents have their own sling in their room for the lift. Surveyor asked CNA-C how it is determined that a sling is appropriate for a resident. CNA-C stated that the resident's sling is usually located in their chair and if there is not a sling present then CNA-C would go to the supervisor and get a sling. Surveyor asked if the type of sling to be used for each individual resident is located anywhere that the staff could look. CNA-C stated that the resident Kardex states the type of transfer a resident is and if the resident provided their own sling, then it is documented on the Kardex, otherwise it just lists the type of transfer. Surveyor asked how staff assess if the sling in the resident's room is the appropriate sling for the resident. CNA-C stated because the sling is in the resident's room, usually in their chair, would just assume it was the resident's sling. CNA-C stated that some slings will have resident's name on them, but not all of the slings are labeled. On 4/1/25 at 1:50 PM, Surveyor interviewed Director of Therapy (DOT)-G who stated therapy does not assess a resident for sling size. Therapy assesses the resident for the appropriate transfer and the sling size is determined by nursing following the manufacturer's sling recommendations. DOT-G stated R291 was not receiving therapy services during the time of the fall or when R291 was admitted on to Hospice but was aware R291's transfer status changed to a (Hoyer-mechanical lift) transfer. On 4/1/25 at 2:29 PM, Surveyor interviewed RN Supervisor-E who stated that each resident should have their own sling in their room and the sling should have the resident's name on the sling. Surveyor asked if a resident did not have a sling in their room, where do staff find an appropriate sling. RN Supervisor-E pointed to a shelf that had several slings on it and stated they would give the staff one of those. RN Supervisor-E stated that staff would take the sling that matches what the resident usually uses. Surveyor asked if there was anything documented regarding the type and size of sling a resident should use or how it is determined what size sling a resident should use. RN Supervisor-E stated they were not sure. On 4/1/25 at 3:36 PM, Surveyor interviewed LPN-F who stated that usually the resident is already on a Hoyer sling when they help with transfers, so never really look at the slings. LPN-F stated the residents' slings are usually in the residents' chair. LPN-F said staff use common sense as well, if a resident is large, staff are not going to use a small sling, staff would use a larger sling. On 4/2/25 at 7:54 AM, Surveyor observed R21 sleeping in bed. Surveyor noted a blue mesh sling on R21's Broda chair, Surveyor did not locate R21's name on the sling. The sling was labeled with (brand name) patch on the back of the mesh sling. Surveyor noted another sling on a walker that was blue mesh with a green striping around the edges of the sling. Surveyor did not locate R21's name on the sling but noted size large was marked on the (brand name) patch and labeled with Integra H. Surveyor noted the brand of the two slings were not the same. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/2/25 at 8:28 AM, Surveyor observed CNA-K in R21's room assisting R21 with breakfast. Surveyor asked CNA-K what sling is used for R21. CNA-K stated that R21's name will be on the sling. Surveyor and CNA-K looked at the sling located on R21's Broda chair. CNA-K noted that R21's name was not on the sling. Surveyor asked CNA-K what Integra H meant; CNA-K was not sure. Surveyor asked if CNA-K could locate a size on the sling. CNA-K could not locate a size on the sling. Surveyor and CNA-K looked at the sling that was on R21's walker. CNA-K could not locate R21's name on the sling. Surveyor asked CNA-K what sling CNA-K will use on R21. CNA-K stated that R21's slings must be in laundry getting washed, so staff put the two slings in R21's room. CNA-K stated that the sling on the Broda chair does not look like R21's typical sling, but the sling on R21's walker does. Surveyor asked CNA-K how it is verified that the slings are appropriate for R21. CNA-K stated that they are in R21's room so would assume they are the correct slings. On 4/2/25 at 10:47 AM, Surveyor observed CNA-K, CNA-J, and CNA-H transfer R21 from the bed to R21's Broda chair using a Hoyer lift. Surveyor observed a blue mesh sling underneath R21. Surveyor asked what sling was used to transfer R21. CNA-K stated the sling that was on R21's Broda chair. Surveyor asked CNA-K if it was the same blue mesh sling that was noted in R21's chair in the morning. CNA-K stated yes it was the same sling. Surveyor noted the blue mesh sling with green trim was still on R21's walker. Surveyor asked whether CNA-K confirmed that was the correct sling to use. CNA-K stated the sling was in R21's Broda chair indicating it was R21's sling to use. On 4/2/2025 at 8:03 AM, Surveyor interviewed CNA-J who stated residents usually have blue Hoyer slings, some have holes all over it (mesh) and others are just plain fabric, some of the legs straps cross, others do not. Surveyor asked what happens if a resident does not have a Hoyer sling in their room. CNA-J stated that staff would get one from the laundry room or nurse's station. CNA-J stated they would grab a sling that looked like the one the resident usually uses. Surveyor asked how it would be verified that a sling would be appropriate to use for the resident. CNA-J stated that by working a lot you get to know what sling to use for a resident. Surveyor asked if there was anything to indicate what size or type of sling a resident should have that staff could look at. CNA-J replied they were not sure. On 4/2/25 at 9:47 AM, A Surveyor observed CNA-J assisting R23 and interviewed CNA-J who stated every resident has a blue or black Hoyer sling, if the sling is a different color, it would not be used. CNA-J stated therapy assesses what size Hoyer sling residents need and then lets staff know what sling to use. Surveyor asked what sling R23 would need. CNA-J stated based on R23's size, R23 would need a small. Surveyor and CNA-J looked at the sling in R23's room which was a blue mesh sling and saw a L written on the tag and (brand name) patch on back of the sling. CNA-J stated that maybe R23's sling is large. At that time CNA-K entered R23's room and stated that the sling in R23's room is small because the cotton sling is bigger than that one. CNA-K stated that resident's do not have names on the slings, staff just say what size is needed. Surveyor reviewed the Resident care card and noted that R23's Transfer column documented: -Hoyer (use personal grey Hoyer sling) Surveyor noted that there was not a grey sling located in R23's room and staff used a blue mesh sling to transfer R23 with the lift. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/2/2025 at 9:59 AM, Surveyor interviewed Laundry Service Specialist (LSS)-O who stated that slings are received in soiled bags and washed individually. LSS-O stated the social worker will get slings and put a name on it if it is the resident's personal sling. Otherwise, the slings are put into rooms and are shared. LSS-O stated most of the slings do not have labels on them and are community slings that can be used for everyone. On 4/2/25 at 9:58 AM, Surveyor interviewed EZ way employee-L who stated the company only recommends their brand of sling be used with the EZ way lift Hoyer and stated all Hoyer slings are made in house at the company. EZ way employee-L stated that the Hoyer slings are color coded according to weight and indicate what size the resident would need when using a sling for Hoyer transfers. Surveyor asked if EZ way employee-L has heard of the 2 brand slings Surveyors observed in resident rooms. EZ way employee-L stated they have not heard of those brands and recommends only using the EZ way slings for EZ way Hoyer lifts. On 4/2/25 at 11:13 AM, Surveyor interviewed Direct Supply Account Manager (DS AM)-M who stated direct supply Hoyer slings typically do not have logos on them and would recommend using only direct supply slings with direct supply lifts. DS AM-M stated that there is a compatibility list located on the website to determine if the slings are appropriate to use with a direct supply lift. Surveyor asked DS AM-M if the two brands of slings Surveyor observed in resident rooms are compatible with Direct Supply lifts. DS AM-M stated DS AM-M did not see the two brands on the compatibility list to use with a Direct Supply lift. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/2/25 at 1:42 PM, Surveyor interviewed NHA-A and DON-B who stated that the slings in the facility for resident use were purchased from Direct Supply. Surveyor asked how it is determined what sling can be used with the lifts. NHA-A stated that all slings are compatible with both Hoyer lifts. Surveyor shared with NHA-A and DON-B that the EZ way company recommended only EZ way slings be used with the EZ way Hoyer lift and did not recommend other slings be used with it. Surveyor also shared that the two brands of slings observed in resident's rooms were not familiar to EZ way or Direct Supply company representatives. NHA-A stated that Hospice provides their own slings through Invacare and believes they write on the sling and use the two brands observed in residents' rooms. Surveyor asked how it is determined that the brand of slings Hospice provides are compatible with the facility lifts. NHA-A stated they would get back to Surveyor. Surveyor shared that R23 had on the care card to use personal grey sling, and a blue mesh sling was noted in R23's room. Surveyor also shared that the mesh sling in R23's room was a brand that is provided by Hospice, however R23 is not on Hospice. DON-B stated that the care card should be revised and that R23 no longer uses the grey slings. DON-B stated they would go see what sling R23 has in R23's room. Surveyor asked how staff determine what sling is appropriate for the residents. NHA-A stated that slings are based on weight. NHA-A stated that when a resident is admitted or transfer status changes to a Hoyer lift, resident's weight is obtained and a sling is labeled with the resident's name; if a resident is on Hospice, Hospice will order two slings for the resident and label them with integra. NHA-A stated that the sling stays on the resident's side of the room and if there was not a sling, then staff would verify the resident's weight and get the appropriate sling if the resident's sling was not available. Surveyor shared that the slings observed in residents' rooms during survey were not labeled with the resident's name and some slings did not indicate what size the sling was. Surveyor shared that staff statements did not indicate looking at the residents' weight and getting the appropriate size sling but grabbing a sling that looked like the sling the resident had used before. Surveyor shared concerns that the resident care cards did not indicate what size sling or type of sling the staff should use for each resident. Surveyor shared significant concern that there is not a process in place for staff to make sure residents have the appropriate sling to use when doing a Hoyer transfer that could lead to a significant incident if the appropriate sling is not used for the resident. The facility's failure to have a system in place to ensure residents were individually assessed for the level of assistance needed for a mechanical lift transfer, the type and size of sling and lift to use, individualized plans of care were in place regarding lift status, and a system to ensure equipment brought in by families is assessed for appropriateness and safety prior to use created a reasonable likelihood for serious harm, thus leading to a finding of immediate jeopardy. The facility removed the immediate jeopardy on 4/4/25, however, the deficient practice continues at a scope/severity level of E (potential for harm/pattern) as the facility continues to implement the following action plan: Nursing, therapy, recreational therapy, skilled nursing leadership, and hospice departments to be educated on how to determine appropriate Hoyer sling use per resident needs. Date initiated 4/4/25. 40%

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on observation, interview and record review, the facility did not assess the risk for possible entrapment and review the risks & benefits and obtain consent on a quarterly basis for 2 (R1 and R24) of 4 Residents observed having side/bed rails. Findings Include: The facility's Proper Use of Bed Rails effective 7/18/24 documents: .Policy: It is the policy of this facility to utilize a person-centered approach when determining the use of bed rails. Appropriate alternative approaches are attempted prior to installing or using bed rails. If bed rails are used, the facility ensures correct installation, use, and maintenance of the rails. Examples of bed rails include, but are not limited to side rails, bed side rails, safety rails, grab bars and assist bars. Policy Explanation and Compliance Guidelines: Resident Assessment 1. As part of the Resident's comprehensive assessment, the following components will be considered when determining the Resident's needs, and whether or not the use of bed rails meets those needs: a. Medical diagnosis b. Size and weight c. Sleep habits d. Medication(s) e. Acute medical or surgical interventions f. Underlying medical conditions g. Existence of delirium h. Ability to toilet self safely i. Cognition (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	j. Communication k. Mobility(in and out of bed) l. Risk of falling 2. The Resident must also assess the Resident's risk from using bed rails. a. Accident hazards(falls, entrapment, and other injuries sustained from attempts to climb over, around, between, or through the rails, or over the footboard) b. Barrier to Residents from safely getting out of bed c. Physical restraint(hinders Residents from independently getting out of bed or performing routine activities) d. Decline in Resident function e. Skin integrity issues f. Decline in other areas of activities of daily living such as using the bathroom, continence, eating, hydration, walking and mobility g. Other potential negative psychosocial outcomes such as an undignified self-image, altered self-esteem, feelings of isolation, or agitation/anxiety 4. The Resident assessment should assess the Resident's risk of entrapment between the mattress and bed rail or in the bed rail itself. 5. The facility will assess to determine if the bed rail meets the definition of a restraint. Informed Consent 6. Informed consent from the Resident or Resident representative must be obtained after appropriate alternatives have been attempted prior to installation and use of bed rails. This information should be presented in an understandable manner, and consent given voluntarily, free from coercion. 7. The information that the facility should provide to the Resident, or Resident representative includes, but not to: a. What assessed medical needs would be addressed by the use of bed rails b. The Resident's benefits from the use of bed rails and the likelihood of these benefits c. The Resident's risks from the use of bed rails and how these risks will be mitigated d. Alternatives attempted that failed to meet the Resident's needs and alternatives considered but not attempted because they were considered to be inappropriate (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8. Upon receiving informed consent, the facility will obtain a physician's order for the use of the specified bed rail and medical diagnosis, condition, symptom, or functional reason for the use of the bed rail. Ongoing Monitoring and Supervision 15. The facility will continue to provide necessary treatment and care to the Resident who has bed rails in accordance with professional standards of practice and the Resident's choices. This should be evidenced in the Resident's records, including their care plan, including, but not limited to, the following information: a. The type of specific direct monitoring and supervision provided during the use of bed rails, including documentation of the monitoring c. Ongoing assessment to assure that the bed rail is used to meet the Resident's needs d. Ongoing evaluation of risks e. The identification of who may determine when the bed rail will be discontinued f. The identification and interventions to address any residual effects of the bed rail 16. Responsibilities of ongoing monitoring and supervision are specified as follows: b. A nurse assigned to the Resident will complete reassessments in accordance with the facility's assessment schedule, but not less than quarterly, upon a significant change in status, or a change in type of bed/mattress/rail . 1.) R1 was admitted to the facility on [DATE]. R1 currently has an activated Health Care Power of Attorney (HCPOA). R1's Quarterly Minimum Data Set (MDS) completed 3/6/25 documents R1's Brief Interview for Mental Status (BIMS) score to be 7, indicating R1 is severely impaired for daily decision making. R1 has range of motion impairment on 1 side of lower extremity. R1 is dependent for dressing, mobility, and transfers. Use of a siderail is not documented on R1's MDS. R1's current physician orders documents assist rails to both sides of bed every shift for skin integrity with a start date of 1/31/23. Surveyor reviewed R1's Treatment Administration Record (TARS) which reads assist rails to both sides of bed every shift for skin integrity for the following months: October 2024-3 shifts not completed November 2024-4 shifts not completed December 2024-8 shifts not completed (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	January 2025-5 shifts not completed February 2025-6 shifts not completed March 2025-7 shifts not completed R1's care card documents R1 is high fall risk and has assist rails to both sides of bed. R1's care plan contains an intervention initiated on 1/31/23 for self-care deficit: -adaptive device on both sides of bed to assist for bed mobility and repositioning R1's Care Area Assessment (CAA) for self-care deficit completed 9/12/24 documents R1 needs substantial assistance for bed mobility, roll left to right, sitting to lying and lying to sitting on the side of the bed. R1's fall risk evaluation completed 9/3/24 documents R1 is at risk for falls R1's potential for injury related to falling due to impulsiveness and history of falling care plan was initiated 4/7/20 R1's Care Area Assessment (CAA) for at risk for falls completed 9/12/24 documents R1 has a history of falls since admission to the facility. The goal is to be free from major injury if a fall will occur. Surveyor notes that an actual care plan addressing the need for repositioning bars has not been implemented for R1. R1's side rail evaluation completed 3/4/24 with a re-evaluation dated 3/4/25 documents the need for the repositioning bars to assist with bed mobility and transfers. A verbal consent for the repositioning bars was obtained from the activated HCPOA on 3/4/24 with no informed consent obtained with the re-evaluation on 3/4/25. 2.) R24 was admitted to the facility on [DATE]. R24 currently has an activated HCPOA. R24's Quarterly Minimum Data Set(MDS) completed 3/3/25 documents short and long term memory impairment and R24 is severely impaired for daily decision making. R24 has range of motion impairment on 1 side of lower extremity. R24 requires substantial/maximum assistance for mobility and partial/moderate assistance for transfers. Use of a siderail is not documented on R24's MDS. R24 does not have a current physician order for the repositioning bars. R24's care card documents R24 is a fall risk and impulsive and will attempt to self transfer R24 most recent fall risk evaluation completed 3/16/25 documents a score of 18 meaning R24 is high risk for falls. (continued on next page)

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	525382	A. Building B. Wing	04/14/2025

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

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R24's high risk for falls due to confusion, gait/balance problems, incontinence, poor communication/comprehension, unaware of safety needs, and impulsive care plan was initiated on 5/26/24. R24's Care Area Assessment (CAA) for at risk for falls completed 9/26/24 documents R24 is at risk for falls as evidenced by history of fall prior to admission. A significant change MDS was completed due to right rib fracture with increase pain and need for more assistance with upper extremity activities of daily living. The goal is to be free from major injury if a fall will occur. R24's side rail evaluation documents the need for repositioning bars to assist with bed mobility completed 5/26/24 with no re-evaluation completed. A verbal consent for the repositioning bars was obtained from the activated HCPOA on 5/26/24. During the survey process, Surveyor observed bilateral repositioning bars on both R1 and R24's beds. Both beds were observed to pushed next to the wall. On 4/1/25, at 3:26 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A and Director of Nursing (DON-B) that R1 did not have consent obtained when R1's repositioning bars were re-evaluated for the need on 3/4/25. Surveyor shared that both R1 and R24 did not have a re-positioning bar evaluation completed on a quarterly basis and no actual care plan for the need for the re-positioning bars. On 4/2/25, at 9:47 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-J in regards to R1 and R24's repositioning bars. CNA-J confirmed CNA-J takes care of both R1 and R24 on a regular basis. CNA-J has never observed R1 and R24 use the repositioning bars on their own and only sometimes uses the repositioning bars when transferring. On 4/2/25, at 12:08 PM, DON-B confirmed there should be an order for re-positioning bars and the facility tries to have consents signed for the re-positioning bars on a yearly basis. DON-B also confirmed that re-positioning bars should be done quarterly per facility policy. On 4/3/25, at 8:16 AM, DON-B gave Surveyor documentation that on 4/2/25, at 5:54 PM, DON-B completed a new side rail use evaluation, obtained consent from the activated HCPOA and obtained a physician order.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49845 Based on observations, interviews, and record review, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. * The facility does not have a current comprehensive water management plan that includes Water Management team members, flow charts specific to the facility to determine areas of concern or interventions implemented to prevent the spread of opportunistic pathogens (Legionella) in the facility's water systems. *3 observations of staff providing cares and administering medications without proper Personal Protective Equipment (PPE) for R23. *Observations of improper hand hygiene during wound cares for R23. *Observations of no Enhanced Barrier Precautions (EBP) in place for R392. Findings include: Water Management Program (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Facility policy, titled Legionella Water Management Program, with an effective date of 07/2018, documents the following, . Procedure: 1. As part of the infection prevention and control program, our facility has a water management program, which is overseen by the Environmental Services Team. 2. The water management program team will consist of at least the following personnel: a. The infection preventionist; b. The administrator; c. The medical director (or designee); d. The director of maintenance; e. The director of environmental services; and f. The director of clinical services. 3. The purpose of the water management program are to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease. 4. The water management program used by our facility is based on the Center for Disease Control and Prevention and ASHRAE recommendations for developing a Legionella water management program. 5. The water management program includes the following elements: a. An interdisciplinary water management team; b. A detailed description and diagram of the water system in the facility, including the following: (1) Receiving; (2) Cold water distribution; (3) Heating; (4) Hot water distribution; and (5) Waste. C. The identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria, including: (1) Storage tanks; (2) Water heaters; (3) Filters; (4) Aerators; (5) Showerheads and hoses; (6) Misters, atomizers, air washers and humidifiers; (7) Hot tubs; (8) Fountains; (9) Medical devices such as CPAP machines, hydrotherapy equipment; etc d. The identification of situations that can lead to Legionella growth, such as: (1) Construction; (2) Water main breaks; (3) Changes in municipal water quality; (4) The presence of biofilm, scale or sediment; (5) Water temperature fluctuations; (6) Water pressure changes; (7) Water stagnation and; (8) Inadequate disinfection. e. Specific measures used to control the introduction and/or spread of legionella (e.g., temperature, disinfectants); f. The control limits or parameters that are acceptable and that are monitored; g. A diagram of where control measures are applied; h. A system to monitor control limits and the effectiveness of control measures; i. A plan for when control measures are not met and/or control measures are not effective; and j. Documentation of the program. The Facility's document, titled Facility Assessment, with a last completed date of 01/28/2025, documents in part, . Infection Control The facility has conducted an infection control risk assessment which evaluated and determined the risk or potential vulnerabilities within the resident population and the surrounding community. We have evaluated our building for potential for legionella and we have no fountains, window AC units or other standing water that puts us at risk. 1.) The 6/24/21 CDC Toolkit titled, Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings identifies the key elements of a water management program for healthcare facilities to include: 1. Establish a water management program team 2. Describe the building water systems using text and flow diagrams 3. Identify areas where Legionella could grow and spread 4. Decide where control measures should be applied and how to monitor them 5. Establish ways to intervene when control limits are not met 6. Make sure the program is running as designed and is effective (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	7. Document and communicate all the activities The 6/24/21 CDC Toolkit documents, program team members should possess certain skills that are needed to develop and implement your water management program. The team should also include: -Someone who understands accreditation standards and licensing requirements -Someone with expertise in infection prevention -A clinician with expertise in infectious diseases -Risk and quality management staff The CDC toolkit identifies locations in a buildings water system where Legionella can grow and spread to include but not limited to: ~Hot and cold-water storage tanks ~Water heaters ~Water Filters ~Electronic and manual faucets ~Aerators ~Shower heads and hoses ~Pipes, valves, and fittings ~Infrequently used equipment including eye wash stations. ~Ice machines ~Hot tubs Control Measures: Determine Locations Where control measures must be applied and maintained to stay in established control limits. The CDC toolkit identifies factors internal to buildings that can lead to Legionella growth to include: ~Water temperature fluctuations: Provides conditions where Legionella grows best (77 -108 Fahrenheit (F)) ~Water pressure changes ~PH (measurement of acidity or alkalinity of a solution on a scale 0 to 14) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	~Inadequate disinfectant: Does not kill or inactivate Legionella ~Water stagnation: Encourages biofilm growth and reduces temperature and levels of disinfectant. Common issues that contribute to water stagnation include renovations that lead to 'dead legs' and reduced building occupancy. The Wisconsin State Plumbing Code, Chapter SPS 382.50(3)(b)6, requires a nursing homes hot water system to be installed and maintained to provide bacterial control by one of the following methods: ~Water stored and circulation initiated at a minimum of 140 F and with a return of a minimum of 124 F. This standard is best practice even considering the facility was built prior to May 2003 and grandfathered to meet requirement. ~ 5mg/L residual chlorine. ~Another disinfection system approved by the department. Surveyor requested the Facility's Water Management Program (WMP) information from Nursing Home Administrator (NHA)-A, who is also the Facility's current Infection Preventionist. NHA-A provided Surveyor with the Facility's WMP policy and a map. On 04/02/2025, at 11:39 AM, Surveyor interviewed Environmental Services Director (ESD)-AA. ESD-AA informed Surveyor that the map provided does not reflect the water flow and does not indicate risk areas. ESD-AA indicated that water temperature in resident rooms are checked on a daily basis, and indicated logs are kept. ESD-AA informed Surveyor that ESD-AA does not do anything with humidifiers or medical devices. ESD-AA indicated the Facility has no dead legs, water system is a centralized loop and indicated the Facility has portable eye washing station in the kitchen. ESD-AA indicated ESD-AA would have to look into getting further information on the Facility's comprehensive WMP. Surveyor asked ESD-AA who is part of the WMP, ESD-AA was unsure of who all is on the WMP team. On 04/02/2025, at 03:21 PM, Surveyor informed NHA-A that Surveyor needs to see the Facility's comprehensive WMP that includes description of the Facility's building water systems using text and flow diagrams, Identified areas where Legionella could grow and spread, where control measures should be applied and how to monitor them, ways to intervene when control limits are not met and documentation and communicate of all the activities. NHA-A indicated NHA-A would look into it. 04/03/2025, at 09:49 AM, NHA-A informed Surveyor that ESD-AA would be bringing in information soon regarding the WMP. On 04/03/2025, at 09:55 AM, ESD-AA provided Surveyor with a plumbing plan map for first, second floors and basement. Surveyor asked ESD-AA to show Surveyor where on the map are the identified risk areas. ESD-AA informed Surveyor those areas are not listed on the map. ESD-AA was able to provide logs for daily hot ESD-AA water temperatures from resident rooms from 01/2024 to current. ESD-AA indicated ESD-AA started in his current role about 2 months ago and will have to look into the WMP more and indicated there may be something from the previous Environmental Services Director. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/31/25, at 12:56 PM, Surveyor observed a cart containing personal protective equipment (PPE) outside of R23's room and a sign on R23's door indicating R23 required EBP. The EBP sign indicates that everyone must clean their hands, including before entering and when leaving the room. Providers and staff must also wear gloves and a gown for the following high-contact resident care activities: -Dressing -Bathing/showering -Transferring -Changing linens -Providing Hygiene -Changing briefs or assisting with toileting -Device care or use-central line, urinary catheter, feeding tube, tracheostomy -Wound care: any skin opening requiring a dressing On 4/1/25, at 7:07 AM, Surveyor passed R23's room and observed Registered Nurse (RN)-Z administering medications into R23's g-tube. RN-Z was not wearing gloves or a gown. On 4/1/25, at 7:22 AM, Surveyor observed RN-Z at the medication cart outside of R23's room. Surveyor observed RN-Z obtain gloves out of a drawer of the medication cart. RN-Z carried the gloves in their left hand and carried medications with right hand into R23's room and placed the medications on the overbed table. RN-Z came back out to the medication cart and obtained more medications. RN-Z was observed still carrying the gloves in left hand. RN-Z moved the medication cart while carrying the gloves. RN-Z then placed second set of medications the overbed table. RN-Z then put the gloves on. Surveyor did not observe RN-Z perform hand hygiene before putting the gloves on. RN-Z then came back out of R23's room without the gloves on and obtained a towel. Surveyor observed RN-Z put the same gloves on. Surveyor again did not observe RN-Z to perform hand hygiene. Surveyor then observed RN-Z administer each medication into R23's g-tube. RN-Z was not wearing a gown during the administering of medications. Surveyor did observed RN-Z perform hand hygiene before exiting R23's room. On 4/1/25, at 8:53 AM, Surveyor observed Certified Nursing Assistant (CNA)-K exiting R23's room. Surveyor asked CNA-K what CNA-K had completed for R23. CNA-K stated that CNA-K had just finished feeding R23, repositioned her, and checked for incontinence. Surveyor observed that CNA-K had gloves on but was not wearing a gown. Surveyor did observed CNA-K perform hand hygiene before exiting R23's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/2/25, at 7:20 AM, Surveyor observed Licensed Practical Nurse (LPN)-Y go into R23's room and place medications on the overbed table. LPN-Y obtained water from the bathroom sink. LPN-Y then went and obtained gloves. Surveyor observed LPN-Y perform hand hygiene and put gloves on. LPN-Y then stated to Surveyor I should do vitals first. LPN-Y took gloves off and put the gloves on the overbed table. LPN-Y took vitals. LPN-Y then put the same gloves on that were on the overbed table. LPN-Y then administered all medications into R23's g-tube. LPN-Y was not wearing a gown during the administration of medications. Surveyor observed LPN-Y discard the gloves and performed no hand hygiene before exiting R23's room On 4/2/25, at 8:32 AM, Surveyor observed LPN-Y take a gown out of the cart, part of the gown was observed to touch the floor upon removal. LPN-Y went into R23's room and put the gown on. LPN-Y put gloves on and did not perform hand hygiene prior to putting the gloves on. LPN-Y pushed the overbed table away from R23's bed with the gloves on and administered R23's antibiotic through R23's g-tube. LPN-Y took the gloves off, then the gown and performed hand hygiene. Surveyor asked LPN-Y if there was a reason why LPN-Y did not wear a gown the first time LPN-Y administered medications to R23. LPN-Y stated, I forgot. I was supposed to. I was just flying to get things done. On 4/2/25, at 3:07 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B that Surveyor observed RN-Z, CNA-K, and LPN-Y not following EBP by not donning a gown and at times not performing hand hygiene when administering medication through R23's g-tube and when performing cares for R23. No further information was provided by the facility at this time. 51016 3.) Policy document titled: Hand Washing Hand hygiene, Updated 8/2018. Policy statement: {facility} follow CDC guidelines for hand hygiene and promotes hand hygiene as the primary means to prevent the spread of infections. 1, All personnel should be trained and in serviced as needed on the importance of hand hygiene and preventing the transmission of health care associated infections. 2. All personnel shall follow the hand washing hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors. 3. Hand hygiene products and supplies, (sinks soap, towels, alcohol-based hand rub, etcetera) shall be readily accessible and convenient for staff to encourage compliance with hand washing policies. 4. Residents, family members and or visitors will be encouraged to practice hand hygiene through the use of fact sheets, pamphlets and or other written materials provided at the time of admission and or posted throughout the facility. Wash hands with soap and water for the following situations. A. Before and after coming on duty. B. Before and after direct contact with residents. C. Before preparing or handling medications. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	D. Before performing. Any non-surgical invasive procedures? E. Before and after handling an invasive device. (Example urinary catheters. IV Access sites). F. Before donning and after removing sterile or non-sterile gloves. G. Before handling clean or soiled dressings, gauze pads, etcetera H. Before moving from a contaminated body site to a clean body site during resident care. I. After contact with a residence, intact skin J. After contact with bloody or bodily fluids, K. After handling used dressings, contaminated equipment, etcetera. L. After contact with objects (example medical equipment) in the immediate vicinity of the resident. M. After removing gloves. N. Before and after entering isolation precautions settings. O. Before and after eating or handling food. P. Before and after assisting a resident with meals and, Q. After personal use of the toilet or conducting your personal hygiene. 6. Hand hygiene is the final step after removing and disposing of personal protective equipment. 7. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare associated infections On 03/31/25, at 09:02 AM, Surveyor interviewed R392. R392 informed Surveyor that R392 was a retired Registered Nurse. R392 informed Surveyor that R392 was admitted to the facility with a right heel stage 2 pressure wound. Surveyor observed that R392 was not on enhanced barrier precautions (EBP). On 04/01/25, at 08:38 AM, Surveyor interviewed DON-B. DON-B informed Surveyor that R392 had blister on the right heel on R392's 1/17/25 admission to the facility. Surveyor asked DON-B if R392's stage 2 pressure injury was an open wound. DON-B informed Surveyor that R392's wound is open, but it has decreased in size. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 04/02/25, at 07:34 AM, Surveyor observed Certified Nursing Assistant (CNA)-H went into R392's room with a [NAME] stand without donning Personal Protective Equipment (PPE). Surveyor knocked on door to ask CNA-H if R392 was getting up for the day. CNA-H informed the Surveyor that R392 was being taken to the bathroom. Surveyor observed that CNA-H had no PPE on, and that R392 had already been transferred to the bathroom toilet. On 04/02/25, at 08:18 AM, Surveyor observed R392's wound treatment with Director of Nursing (DON)-B and Registered Nurse Manager (RN)-W. Surveyor observed RN-W remove R392's dressing and assist DON-B with wound care. Surveyor witnessed RN-W remove RN-W's gloves. Surveyor observed RN-W prior to performing hand hygiene pick up and place the soiled un-sanitized scissors along with the clean Normal Saline spray bottle in the clean transport bin. Surveyor observed RN-W take the bin to the clean wound cart in the hallway before washing RN-W's hands. Surveyor observed R392 has a wound on the right heel and the wound is not closed and that R392 is not on the required EBP for open pressure wounds. Surveyor observed that DON-B and RN-W donned only gloves for the wound treatment and used no other personal protective equipment as required for EBP when treating an open pressure wound. On 04/02/25, at 03:24 PM, Surveyor informed NHA-A and Director of Nursing (DON)-B about Surveyor's hand hygiene concerns during R392's wound treatment and the concern that R392 was not in enhanced barrier precautions for the open pressure ulcer on R392's right heel. NHA-A informed the Surveyor that NHA-A thought that pressure injuries did not require EBP. Surveyor reviewed the Centers for Medicare & Medicaid Services, Center for Clinical Standards and Quality/Quality, Safety & Oversight Group memo Ref: QSO-24-08-NH on Enhanced Barrier Precautions dated March 20, 2024, with NHA-A and DON-B. NHA-A informed Surveyor they would place R392 immediately into EBP. 4.) On 04/02/25, at 07:40 AM, Surveyor observed R23's wound treatment with Director of Nursing (DON)-B and Registered Nurse Manager (RN)-W. Surveyor noted R23 had pressure reliving boots on in bed, bolster under left arm and R23's left hand splint was in place. Surveyor observed RN-W assist DON-B with wound care and cleaning up stool on R23. Surveyor witnessed RN-W remove RN-W's gloves. Surveyor observed RN-W, prior to performing hand hygiene, pick up and place the soiled un-sanitized scissors along with the clean Normal Saline spray bottle in the clean transport bin. Surveyor observed RN-W take the bin to the clean wound cart in the hallway before washing RN-W's hands. On 04/02/25, at 03:24 PM, Surveyor informed NHA-A and Director of Nursing (DON)-B about the hand hygiene concerns during R23's wound treatment.

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	04/14/2025

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on observation and interview, the Facility does not conduct regular inspection of all bed rails as part of a regular maintenance program to identify areas of possible entrapment for 4 (R1, R24, R28 and R392), of 4 Residents observed with bilateral enabler bars on the beds during the survey process. Findings Include: The facility's Proper Use of Bed Rails effective 7/18/24 documents: .Policy: It is the policy of this facility to utilize a person-centered approach when determining the use of bed rails. Appropriate alternative approaches are attempted prior to installing or using bed rails. If bed rails are used, the facility ensures correct installation, use, and maintenance of the rails. Installation and Maintenance of Bed Rails 12. The facility will assure the correct installation and maintenance of bed rails, prior to use. This includes: iii. Inspecting and regularly checking the mattress and bed rails for areas of possible entrapment v. Checking the bed rails regularly to make sure they are still installed correctly, and have not shifted or loosened over time. c. Observing ongoing precautions such as following manufacturer's equipment alerts and recalls and increasing Resident supervision, especially with the use of air-filled mattresses or or therapeutic air-filled beds that may present a different entrapment risk than rail entrapment. d. Conducting routine preventative maintenance of beds and bed rails to ensure they meet current safety standards and are not in need of repair. Ongoing Monitoring and Supervision 15. The facility will continue to provide necessary treatment and care to the Resident who has bed rails in accordance with professional standards of practice and the Resident's choices. d. The maintenance director, or designee, is responsible for adhering to a routine maintenance and inspection schedule for all bed frames, mattresses, and bed rails. (continued on next page)

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	525382	A. Building B. Wing	04/14/2025

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

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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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/2/25, at 11:45 AM, Surveyor interviewed Environmental Services Director (ESD)-AA regarding conducting regular inspection of all bed frames, mattresses, and bed rails to identify areas of possible entrapment. ESD-AA is responsible for checking bed rails but only when ESD-AA gets a work order to install or on an as needed basis. ESD-AA does regularly inspect and maintain the bed rails as part of ESD-AA's regular maintenance program to check for safety. 1.) R1 was admitted to the facility on [DATE]. R1 currently has an activated Health Care Power of Attorney(HCPOA). R1's current physician orders documents assist rails to both sides of bed every shift for skin integrity with a start date of 1/31/23. R1's care card documents R1 is high fall risk and has assist rails to both sides of bed. R1's care plan contains an intervention initiated on 1/31/23 for self-care deficit: -adaptive device on both sides of bed to assist for bed mobility and repositioning 2) R24 was admitted to the facility on [DATE]. R24 currently has an activated HCPOA. R24 does not have a current physician order for the repositioning bars. R24's side rail evaluation documents the need for repositioning bars to assist with bed mobility completed 5/26/24 with no re-evaluation completed. A verbal consent for the repositioning bars was obtained from the activated HCPOA on 5/26/24. During the survey process, Surveyor observed bilateral repositioning bars on both R1 and R24's beds. Both beds were observed to pushed next to the wall. On 4/2/25, at 3:07 PM, Surveyor shared the concern that R1 and R24's repositioning bars have not been regularly inspected for areas of possible entrapment and safety with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B. No further information was provided by the facility at this time. 51016 3) R28 was admitted to the facility on [DATE]. R28's admission MDS (minimum data set) with an assessment date of 03/13/25 documents a BIMS (brief interview mental status) score of 6 indicating severe impairment of R28's cognition. Section GG mobility documents R28 as requiring supervision or touching assistance to roll side to side in bed. Section P physical restraints documents bed rails as not used for R28. R28's Activity of Daily Living (ADL) dated 3/12/25, revision on 3/12/25, documents, self-care performance deficit r/t (related to) Activity Intolerance, Confusion, Dementia, Fatigue, Impaired balance, Limited Mobility. R28's intervention section includes the following: Adaptive device on both sides of bed to assist for bed mobility and repositioning. (continued on next page)

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	04/14/2025

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/31/25 at 09:13 AM, Surveyor observed R28 in bed with a quarter side rail on both sides of R28's bed. On 04/02/25, at 03:24 PM, Surveyor informed NHA-A and Director of Nursing (DON)-B about the Surveyor's concern the side rails are not being checked by maintenance on R-28's bed as required for entrapment and safety concerns. 4) R392 was admitted to the facility on [DATE]. R392's Significant change in status MDS (minimum data set) with an assessment date of 02/04/25 documents a BIMS (brief interview mental status) score of 13 indicating intact cognition for R392. Section GG mobility documents R392 as requiring partial to moderate assist to roll side to side in bed. Section P physical restraints documents bed rails as not used for R392. R392's Activity of Daily Living (ADL) dated 2/1/25, documents, self-care deficit r/t (related to) periprosthetic fracture around internal prosthetic right knee joint. R392's intervention section includes the following: Adaptive device on both sides of bed to assist for bed mobility and repositioning. On 03/31/25. at 09:02 AM, Surveyor observed R392 in bed with a quarter side rail on both sides of R392's bed. On 04/01/25, at 08:27 AM, Surveyor observed R392 in bed with a quarter side rail on both sides of R392's bed. On 04/02/25, at 03:24 PM, Surveyor informed NHA-A and Director of Nursing (DON)-B about the Surveyor's concerns that the side rails are not being checked by maintenance on R392's bed as required for entrapment and safety concerns.