Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525414	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mercy Health Services	2727 W Mitchell St Milwaukee, WI 53215

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35690 Based on interview, record review, and facility policy review, the facility failed to exercise reasonable care for the protection of personal items for one of one sampled resident (Resident (R) 3) reviewed for protection of personal property out of a total sample of 11 residents. Specifically, when R3 was discharged from his five-day respite stay, the facility was unable to provide him with all of the personal items he had admitted to the facility with. This failure has the potential to cause undue stress and expense to the family and/or resident. Findings include: Review of the Resident Rights policy, revised 07/2022, revealed, . The resident has the right to retain and use personal possessions, including furnishings and clothing, as space permits . Review of R3's Admission Record, located in the electronic medical record (EMR) under the Profile tab, revealed R3 was admitted to the facility on [DATE] for a five-day respite state. R3 had a diagnosis of Alzheimer's disease. Review of R3's discharge Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/20/24, located in the EMR under the MDS tab, revealed R3 had a Brief Interview for Mental Status (BIMS) score of 2/15, which indicated the resident was severely cognitively impaired. Review of the Grievance/Complaint Report. provided by the facility and dated 09/06/24, revealed R3's family member had contacted the Administrator regarding R3's personal belongings of clothing and a back scratchier. During an interview on 09/18/24 at 12:45 PM, R3's family member said when she brought R3 home, the facility did not give her all of his clothes that he had admitted with. She said after she brought him home, she called the Administrator to report her concerns. She said she did receive a few of his items in the mail but received clothing that belonged to another resident because their name was written on the collar. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/19/24 at 7:30 PM, Certified Nurse Aide (CNA) 1, CNA2 and CNA3 said whenever they assist a resident with their discharge, they use the inventory sheet to compare what personal items the resident had when they admitted and what personal items the resident leaves with to ensure they have all of their personal items. All agreed this was very important because residents' items are important to the residents. During an interview on 09/19/24 at 8:15 PM, the Administrator said that when R3 discharged on [DATE], facility staff were unable to give him all clothes he had admitted with. She said after hearing from R3's family regarding the missing clothes, she sent the family some of his additional clothing via certified mail. The Administrator said they had not been able to provide everything to R3 at that time. During the survey, the Administrator said she had found more of R3's additional items and would contact the family to determine what else was missing and what the facility could purchase to ensure R3 had everything he had admitted with.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35690 Based on interview, record review, and policy review, the facility failed to investigate a potential misappropriation of medication for one of one resident (Resident (R) 3) reviewed for misappropriation of medication out of total sample of 11. Specifically, the failure to ensure misappropriation had not occurred, had the potential to allow one nurse to continue to pass medications to residents for an indefinite period. Findings include: Review of the facility provided policy titled, Medication Administration General Guidelines, dated 01/2024, revealed . Medications are to be administered at the time they are prepared . The individual who administered the medication dose records the administration on the resident's MAR (Medication Administration Record) immediately following the medication being given. In no case should the individual who administered the medication report off-duty without first recording the administration of any medications . Review of the facility provided policy titled, Abuse, Neglect and Exploitation, dated 07/15/22, revealed an immediate investigation is warranted when allegations or suspicion of abuse . occur . Providing complete and thorough documentation of the investigation . Review of R3's Admission Record, located in the electronic medical record (EMR) under the Profile tab, revealed R3 was admitted to the facility on [DATE] for a five-day respite stay. R3 had a diagnosis of Alzheimer's disease. Review of R3's discharge Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/20/24 and located in the EMR under the MDS tab, revealed R3 had a Brief Interview for Mental Status (BIMS) score of 2/15, which indicated the resident was severely cognitively impaired. Per the MDS, the resident exhibited delusions during the assessment period. Review of R3's Medication Administration Record (MAR), located in the EMR under the Orders tab, revealed R3 had an order for Lorazepam (also known as Ativan, an anti-anxiety medication) oral tablet 0.5mg (milligrams), one tablet by mouth every four hours as needed for anxiety or restlessness with a start date of 08/15/24. R3 received one tablet of the medication on 08/15/24 at 10:42 PM, 08/16/24 at 12:29 AM, 3:45 AM and 12:22 PM, and 08/17/24 at 8:14 PM. Review of R3's Medication Administration Record (MAR), located in the EMR under the Orders tab, revealed R3 also had an order for Lorazepam oral tablet 0.5mg (milligrams), two tablets by mouth every four hours as needed for anxiety or restlessness If 1 (one) tab is ineffective second tab can be administered two hours before next dose. R3 received two tablets on 08/16/24 at 8:19 AM, 08/17/24 at 8:12 PM, 08/18/24 at 9:06 PM, 08/19/24 at 7:48 AM and 8:28 PM, and 08/20/24 at 8:31 AM. Review of the Resident Controlled Substance Record, revealed on 08/18/24 seven Lorazepam were signed out, however, according to the MAR and the Progress Notes, only four tablets were given. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Progress Notes under the Progress Notes tab revealed R3 received four 0.5mg tablet of Lorazepam on 08/18/24. The Resident Controlled Substance Record, the Progress Notes and the MAR revealed seven Lorazepam were signed out on 08/18/24, but only four were documented on the MAR as being administered to R3. During an interview on 09/18/24 at 5:22 PM, the Director of Nursing (DON) said they had begun their investigation 09/06/24 when R3's family member contacted the facility concerned about how much medication R3 received during his five-day respite stay. The DON confirmed Registered Nurse (RN) 1, who administered the medication on 08/17/24, 08/18/24 and 08/19/24 did not document in the MAR on 08/18/24 that the Lorazepam had been administered to the resident. She said the nurse had documented on the Resident Controlled Substance Record that she had removed three 0.5mg Ativan on 08/18/24 and two 0. 5mg Ativan on 08/19/24. The DON said when they completed the investigation, they were investigating whether the resident had received too much Ativan. The DON stated they did not investigate whether the medication had been misappropriated. The DON said RN1 received education to ensure administered medication was documented on the MAR. She said RN1 did not receive education until 09/16/24, 10 days after the investigation started, because that was the first day they had worked together. RN1 worked four shifts prior to education. During an interview on 09/19/24 at 9:18 AM, the Regional Nurse Consultant (RNC) confirmed Registered Nurse (RN) 1, who administered the medication on 08/17/24, 08/18/24 and 08/19/24 did not document in the MAR on 08/18/24 that the Lorazepam had been administered to R3. The RNC said it had never occurred to her that the medication had been misappropriated, just that RN1 had not documented. During an interview on 09/19/24 at 5:51 PM, the Assistant Director of Nursing (ADON) said when a narcotic was administered, it was important to sign the medication out in the Resident Controlled Substance Record and the MAR at the same time. He said that if it was only documented in the Resident Controlled Substance Record and not in the MAR, he would contact the nurse for the previous shift to verify whether the medication had been administered to avoid a double dose, which could increase sedation and risk of falls for the resident.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35690 Based on interview, record review, and policy review, the facility failed to clarify a physician's order for as needed (PRN) lorazepam (Ativan, a controlled anti-anxiety medication) for one of 11 sampled resident (Resident (R) 3) reviewed for medication administration out of a total sample of 11. Specifically, the failure to clarify the order caused confusion in medication administration for R3. Findings include: Review of the facility provided policy titled, Medication Orders Controlled Substance Medication Orders, dated 01/2023, revealed . Dosage form . Time and frequency of administration . Elements of a valid controlled substance prescription PRN (as needed) orders clearly delineate the condition for which they are being administered . Review of R3's Admission Record, located in the electronic medical record (EMR) under the Profile tab, revealed R3 was admitted to the facility on [DATE] for a five-day respite stay. R3 had a diagnosis of Alzheimer's disease. Review of R3's discharge Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/20/24 and located in the EMR under the MDS tab, revealed R3 had a Brief Interview for Mental Status (BIMS) score of 2/15, which indicated the resident was severely cognitively impaired. Per the MDS, the resident exhibited delusions during the assessment period. Review of R3's Medication Administration Record (MAR), located in the EMR under the Orders tab, revealed R3 had an order for lorazepam oral tablet 0.5mg (milligrams), one tablet by mouth every four hours as needed for anxiety or restlessness with a start date of 08/15/24. Review of R3's Medication Administration Record (MAR), located in the EMR under the Orders tab, revealed R3 also had an order for lorazepam oral tablet 0.5mg (milligrams), two tablets by mouth every four hours as needed for anxiety or restlessness. It was recorded, If 1 (one) tab is ineffective second tab can be administered two hours before next dose. During an interview on 09/18/24 at 5:22 PM, the Director of Nursing (DON) stated R3's family member had contacted the facility regarding the amount of lorazepam R3 had received during his stay, and when the facility began an investigation into the concern, they had identified the orders for the lorazepam were confusing. The DON stated the order should have been clarified upon R3's admission. She said she and the Assistant Director of Nursing (ADON) had received education, and she had sent a text to all nurses with the guidance. During an interview on 09/19/24 at 9:18 AM, the Regional Nurse Consultant (RNC) confirmed the order should have been clarified upon R3's admission. The RNC said she had provided the DON and the ADON with education on 09/06/24, when they started their investigation, regarding the importance of clarifying Range Orders and a Standard Dose Order should be obtained.