

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525523	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2025
NAME OF PROVIDER OR SUPPLIER Alexian Village of Milwaukee		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>20243</p> <p>Based on interviews, record review, and facility policy review, the facility failed to notify the resident representative of a fall for one of three residents (Resident (R) 7) reviewed for notification out of a total sample of 17. This has the potential to cause family members to not have the opportunity to be involved in the resident's care.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Change in a Resident's Condition or Status, revised 02/2022, indicated that the community . shall promptly notify the resident, his or her health care provider, and representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). Unless otherwise instructed by the resident, a nurse will notify the resident's representative, consistent with his or her authority, when . The resident is involved in any accident or incident that results in an injury including injuries of an unknown source .</p> <p>Review of R7's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/18/24 and provided by the facility revealed the resident had a Brief Interview for Mental Status (BIMS) score of five out of 15, which indicated the resident was severely cognitively impaired. It was recorded that R7 had diagnoses that included diabetes mellitus, hyperlipidemia, thyroid disorder, osteoporosis, hip fracture, and seizure disorder.</p> <p>Review of R7's Interdisciplinary Notes, dated 11/22/24 and provided by the facility, indicated that R7 experienced an unwitnessed fall at 3:20 PM. R7 was found lying down on the floor, alert, giggling, and with a pillow under her head. R7 stated that she did not know how she got to the floor.</p> <p>During an interview on 03/20/25 at 9:00 AM, the Administrator and Director of Nursing (DON) were requested to provide documentation of notification to R7's representative of the fall on 11/22/24.</p> <p>During an interview on 03/20/25 at 4:00 PM, Medical Records (MR) stated that representative notification could not be located.</p> <p>During an interview on 03/20/25 at 5:30 PM, the Administrator stated that her expectation was that family representatives, case workers and physicians be notified of any falls.</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20243</p> <p>Based on review of facility policy, record review, and interview, the facility failed to ensure the right to be free from verbal and potential sexual abuse for two residents (Residents (R) 3 and R12) of four residents reviewed for abuse/neglect out of a total sample of 17. The facility failed to ensure R3 was protected from verbal abuse by Certified Nursing Assistant (CNA1). The facility failed to protect R12 from potential sexual abuse from R13. These failures had the potential to cause physical harm, pain, or mental anguish.</p> <p>Findings include:</p> <p>Review of a facility policy titled, Abuse Prevention, dated 08/2024, indicated, . The community's goal is to achieve and maintain an abuse-free environment. As part of the resident abuse prevention program, the administration will provide a safe resident environment and protect the residents from abuse by anyone including community associates, other residents, consultants, volunteers, associates from other agencies, family members, legal representatives, friends, visitors, or any other individual . This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. Sexual abuse is non-consensual sexual contact of any type with a resident . Generally, sexual contact is non-consensual if the resident appears to want the contact to occur but lacks the cognitive ability to consent .</p> <p>1. Review of a document provided by the facility titled, Profile Face Sheet indicated R3 was admitted to the facility on [DATE] with diagnoses that included polyneuropathy, rheumatoid arthritis, depression, and anxiety.</p> <p>Review of R3's quarterly Minimum Data Set (MDS), provided by the facility and with an Admission Reference Date (ARD) of 02/10/25, recorded R3 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact.</p> <p>Review of a Facility Related Incident (FRI), provided by the State of Wisconsin, indicated that R3 was verbally abused by Certified Nursing Assistant (CNA1). Review of a Facility investigation revealed that on 12/05/24 at 2:00 PM, the Administrator was answering a call light and walked into R3's room. R3 was in her wheelchair crying. She reported that CNA1 had hit her hand in the dining room after she had spilled her food and plate on the floor. R3 also stated that CNA1 came into her room and told her I'll be watching you. R3 stated that made her fearful. The schedule was reviewed and CNA1 had worked that evening. CNA1 was suspended from work pending investigation. An x-ray was ordered on R3's hand that resulted in no fractures. Staff were interviewed and no one witnessed CNA1 hitting the resident on her hand. Witnesses at the time stated that CNA1 yelled at R3. Skin assessments were completed with no negative outcome.</p> <p>Interview with R3 on 03/19/25 at 1:33 PM revealed, [CNA1] got mad at me because I spilled my food on the floor. She hit my hand and yelled at me. R3 became upset and the questioning was stopped. R3 stated she is happy in the facility and feels safe now that the CNA is no longer there.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of CNA1's personnel file revealed that she was terminated on 12/18/24. She had previous incidents where she was confrontational with staff and had been counseled.</p> <p>During an interview with the Administrator on 03/20/25 at 5:26 PM, the Administrator stated, This facility will not tolerate abuse of any kind. The police will be called and if substantiated, then the employee will be terminated.</p> <p>2. Review of R12's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/12/24 and provided by the facility, indicated R12 was admitted to the facility on [DATE] and had diagnoses of dementia, gastroesophageal reflux disease without esophagitis, and osteoarthritis. It was recorded that R12 did not have a Brief Interview for Mental Status (BIMS) score for cognitive status.</p> <p>Review of R12's Care Plan, dated 12/24/24 and provided by the facility, indicated R12 had memory problems, impaired decision-making skills, and impaired ability to comprehend dementia.</p> <p>Review of R13's quarterly MDS with an ARD of 12/11/24 and provided by the facility indicated that R13 was readmitted to the facility on [DATE] with diagnoses of cancer, coronary artery disease, heart failure, colitis, renal insufficiency, diabetes mellitus, hyperlipidemia, dementia, and depression. It was recorded R13's BIMS score was 10, which indicated R13 was moderately cognitively impaired.</p> <p>Review of the facility's Incident Investigation Summary, dated 03/02/25 and provided by the facility, indicated that R13's guardian reported that R13 attempted to get into bed with R12. The investigation revealed the resident fell while trying to get it in the bed. After the incident R12 was moved to a different unit, psychiatric services were ordered, and behavior monitoring for R13 was being conducted.</p> <p>In an interview on 03/18/25 at 2:25 PM, R13 stated that he missed his lady friend who is now living downstairs. When asked what happened, R13 stated that R12 asked him to sleep with her. R13 stated that when he got into R12's bed he knew they were not aligned in the bed properly. When asked if R12 was awake, R13 did not respond. R13 stated that R12 was ok with him getting in bed with her and that they were both dressed for sleep.</p> <p>In an interview on 03/20/25 at 5:30 PM, the Administrator stated that R13's friendship with R12 was known by staff. The Administrator stated that the expectation was for all known resident relationships to be communicated to the interdisciplinary team so that assessments and interventions will be initiated and implemented.</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>20243</p> <p>Based on observation, document review, interview and facility policy review, the facility failed to prevent misappropriation of resident property for five of five sampled residents (Resident (R) 9, R10, R11, R16, and R17). The facility failed to ensure security resulting in narcotic drug diversion by one of one staff (Registered Nurse 1). Failure to protect residents' property has the potential to affect the residents mental, emotional and financial status.</p> <p>Findings include:</p> <p>Review of facility's policy titled, Personal Property revised on 12/19 indicated that residents are permitted to retain and use personal possessions and appropriate clothing as space permits. A representative of the admitting office will advise the resident, prior to or upon admission, as to the types and amount of personal clothing and possessions that the resident may keep in his or her room.</p> <p>1. Review of facility's Investigation Summary Folder indicated that on 01/31/25 the former Social Services Director (FSSD) notified the Administrator that R11's envelope containing her wallet, \$283.00 in cash, credit card, debit card, driver's license and a Foodshare card were missing from the locked closet in the SSD office.</p> <p>The Administrator and Business Office Manager (BOM) inspected and reconciled all Valuable Envelopes found in the SSD's closet. The audit revealed that R9 was missing \$352.00; R10 was missing \$90.00; R16 was missing \$1.00; and R17 was missing \$15.00.</p> <p>Review of the facility's Investigative Summary dated 02/07/25 indicated that R9 and R10's money would be reimbursed.</p> <p>Review of R9's Check Request Form dated 02/14/25 indicated a request to submit \$352.00 reimbursement to R9's trust fund.</p> <p>Review of the facility's Investigation Summary Folder indicated that there was no documentation of receipt for actual reimbursement to R9 for \$352.00, R10 for \$90.00, R16 for \$1.00 and R17 for \$15.00.</p> <p>Review of the facility's Investigation Summary Folder provided by the facility indicated that there was no documentation of a receipt for actual reimbursement to R11 for driver's license replacement.</p> <p>In an interview on 03/20/25 at 9:00 AM documentation was requested for reimbursements from the Administrator. No additional documentation was provided by the facility.</p> <p>In an interview on 03/20/25 at 2:30 PM the SSD stated that he was aware of the process for handling resident valuables. The SSD stated that Social Services is not involved in the process and does not keep valuables in the SSD office. The SSD stated that residents' valuables kept in a locked box in the medication room and maintained by nursing staff who have keys to the medication room.</p> <p>(continued on next page)</p>

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 03/20/25 at 2:45 PM, Licensed Practical Nurse (LPN)2 unlocked the medication room door. Observation of a large black box on top of the counter, locked with a binder notebook next to it.</p> <p>In an interview on 03/20/25 at 5:30 PM the Administrator stated that going forward her expectation is that the new system will remain secure, that residents and staff are educated on a continual basis, and that the facility's Quality Assessment Performance Improvement (QAPI) committee will continue to monitor the process.</p> <p>2. Review of the undated facility's policy titled, Controlled Medication Management; Suspected Diversion, revealed, . audit of all narcotics for correct medication and counts; staff with access to the controlled medication lock box will be sent for drug testing and background checks reviewed; MD [physician] notified along with the Medical Director and police department .storage cabinet for controlled substances for destruction is to be fixed and not moveable; slot large enough to put medications in, small enough that no one can put an arm in it or other item to retrieve controlled substances for destruction; deep enough that medications cannot be retrieved .</p> <p>Review of a Facility Related Incident (FRI) provided by the State of Wisconsin indicated that the facility identified that a diabetic injection pen was missing that was supposed to have been delivered by the pharmacy. Both floor nurses stated that they had not received the medication. Video footage from 12/10/24 was reviewed by the Assistant Director of Nursing (ADON) and the issue was resolved. Upon review of the video, RN1 was seen removing drugs with a coat hanger from the third-floor narcotic destruction box. RN1 put the pills in her pockets. The Director of Nursing (DON) was notified and reviewed the video footage. The Administrator was notified and RN1 was removed from the floor and brought to the Administrators office. A urine drug test was completed and was negative. The police were called and could not come to the facility due to a snowstorm. RN1 was suspended and never came back to the facility. RN1 was an agency nurse who had been employed by the facility for two years.</p> <p>Interview on 03/19/25 at 2:19 PM, the Staffing Coordinator (SC) stated, I do not know why I do not have RN1's background check. I have checked my emails, and I do not have one from Prime Med Staffing. The agency sends one to us before hire. RN1 was hired on 09/16/22 and left on 12/19/24. When asked why she did not call and get one on RN1, SC stated I do not know.</p> <p>During an interview on 03/19/24 at 2:28 PM with the Director of Nursing Prime Med (DPM) revealed Background checks are sent to the facility by email. I have no idea if I sent one or not. My email does not go back that far. RN1 was eligible for work on 07/01/22 when I checked her license. An incident took place involving RN1 and a resident credit card from a different facility and her license was suspended on 11/03/22. RN1 was working for Alexian Village at the time of her suspension. We are not notified of suspended licenses.</p> <p>Interview on 03/19/25 at 3:40 PM, the police department stated that it was an ongoing investigation and no further details were given.</p> <p>During an interview with the Regional Clinical Nurse (RCN) on 03/19/25 at 4:46 PM revealed, The facility called me about this incident, and I requested to see the video. RN1 took medications out of the narcotic destruction box. I told the facility to call the police, do a urine test on RN1, complete education on drug diversion, and complete an audit of all medications. I had a verbal communication with the DON that all had been completed.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A receipt was provided to the survey team for a new destruction box that is waist high and bolted to the floor on the second floor. Pharmacy records were reviewed for a medication audit of both medication carts and storage rooms, along with the Cubex that stores emergency drugs and the destruction box. The facility provided an in-house audit of all drugs, and no other drugs were missing. Drug diversion training was provided for all staff and sign-in sheets were reviewed. Human Resources provided a list of all new hires for 2025 to 03/20/25, and all background checks had been completed.</p> <p>The contract for Prime Med Staffing was reviewed. The contract was dated 03/15/21 and stated Nurse Qualifications as follows: Caregiver Background Check Process; Wisconsin Nurse Aide Training and Registry Information; WI Caregiver Misconduct Registry.</p> <p>Review of RN1's background check provided by Prime Med Staffing revealed On 01/25/21, RN1 had an incident involving a fentanyl patch. The facility at the time concluded that the patch was never given to the resident and a verbal warning and training was provided to RN1. However, RN1 was terminated on 04/12/21. On 05/08/22, RN1 was now working in a different facility, and an incident took place of a credit card taken from a resident and used. RN1 was terminated from that facility on 05/18/22. For a period of at least two years, agency shall provide a copy of this Order immediately to supervisory personnel at all settings where RN1 works as a caregiver. On 12/08/22, the Wisconsin Board of Nursing issued a Final Decision and Order limiting RN1's license to practice as a registered nurse with certain terms and conditions. Pursuant to the Order, Respondent's license may be suspended, without hearing, for substantial or repeated violation of any provision. Information has been received that demonstrates RN1 is in violation of the terms of the Order. As a result, the following is entered: 1.) RN1's professional nursing license is hereby suspended until further notice. 2.) This order is effective at the date of its signing. Signed 01/23/25, Wisconsin Board of Nursing.</p> <p>43050</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43050</p> <p>Based on interview, record review, and review of facility policy, the facility failed to ensure that allegations of injury of unknown origin, verbal abuse, and neglect were reported to the State Survey Agency (SSA) in a timely manner for three residents (Resident (R) 2, R3, and R5) reviewed in a total sample of 15 residents. Specifically, the facility failed to report timely an allegation of injury of unknown origin involving R2; an allegation of verbal abuse involving R3; and an allegation of neglect involving R5. This failure had the potential for other allegations to not be reported in a timely manner.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Abuse Investigation and Reporting, dated 12/2024 indicated, . Alleged violations involving abuse, neglect, exploitation or mistreatment will be reported immediately but not later than two hours .</p> <p>1. Review of R2's Profile Face Sheet indicated R2 was admitted to the facility on [DATE] with diagnoses of Alzheimer's, congestive heart failure, and chronic kidney disease.</p> <p>Review of a Facility Related Incident (FRI) provided by the State of Wisconsin indicated that R2 had an injury of unknown origin resulting in skin tears to her little and middle fingers of the right hand. The incident occurred on 10/20/24 and was not reported to the SSA until 12/09/24.</p> <p>2. Review of R3's Profile Face Sheet indicated R3 was admitted to the facility on [DATE] with a diagnoses of polyneuropathy, rheumatoid arthritis, depression, and anxiety.</p> <p>Review of an FRI provided by the State of Wisconsin indicated that R3 was verbally abused by Certified Nursing Assistant (CNA1). This verbal abuse was reported by the resident on 12/05/24 and not reported to the SSA until 12/12/24.</p> <p>3. Review of R5's Profile Face Sheet indicated R5 was admitted to the facility on [DATE] with diagnoses of fracture of lower end of femur, contracture of right knee, and lymphedema.</p> <p>Review of a FRI provided by the State of Wisconsin indicated that R5 was neglected by the facility for not providing care. This incident took place on 12/26/24 and was not reported to the SSA until 01/03/25.</p> <p>4. Review of a FRI provided by the State of Wisconsin indicated misappropriation of property (Drug Diversion). The incident was found while watching a video tape on 12/19/24 of a Registered nurse (RN1) taking drugs from the narcotic destruction box. This incident was not reported to the SSA until 12/20/24.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/20/25 at 5:26 PM, the Administrator revealed My expectations are that reporting needs to be immediate for abuse, neglect, and injuries of unknown origin. Then the investigation has to be completed within five days or notify the SSA of why it is not complete and send in what you have.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43050</p> <p>Based on review of facility policy, record review, and interview, the facility failed to ensure two resident (Resident (R) 3 and R5) out of a sample of three residents reviewed for abuse allegations, had a thorough investigation completed for R5 and the five-day report was not submitted timely to the State Agency (SA) for R3. This failure had the potential to lead to continued episodes of abuse.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Abuse Investigation and Reporting, dated 12/2024, .The Administrator will monitor that any further potential abuse, neglect, exploitation, or mistreatment is prevented while the investigation is in progress .Review the resident's medical record to determine events leading up to the incident .Interview the person reporting the incident, any witnesses, staff on all shifts who had contact with the resident, the resident's roommate, family members, and visitors. Interview other residents to whom the accused employee provides care or services, and review camera footage if available .Alleged violations involving abuse, neglect, exploitation or mistreatment will be reported immediately but not later than two hours .The Administrator or designee, will provide the appropriate agencies with a written report of the findings of the investigation within five working days of the occurrence of the incident.</p> <p>1. Review of a document provided by the facility titled Profile Face Sheet indicated R3 was admitted to the facility on [DATE] with a diagnoses of polyneuropathy, rheumatoid arthritis, depression, and anxiety.</p> <p>Review of a Facility Related Incident (FRI) provided by the State of Wisconsin indicated that R3 was verbally abused by Certified Nursing Assistant (CNA1). This verbal abuse was substantiated. Further review of the FRI revealed that the facility failed to submit in the five-day reporting to the State Agency (SA) the outcome of CNA1.</p> <p>2. Review of a document provided by the facility titled Profile Face Sheet indicated R5 was admitted to the facility on [DATE] with diagnoses of fracture of lower end of femur, contracture of right knee, and lymphedema.</p> <p>Review of a FRI provided by the State of Wisconsin indicated that R5 was neglected by the facility for not providing care. Further review of the FRI revealed that the facility failed to interview other residents on the night in question.</p> <p>During an interview with the Administrator on 03/20/25 at 5:26 PM, the Administrator stated, My expectation is that a complete investigation will take place with interviews of witnesses and staff, record review, and the investigation should tell a story, a complete story.</p>		