STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525523	A. Building B. Wing	12/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alexian Village of Milwaukee	9255 N 76th St Milwaukee, WI 53223

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 51016 Based on interview and record review the facility did not ensure 1 (R38) of 1 sampled resident's potential allegation of misappropriation of property was reported to the State Survey Agency or the Nursing Home Administrator within 24 hours. *R38's family reported a missing necklace on 11/29/24 to a facility staff member. R38's missing gold necklace was not reported to the Nursing Home Administrator until 12/2/24. The investigation into R38's missing gold necklace did not start until 12/2/24. Finding include: The facility policy entitled Abuse Investigation and Reporting revised on 11/2023 documents: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment, ., and/or injuries of unknown source (abuse) shall be promptly reported to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by community management. Conclusions of investigations will also be reported, as defined by the [Facility Name] Abuse Prevention policy. R38's current admission was on 10/21/23. On 12/2/24, at 8:30 AM, Surveyor noted, during record review, a nurses note dated 11/29/24. Licensed Practical Nurse (LPN)-E charted; Client's family and son at bedside today reporting client was missing gold necklace chain which they noticed she did not have since Wednesday 11/27. Room checked and item not located. Attempt made to update social worker on reported item was unsuccessful. Call placed to administrator NHA (Nursing Home Administrator)-A, voice message left. Family updated that social worker will be in contact to follow up. (continued on next page)

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

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/2/24, at 11:53 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A. Surveyor asked, what the facility's procedure, and what actions were implemented around R38's reported missing necklace. NHA-A informed Surveyor NHA-A was not made aware of R38's missing necklace. NHA-A read LPN-E's chart entry dated 11/29/24 regarding R38's missing necklace. NHA-A informed Surveyor NHA-A was in the building and NHA-A was not informed about R38's missing necklace. NHA-A informed Surveyor NHA-A would have reported it and started an investigation right away. Surveyor asked if that was the facility's normal procedure in cases of missing items such as jewelry. NHA-A replied, yes. NHA-A informed Surveyor, we have a lot of agency staff, they may not have informed me, I know that's not an excuse but its what I have. NHA-A told Surveyor, If I (NHA-A) was informed, I (NHA-A) would have reported it right away and started the investigation that day. On 12/3/24, at 8:10 AM, Surveyor interviewed LPN-E, LPN-E informed the Surveyor, that LPN-E left a message on NHA-A's voicemail right after R38's family reported the necklace missing. LPN-E left a note on the social worker's desk informing the social worker of R38's missing gold necklace. R38's family told LPN-E that it was noticed missing by them on 11/27/24. LPN-E told Surveyor, R38's missing necklace was not that surprising to the family, because R38 plays with it constantly. LPN-E informed Surveyor, that LPN-E told R38's family that the missing necklace still had to be investigated, and that NHA-A had to be notified right away. LPN-E said, they did leave a voicemail about R38's missing necklace right away for NHA-A. On 12/3/24, at 11:33 AM, Surveyor interviewed Executive Director-B. Surveyor inquired what is the facility's procedure and actions with reported missing jewelry items. Executive Director-B informed Surveyor, that the Social Worker should be informed, and the grievance officer should be informed right away. Surveyor inquired who the grievance officer is. Executive Director-B informed the Surveyor, that it would be NHA-A. Executive Director-B explained to Surveyor, NHA-A and the social worker would make sure the item was not in safe keeping with the facility. NHA-A would make the decision to report to the state agency and or start an investigation; based on whether the facility had the item or if the item could be located right away. Executive Director-B explained, after we verify, we do not have the item in question, we will do the 24-hour report to the state agency and investigate. Surveyor asked what should have been done in the case of R38's missing gold necklace. Executive Director-B informed Surveyor, the facility process of reporting and investigation should have started immediately.

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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** 16584 UNCORRECTED AT REVISIT Based on record review and interviews, the facility did not ensure they thoroughly investigated and attempted to find the root cause of a fall for 1 (R361) of 3 residents reviewed for being at risk for falls. R361 experienced an unwitnessed fall in her room on 11/12/24. When family entered the room, the wardrobe/dresser was observed to be on top of R361 who was lying on the floor of her room. R361 stated that she lost her balance while attempting to ambulate to the bathroom by herself after calling for help from staff with no response. Post fall, the facility did not review the wardrobe dressers utilized by facility residents to ensure they were safely secured to prevent other residents from having the wardrobe/dresser fall over creating a safety concern. The deficient practice has the potential to effect a pattern of the 76 residents currently residing in the facility with the same wardrobes/dressers. Findings include; Falls Policy: The facility policy, entitled, Falls dated revised, 7/2023, states (in part) .Policy statement: The purpose of this procedure is to provide guidelines for evaluation of a resident in the event a fall occurred and to assist associates in identification of potential causes of the fall. *Policy Detail: Direct care associates shall evaluate the area where the fall occurred for possible contributors. The documentation of the identified interventions should be maintained in the resident clinical record and available to the direct care associates. The falls should be reviewed at the Daily Stand-up meeting following the fall for identification of any additional individualized interventions to reduce the risk of falls. An incident report shall be completed for the resident falls by a licensed nurse after the fall occurs. R361 was admitted to the facility on [DATE] for rehabilitation due to shortness of breath from Pneumonia. R361 was responsible for self and did not have an Activated Power of Attorney for Healthcare. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the admission Minimum Data Set (MDS), dated [DATE], R361 is occasionally incontinent of bowel and bladder and there is no toileting plan in place for either. R361 has a Brief Interview for Mental Status (BIMS) score of 15 indicating R361 is cognitively intact. R361 has not had any falls at the facility since her admission. On 11/3/24, the facility conducted a falls assessment and determined R361 is at moderate risk for falls. A review of the plan of care indicated that R361 has potential for falls related to recent admission to community. Interventions included to keep pathways clear and provide adequate lighting. The plan of care for Activities of Daily Living documents that R361 needs extensive assist with 1 staff person support to pivot transfer with assistive device. R361 also needs extensive assistance with 1 person for support for toileting. The Certified Nursing Assistant (CNA) care card indicates that R361 needs extensive assistance with 1 staff person support for toileting and does not use any bowel/ bladder appliances. R361 is continent of bladder and incontinent of bowel. R361 also needs extensive assistance with 1 person staff support for transferring and ambulation. A Nursing Note dated 11/14/27 at 10:37 a.m. documents, late entry fall on 11/12/24 at 7:00 p.m. Staff was alerted by family that [R361] had a fall. Family stated when she walked in the room the wardrobe was on her [R361] and she flipped it off her. [R361] states she had to go to the bathroom and was walking to the bathroom when she fell . Vital signs and range of motion within normal limits. Head to toe assessment completed and no injury noted. Initially [R361] had no complaints of pain but then stated her right knee was hurting. 911 called and transferred [R361] to the hospital. Per follow-up on 11/13/24 at 7:00 a.m., hospital nurse stated [R361] had no injuries, and all testing was within normal limits. R361 had not returned to the facility following the transport to the hospital on 11/12/24. On 12/2/24, Surveyor requested to review the falls investigation for R361 from 11/12/24. Nursing Home Administrator (NHA)- A provided Surveyor with the Fall Scene Investigation Form, for the fall on 11/12/24 that happened at 7:00 p.m. The form documents that R361 was in her room, and incontinent of feces. R361's statement, I needed to go to the bathroom, and no one was coming so I was walking to the bathroom. The fall was unwitnessed and R361 was observed sitting on the floor. The call light was not activated at the time of the fall. It was unknown if R361 hit her head. The factors noted related to the fall were that R361 was ambulating independently and R361 is to ambulate with the assist of 1 person and her walker. Environmental factors observed was that the wardrobe was face down on the floor. The investigation indicates that the last time R361 was visually observed was 6:40 p.m. on 11/12/24. R361 had gripper socks on and needed items were in reach and R361 was incontinent of bowel. Surveyor reviewed the Nurse follow-up responsibilities post fall form dated 11/12/24. Task # 6 states to use a Hoyer lift to get resident off the floor. Written documentation stated that emergency medical services (EMS) got R361 off the floor. Surveyor reviewed written statements from staff members that were included in the facility's investigation. The following was noted: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA- J documented that he worked both units on the 2nd shift on 11/12/24. CNA- J stated that he observed R361 in her chair in her room as he was passing out the dinner meal trays and this was approximately 6:40 p. m CNA- J did not document that he had provided any cares to R361 during his shift on 11/12/24 prior to the fall. Licensed Practical Nurse (LPN)-F documented that he observed R361 at 6:35 p.m., on 11/12/24, sitting on the Broda chair when staff was making rounds and passing medications to other residents. At 7:05 p.m., R361's family was heard yelling loudly that R361 was on the floor and claimed she pushed the board (sic) off of R361. LPN- F documented he called EMS immediately. CNA- G documented that she was assisting other residents on 11/12/24 when she heard yelling from R361's room. R361's family stated that the dresser was on top of R361 when she came into the room, and she pushed it off her. CNA- G did not indicate she had provided any cares to R361 prior to the fall. Acting Director of Nursing (ADON)-C documented that she was in the office on 11/12/24 when she heard a loud thump and then seconds later heard yelling coming from a woman. When ADON- C arrived, R361's family member was screaming at staff stating that the dresser was on top of R361. ADON- C observed R361 laying on her back leaning toward her right side with the family member behind her trying to lift R361 up. The floor nurse dialed 911 as well as R361's family member called 911. R361's family member had asked why staff had not done rounds and ADON- C explained that R361 was last checked on at 6:30 p.m. by nursing staff and stated R361 was sitting in her recliner with the call light in reach. R361 had stated that she had called for help to go to the bathroom, nobody came so she tried to go to the bathroom herself and fell on the ground. Surveyor noted there are conflicting statements about where R361 was seated during observations prior to their fall. Surveyor noted staff identified R361 being seated in a Broda chair and others state a recliner. This would be relevant information to know as part of the investigation of the fall. Registered Nurse (RN)-H documented that she had heard the yelling coming from the C- Unit at 7:00 p.m. and went to make sure all residents were safe. RN- H observed R361 sitting on her buttock on the floor with her legs stretched forward facing the door. The dresser was lying on the floor adjacent to R361. RN- H assessed R361 for injuries. No signs of apparent injuries and denied pain. R361 was incontinent of stool at the time of the assessment. No walker or wheelchair nearby. The call light was not on. At 6:30 p.m., RN-H stated she was in R361's room administering medications and R361 was eating supper. The CNA assigned to R361 was entering room to assist R361 with supper. Surveyor noted that after reviewing the written statements included in the fall's investigation, no staff member had provided a time that they provided cares for R361. There is no information as to when R361 was last toileted or if anyone had heard R361 requesting help to go to the bathroom. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/2/24 at 1:50 p.m., Surveyor interviewed NHA-A regarding the 11/12/24 fall investigation for R361. NHA-A confirmed that no one had witnessed R361's fall. NHA-A stated that is was right after R361's family member-K arrived to the unit and then entered the resident's room that she (family member-K) began yelling loudly regarding the dresser being on top of R361. NHA-A stated that family member-K would not allow R361 respond to questions about what had happened and how the dresser fell to the ground. NHA-A stated that there was no possible way that the dresser had fallen on R361 and that maybe family member-K had pushed it to the floor. NHA-A stated that staff were trying to calm family member-K down and that staff and family member-K had separately called 911. NHA-A stated that Maintenance staff came into room after the incident and tried to re-enact the fall and see how the dresser ended up on the ground. It was said that nobody could believe that R361 could have knocked over the dresser when she fell as it was a heavy piece of furniture. NHA- A was asked who was assigned to care for R361 on 2nd shift 11/12/24. NHA-A stated she was not aware and would have to follow-up. Surveyor asked why the investigation did not include information about the last time R361 was assisted with toileting because R361 claimed she had been waiting for a long time for help to go to the bathroom and that is when she decided to take herself, resulting in the fall. NHA-A stated that the focus of the investigation became about the dresser and if it had really fallen on R361. NHA-A stated that the dresser was removed from R361's room right away and was replaced. It did not appear that there was anything structurally wrong with the dresser that would have caused it to fall to the ground. Surveyor conducted a review of the staff schedule for 11/12/24. It was noted that not all of the staff that were working on the 2nd shift on 11/12/24 and may have had knowledge about the fall, were interviewed as part of the investigation into R361's fall. On 12/3/24 at 8:32 a.m., Surveyor spoke with Scheduler- D who provided an explanation of the schedule and how the assignments were made. Scheduler- D stated that on the 2nd shift on 11/12/24, the nurse would have made the assignments for what CNA was responsible for caring for what residents. Scheduler- D was unable to confirm what CNA was assigned to provide cares for R361 on 2nd shift on 11/12/24. As of the time of exit from the survey, NHA-A also was not able to provide confirmation who was responsible for providing cares to R361 on 11/12/24 on 2nd shift. On 12/3/24 at 10:03 a.m., Surveyor interviewed Plant Operations Director (POD)- I regarding R361's fall and the allegation that the dresser had fallen on top of her. POD- I stated that the wardrobe was full of R361's belongings at the time of the fall and staff had observed the wardrobe on the ground. The dresser/ wardrobe was put upright and back in place in R361's room after she was transported out. POD- I stated that they had tried to move the dresser to determine how the dresser fell and it proved to be very difficult for Maintenance staff to get the dresser to tip and rock back and forth. POD-I stated that the same dresser is still in place in the room that R361 resided and there was no damage to the dresser and all drawers, and the doors were functioning properly. POD- I stated that they did not check the condition of any of the other dressers/ wardrobes in other resident rooms and there have not been any other incidents involving falls and furniture. The facility conducted a falls investigation with the primary focus being on the dresser and if it had actually fallen on R361 the night of 11/12/24. The facility's investigation did not include a root cause analysis regarding the actual fall itself and why R361 attempted to toilet herself after requesting assistance and not receiving it. In addition, the facility did not assure that all dressers/ wardrobes were secured/safe and in good repair.