

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  07/28/2025
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)		
F 0609  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.  (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER  
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility did not report to the State survey agency and/or Law Enforcement in a timely manner timely for 1 (R2) of 1, abuse allegations reviewed.* On 6/2/2025, R2 reported an incident to Physical Therapy (PT)-D of inappropriate touching from R1. Staff did not report the allegation to Nursing Home Administrator (NHA)-A until 6/3/25. Findings include: The facility's policy, titled Abuse Investigation and Reporting, dated as last approved 12/2024, documents: Reporting: A. Alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of property will be reported to the administrator or designee. B. Alleged violations involving abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported: 1. Abuse or serious bodily harm - Immediately but no later than 2 hours. R2 was admitted to the facility on [DATE] with diagnoses of Falls, Pneumonia, Heart Failure and Atrial Fibrillation. R2's Discharge Minimum Data Set (MDS), dated [DATE], documented a brief interview mental status (BIMS) score of 15, indicating R2's cognition was intact. The MDS also documented that R2 was understood and understands others. The facility's self-reported incident dated 6/3/2025 documented: The following is a summation of the investigation regarding R1 and R2. R2 reported that R1 put her hands down R2's pants. Administrator notified 6/3/25 at 11:00 AM; Initial self-report submitted to the state on 6/3/25 at 11:37 AM. Initial Intervention/Response to Allegation: Residents were separated, alleged victim moved to assisted living facility. The facility's self-report included a statement from R2 which documented: Can you tell me what happened? This resident (R1) wanted to latch onto me (R2) always walking at me. At lunch yesterday (6/2), she came over to me and put her (R1) hand on my left leg. Who did you report this incident to? Physical Therapy. Surveyor reviewed the Facility Investigative Summary, which documented, that the affected resident reported the event to a member of the therapy team, who wrote the information on a stop and watch form. The Stop and Watch Early Warning Tool written by Physical Therapist (PT)-D and dated 6/2/25 at 6:45 PM documents: The patient (R2) reported that while in the dining room for lunch, R1 put a hand inside his (R2) shorts- He (R2) told R1 to stop which R1 did and then reported the incident to the nurse on R2's unit. Surveyor noted that NHA-A was notified of the incident on 6/3/25 at 11:00 AM, while the incident occurred, and staff was aware on 6/2/25 at 6:45 PM. Surveyor noted there was at least a twelve-hour delay in facility staff reporting the potential sexual abuse incident to NHA-A. On 7/9/2025, at 10:03 AM, Surveyor interviewed PT-D, the therapist that filled out the Stop and Watch form. PT-D stated that PT-D notified the Nurse (RN)-C, on the unit and gave the Stop and Watch form to RN-C. The form was dated 6/2/2025. PT-D stated, R2 reported another resident in the lunchroom touched R2's leg and moved up and put R1's hand in R2's shorts. R2 told R1 to stop and R2 removed himself from the table. On 7/9/2025, at 11:40 AM, Surveyor interviewed RN-C, who stated that RN-C remembers working on 6/2/2025, and remembers receiving the Stop and Watch form from PT-D. RN-C indicated that, he didn't update anyone. RN-C informed surveyor that RN-C talked to R2, about the allegations and R2 stated nothing happened. RN-C stated, I don't know why they're making a big deal of this, because the resident denied it, so I wouldn't need to report it. Surveyor noted that NHA-A was notified of the incident on 6/3/25 at 11:00 AM, while the incident occurred, and staff was aware on 6/2/25 at 6:45 PM. Surveyor noted there was at least a twelve-hour delay in facility staff reporting the potential sexual abuse incident to NHA-A. On 7/9/2025, at 12:18 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Clinical Services (DCS)-B, NHA-A stated the Stop and Watch form should not be used for reporting abuse. NHA-A indicated that RN-C should report abuse right away to NHA-A. NHA-A stated this is why we did the plan of correction, because of the late reporting. Surveyor stated still having concern with reporting, as RN-C, during an interview with surveyor stated that RN-C did not need to report that incident. On 7/28/25 at 2:37 PM, Surveyor interviewed NHA-A regarding the above incident. Surveyor asked NHA-A if the above incident should have been reported immediately to NHA-A. NHA-A informed Surveyor that RN-C and PT-D should have reported the above incident immediately and not utilized the Stop and Watch form to report abuse. No additional information was provided as to why facility did not ensure that R2's allegation of abuse was not reported in a timely manner to NHA-A.</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility did not ensure residents received the necessary behavioral health care and services to maintain the highest practicable mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care for 1 (R1) of 1 resident reviewed for related to the residents emotional and mental well-being.*Surveyor reviewed a facility self-report from 6/13/2025, which pertained to behaviors of inappropriate touching with R1 being the aggressor. Nurse Practitioner (NP)-E, stated that currently R2's, psychiatric services are being managed by NP-E. NP-E indicated not being updated regarding alleged behaviors of R1's hands going inside of R2's shorts. There was no documentation that R1's POA was contacted in attempt to obtain consent for psychiatric services. Findings include:R1 was admitted to the facility on [DATE] with diagnoses of dementia and depression.R1's quarterly Minimum Data Set (MDS), dated [DATE], documented a brief interview of mental status (BIMS) score of 1, indicating severe cognitive impairment, is sometimes understood and sometimes understands others. Surveyor noted a care plan was not initiated to address R1's depression including how depression was manifested for R1 or interventions to address those manifestations.Surveyor reviewed a document titled, Psychiatric Consult, dated 1/13/2025, documented: Case discussed with staff at BMC (Behavior Management Consult) meeting. They report that Resident has been tearful latterly for unknown reasons. Would recommend increasing the Depakote back to 250mg BID (twice a day).Crying and anxiety appear to be related to her dementia and Depakote will assist stabilizing the mood to assist in treating her current symptoms. Will plan to follow up in 1 month once she (R1) has had to time to adjust. Staff encouraged to notify BSI (Behavioral Solutions) with any concerns. R1 had discontinued services in February 2025, due to services no longer being available from that provider. The facility had the NP (nurse practitioner)-E take over care for Psychiatric care until they can get a new consent form signed by R2's Power of Attorney (POA). However, Surveyor could not locate any documentation that NP-E was actively being notified of R1's behaviors. Surveyor reviewed facility's self-reported incident dated 6/3/2025 documented: The following is a summation of the investigation regarding R1 and R2. R2 reported that R1 put her hands down R2's pants. Administrator notified 6/3/25 at 11:00 AM; Initial self-report submitted to the state on 6/3/25 at 11:37 AM. Initial Intervention/Response to Allegation: Residents were separated, alleged victim moved to assisted living facility. The facility's self-report included a statement from R2 which documented: Can you tell me what happened? This resident (R1) wanted to latch onto me (R2) always walking at me. At lunch yesterday (6/2), she came over to me and put her (R1) hand on my left leg.Who did you report this incident to? Physical Therapy. Surveyor reviewed the Facility Investigative Summary, which documented, the affected resident reported the event to a member of the therapy team, who wrote the information on a stop and watch form.The Stop and Watch Early Warning Tool written by Physical Therapist (PT)-D and dated 6/2/25 at 6:45 PM documents: The patient (R2) reported that while in the dining room for lunch, R1 put a hand inside his (R2)shorts- He (R2) told R1 to stop which R1 did and then reported the incident to the nurse on R2's unit. Surveyor noted that NHA-A was notified of the incident on 6/3/25 at 11:00 AM, while the incident occurred, and staff was aware on 6/2/25 at 6:45 PM. Surveyor reviewed R1's medical record and could not locate any documentation that R1's psychiatric provider was notified of R1's behavior on 6/2/25. Surveyor could not locate any documentation that R1 received medically related social services to debrief and evaluate R1's behaviors on 6/2/25. Surveyor could not locate any documentation that NP-E was notified of R1's behaviors on 6/2/25.On 7/9/2025, at 12:18 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Clinical Services (DCS)-B. Surveyor asked for documentation of the POA being reached out to for psych services. NHA-A indicated there was no documentation showing the POA was contacted or how many times the facility reached out to the POA.At the end of the day meeting, Surveyor informed both NHA-A and DCS-B of concern that R1 had behaviors that were not reported to the medical professional that was overseeing R1's psychiatric services. There was no documentation that R1's POA was informed or received a request for R1 to receive psychiatric services after 1/13/25 or that staff contacted NP-E after R1's behavior on 6/2/25. No additional information was provided as to why the facility did not ensure that R1 received medically related social services after 1/13/25 and after 6/2/25.</p>		