

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/31/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525524	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2024
NAME OF PROVIDER OR SUPPLIER St Anne's Salvatorian Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 3800 N 92nd St Milwaukee, WI 53222	
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28154 Based on interview, record review, and facility policy review, the facility failed to report to the State Survey Agency (SA) an allegation of physical abuse for one of two residents (Resident (R) 6) reviewed for abuse out of a total sample of 16. This had the potential to compromise or impede the protection of residents when allegations of abuse were made. Findings include: Review of R6's Admission Record, from the electronic medical record (EMR) Profile tab, showed a facility admitted [DATE] with medical diagnoses that included psychosis, intellectual disabilities, type II diabetes, neuropathy, cognitive communication deficit, and major depressive disorder. Review of R6's Progress Note, dated 06/20/24 at 5:41 PM and located under the Progress Notes tab of the EMR, revealed, . Writer was informed by CNA [Certified Nurse Aide] staff a man slapped resident while in the dining room during supper, resident was taken to the room by staff, writer proceeded to go and talk to resident to obtain details as to what happened in the dining room. Resident stated she was given a cheeseburger and was not suppose [sic] to have it, writer then stated did you eat the cheeseburger, resident stated no, she ate a jelly sandwich instead. Writer then proceeded to ask resident about being slapped by a man in the dining room, resident was speaking quickly with jumbled words, Writer then asked were you slapped by anyone in the dining room, resident stated no, writer asked resident did anyone touch you while in the dining room, resident stated no, resident stated the man waved at her and said he can't talk right now. Writer spoke with dining room server and was informed resident was calling for the male kitchen staff person to come over by her and when the male staff waved hello and said he couldn't talk, resident became upset because he would not come to her when she called him and she yelled out loud. ADON [Assistant Director of Nursing] made aware and male staff were reminded to be mindful of their distance and no touching of resident . Review of a handwritten list of facility reported incidents, provided by the Administrator, revealed no documented evidence that the allegation of physical abuse involving R6 was reported to the SA. During an interview on 08/07/24 at 2:30 PM, the Administrator confirmed the incident was not on the list of facility reported incidents that was provided to the surveyor. The Administrator stated she was still working with the previous administrator on 06/20/24 and did not know why the allegation had not been reported to the SA. (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	During an interview on 08/07/24 at 6:34 PM, the Nurse Consultant (NC) stated the expectation was for allegations of abuse, neglect, or misappropriation to be reported to the SA. The NC confirmed that slapping was an allegation of physical abuse. Review of the facility's policy titled, Comprehensive Abuse, [sic] Neglect, Mistreatment and Misappropriation of Resident Property Program, reviewed 11/08/23, revealed, . Physical Abuse includes hitting, slapping, punching, biting, and kicking . It is the policy of this facility that abuse allegations are reported per Federal and State Law. The facility will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury . to the Executive Director of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures . Employees must always report any abuse or suspicion of abuse immediately to the Executive Director . The Executive Director, will involve key leadership personnel as necessary to assist with reporting, investigation and follow up . Initial reporting of allegations: If an incident or allegation is considered reportable, the Executive Director or designee will make an initial (immediate or within 24 hours) report to the State Agency. A follow up investigation will be submitted to the State Agency within five (5) working days. When making a report, Misconduct Incident Reporting (MIR) system will be use .		

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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** 28154 Based on interview, record review, and facility policy review, the facility failed to complete a thorough investigation of an allegation of physical abuse for one of two residents (Resident (R) 6) reviewed for abuse out of a total sample of 16. The failure to conduct a thorough investigation had the potential to compromise and/or impede the protection of residents against abuse. Findings include: Review of R6's Admission Record, from the electronic medical record (EMR) Profile tab, showed a facility admitted [DATE] with medical diagnoses that included psychosis, intellectual disabilities, type II diabetes, neuropathy, cognitive communication deficit, and major depressive disorder. Review of R6's Progress Note, dated 06/20/24 at 5:41 PM and located under the Progress Notes tab of the EMR, revealed, . Writer was informed by CNA [Certified Nurse Aide] staff a man slapped resident while in the dining room during supper, resident was taken to the room by staff, writer proceeded to go and talk to resident to obtain details as to what happened in the dining room. Resident stated she was given a cheeseburger and was not suppose [sic] to have it, writer then stated did you eat the cheeseburger, resident stated no, she ate a jelly sandwich instead. Writer then proceeded to ask resident about being slapped by a man in the dining room, resident was speaking quickly with jumbled words, Writer then asked were you slapped by anyone in the dining room, resident stated no, writer asked resident did anyone touch you while in the dining room, resident stated no, resident stated the man waved at her and said he can't talk right now. Writer spoke with dining room server and was informed resident was calling for the male kitchen staff person to come over by her and when the male staff waved hello and said he couldn't talk, resident became upset because he would not come to her when she called him and she yelled out loud. ADON [Assistant Director of Nursing] made aware and male staff were reminded to be mindful of their distance and no touching of resident . During an interview on 08/07/24 at 2:30 PM, the Administrator confirmed there had not been an investigation of the allegation of physical abuse involving R6. During an interview on 08/07/24 at 6:34 PM, the Nurse Consultant (NC) confirmed that slapping was an allegation of physical abuse. The NC stated the expectation was that abuse allegations would be investigated. The NC confirmed that an investigation should have been conducted related to R6's allegation she had been slapped and that the investigation would include interviewing all staff present and other residents. Review of the facility's policy titled, Comprehensive Abuse, [sic] Neglect, Mistreatment and Misappropriation of Resident Property Program, reviewed 11/08/23, revealed, . It is the policy of the facility that each resident will be free from abuse. The term abuse will be used throughout this Policy and Comprehensive Abuse, Neglect, Mistreatment and Misappropriation of Resident Property Program to relate to . physical abuse . Investigation . The investigation is the process used to try to 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. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Investigation of Abuse: When an incident or suspected incident of abuse is reported, the Executive or designee will investigate the incident with the assistance of appropriate personnel . The investigation will include: i. Who was involved ii. Residents' statements . iv. Involved staff and witness statements of events v. A description of the resident's behavior and environment at the time of the incident vi. Injuries present including a resident assessment vii. Observation of resident and staff behaviors during the investigation viii. Environmental considerations *All staff must cooperate during the investigation to assure the resident is fully protected .		