STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525524	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Anne's Salvatorian Campus	3800 N 92nd St Milwaukee, WI 53222

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49435 Based on observations, interviews, and record review, the facility did not ensure that residents with pressure injuries received necessary treatment and services consistent with professional standards of practice to promote healing and prevent new pressure injuries from developing for 1of 2 residents (R5) reviewed for pressure injuries. R5, who was assessed to be at risk for pressure injuries, developed a stage 2 coccyx pressure injury on [DATE]. Facility staff did not complete a thorough assessment with measurements of the pressure injury until [DATE]. R5's care plan was not updated with new offloading interventions after the development of the coccyx pressure injury. On [DATE], R5 developed a Deep Tissue Injury (DTI) to R5's right heel. R5's care plan was not updated with new interventions after the development of the right heel deep tissue injury. The facility wound Nurse Practitioner (NP)-G completed weekly assessments of R5's two pressure injuries. On [DATE], NP-G was unable to complete the weekly assessment. The facility Wound Nurse, who is the Assistant Director of Nursing (ADON)-E, completed R5's wound assessment. ADON-E completed measurements but did not complete a thorough assessment that included a thorough description of the wound bed. On [DATE], R5's coccyx pressure injury declined to an unstageable pressure injury. R5's care plan was not updated with new interventions after the coccyx wound worsened. R5 was hospitalized from [DATE] through [DATE] with sepsis related to bilateral parotitis (inflammation and infection of both parotid glands [salivary glands located in front of the ears]). While hospitalized , R5's pressure injuries were both staged as unstageable. R5 was readmitted to the facility on [DATE] on hospice. Facility staff determined that hospice staff would be responsible for assessing and treating R5's pressure injuries. Communication between the facility and hospice staff was not clear. Hospice Nurse, Registered Nurse (RN)-J told Surveyor that RN-J was not aware that RN-J was the only staff member caring for R5's pressure injury. NP-G was no longer involved in R5's care. From [DATE] through [DATE], R5's coccyx pressure injury was not measured, and a thorough assessment was not documented by the facility staff or hospice staff. From [DATE] through [DATE], hospice staff measured R5's heel wound 3 out of the 6 weeks, but a thorough assessment of the pressure injury was not completed. On [DATE], R5 developed a wound to R5's right lateral leg. The facility staff or hospice did not complete an assessment of R5's wound with measurements or a description of the wound bed. RN-J measured the new wound for the first time on [DATE] and determined the wound was a laceration. Facility staff and Hospice staff did not determine the root cause of the new wound to R5's right lateral leg and did not update R5's care plan with new interventions. On [DATE], R5 died while in hospice at the facility. Findings include: (continued on next page)

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The facility policy titled, Pressure injury prevention and managing skin integrity with a review date of [DATE], documents, in part: Policy: Prevention measures are put in place to reduce the occurrence of pressure injuries . Risk Assessment: . Based on the individual's Braden Scale Score, pressure reduction interventions will be implemented by nursing and documented in the individual's medical record . Identify Interventions: The care and intervention for any identified skin breakdown or wound is intended to prevent any further advancement of the wound or additional skin breakdown . Identification of risk factors present or acquired that compromise skin integrity will be considered. Weekly Wound Rounds: Upon identification of abnormal skin findings, a licensed nurse will complete a skin assessment. Individual with abnormal skin concern(s) will be added to weekly wound rounds. Registered Nurse (RN) or designee will: Conduct weekly skin evaluation. Update the [Primary Care Provider] with any decline in wound appearance, or as necessary. Update the Care plan with any new interventions as applicable . R5 was admitted to the facility on [DATE] with diagnosis that include Chronic Kidney disease, Type 2 Diabetes, Dementia, Stroke history, Encephalopathy and Adult Failure to Thrive. R5's Significant Change Minimum Data Set assessment dated [DATE] documents R5 has a moderate cognitive impairment. R5 is dependent for bed mobility, hygiene cares, and transfers. R5 has a catheter and is always incontinent of bowel. R5 is at risk for pressure injury development but does not have any unhealed pressure injuries. R5's Braden Scale for Predicting Pressure Ulcer Risk assessment dated [DATE] documents a score of 15 making R5 at risk for developing a pressure injury. R5's potential for pressure ulcer development care plan, with an initiation date of [DATE], documents the following interventions: The resident will have intact skin, free of redness, blisters, or discoloration by/through review date. Educate the resident/family/caregivers as to causes of skin breakdown; including: transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition, and frequent repositioning. The resident requires pressure reducing mattress on bed and pressure reducing cushion in [wheelchair]. R5's potential impairment to skin integrity care plan, with an initiation date of [DATE], documents the following interventions: Encourage good nutrition and hydration in order to promote healthier skin. Follow facility protocols for treatment of injury. Keep skin clean and dry. Use lotion on dry skin. Use a draw sheet or lifting device to move resident. Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. R5's progress note dated [DATE] documents, in part: Resident was recently hospitalized for [Altered Mental Status] and delirium. Resident was in hospital from ,d+[DATE] to ,d+[DATE]. [By mouth] intake has decreased. Intake was ~75% most meals, intake is now 38% on average. Writer notified [Registered Dietician] of decrease in intake .Resident receives diabetic house supplement [Every day]. Resident has house snack order in the evening for [Diabetes] and will often snack at other times. Resident might be enrolling in hospice after evaluation. No wounds. Surveyor noted R5's meal consumption was significantly decreased, hospice was being considered due to R5's health decline, and R5 did not have any wounds. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R5's progress note dated [DATE] at 11:27 AM documents: This writer informed that resident had an open area to her coccyx. writer updated resident's daughters and house Nurse Practitioner. Resident will be put on wound rounds to be seen by wound NP on [DATE]. Surveyor reviewed R5's Electronic medical record and did not locate an assessment that included measurements or a thorough description of the coccyx wound bed. Surveyor noted that a comprehensive assessment of R5's coccyx pressure injury was not completed by facility staff on the day the coccyx pressure injury was found. R5's initial Wound Evaluation completed by NP-G dated [DATE] documents, in part: Coccyx (stage 2 pressure ulcer) Partial thickness wound with 100% smooth pink tissue at the base. Wound measuring 1 x 0.7 x 0.1 cm . Plan: Cleanse with [Normal Saline] or wound cleanser, then apply skin prep to the peri wound and cover with bordered foam. Change 3 [times]/week. Continue offloading measures. Surveyor reviewed R5's MD orders. Surveyor noted that the treatment for R5's coccyx wound was entered as a MD order on [DATE]. On [DATE], R5's potential impairment to skin integrity care plan focus was updated with stage 2 open area to coccyx. Surveyor noted the only offloading measures on R5's care plan was an air mattress and cushion in wheelchair. No additional offloading measures like turning and repositioning were implemented after the development of the coccyx pressure injury. On [DATE] 08:26 AM Surveyor interviewed Certified Nursing Assistant (CNA)-F. Surveyor asked what CNA-F would do if CNA-F identified a new wound on a resident. CNA-F stated that CNA-F would report it to the nurse. Surveyor asked if CNA-F was familiar with R5's wound care. CNA-F stated that CNA-F would reposition R5 every 2 hours. CNA-F stated that staff would float R5's heels when R5 was in bed. CNA-F stated aside from that, the nurses took care of the wound care. On [DATE] at 8:04 AM, Surveyor interviewed Registered Nurse (RN)-H. Surveyor asked if RN-H could explain what a nurse should do if a new wound is found on a resident. RN-H stated that RN-H would measure and assess the wound. RN-H stated that not all nurses would do this because they are not all comfortable, but RN-H stated that she would definitely measure and assess the wound. RN-H would call the MD, Risk management team and the Power of Attorney, if applicable. RN-H would put the resident on the 24-hour board and implement an intervention. RN-H stated that it depends on the wound, but would implement repositioning, floating heels, etc. depending on where the wound was found. RN-H stated after finding a wound, the resident would be included in the weekly wound rounds. Surveyor asked if RN-H was familiar with R5 and the development of R5's pressure injuries. RN-H stated that the facility had been speaking with R5's family and they were talking about hospice before the wounds developed. RN-H stated R5's family were not agreeable to hospice in June or July of this year. RN-H stated that staff were implementing repositioning and propping up R5's heels as interventions after R5's wound developed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 10:41 AM, Surveyor interviewed ADON-E. Surveyor asked what the process is when a nurse finds a new wound on a resident. ADON-E indicated the nurse should measure the wound, cover the wound and report it to the MD, Power of Attorney, and the management team. ADON-E stated that the resident would be added to the weekly wound rounds and the NP would do a thorough assessment of the wound and recommend treatment. Surveyor asked what interventions were in place to prevent the development of a pressure injury for R5. ADON-E stated that R5 was on an air mattress, had a cushion on R5's chair and stated R5 was always using a blue floater pillow for floating R5's heels. Surveyor asked if those interventions should be listed on R5's care plan. ADON-E stated yes. On [DATE] at 8:18 AM, Surveyor interviewed Director of Nursing (DON)-B and Clinical Nurse Coordinator (CNC)-D. Surveyor asked what the process is when a nurse finds a new wound on a resident. DON-B stated the nurse should do an assessment, notify the doctor, power of attorney and wound care nurse (ADON-E). Surveyor asked what the initial assessment should include. DON-B indicated the wound should be measured and have a description of the wound bed including the surrounding skin, drainage, and odor. DON-B stated that an intervention should be placed to address the area of concerns. Surveyor noted that staff stated that turning and repositioning, as well as floating heels was possibly implemented but the interventions were not present on R5's care plan so that all staff caring for R5 were aware of plan. R5's MD order dated [DATE] documents: Reduced sugar House supplement between meals twice daily. R5's Wound Evaluation completed by NP-G dated [DATE] documents, in part: Coccyx (stage 2 pressure ulcer). Partial thickness wound with 100% smooth pink tissue at the base. Wound measuring 1.5 x 3.0 x 0.1 cm . Status: deterioration. Plan: Cleanse with [Normal Saline] or wound cleanser, then apply skin prep to the peri wound and cover with bordered foam. Increase frequency of changes to daily and [as needed]. Continue offloading measures. Surveyor reviewed R5's MD orders and noted that the frequency of dressing changes was updated to daily and [as needed]. On [DATE], R5's potential impairment to skin integrity care plan was updated with the following intervention: [Treatment] per MD order. Surveyor noted no additional offloading measures like turning and repositioning were entered on R5's care plan after the coccyx pressure injury deteriorated. R5's Wound Evaluation completed by NP-G, dated [DATE] documents, in part: Coccyx (stage 2 pressure ulcer). Partial thickness wound with 100% smooth pink tissue at the base. Wound measuring 0.2 x 0.8 x 0.1 cm . Continue offloading measures. Right lateral heel (DTI). Absorbing fluid filled blood blister measuring 5 x 7.5 x UTD cm . Status: New. Plan: Apply skin prep followed by ABD pad and secure with kerlix, change 3 [times]/week. Prevalon boot to be worn whenever in bed. Surveyor noted the coccyx wound improved and the treatment remained the same. Surveyor noted R5 developed a new pressure injury to R5's right lateral heel. Surveyor reviewed R5's MD orders and noted the treatment for R5's right lateral heel wound was entered as a MD order on [DATE]. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On [DATE], R5's potential impairment to skin integrity care plan focus was updated with DTI to right lateral heel. Surveyor reviewed R5's Care plan and noted that no new interventions were placed after R5 developed the new pressure injury to R5's Right heel. Surveyor noted NP-G recommended a Prevalon boot to be worn whenever in bed and this intervention was not added to R5's care plan. On [DATE] at 10:41 AM Surveyor interviewed ADON-E. Surveyor asked about interventions for R5's heels. ADON-E stated that ADON-E believed that R5 had a Prevalon boot in place. Surveyor asked if that intervention should be listed on the care plan. ADON-E stated yes. Surveyor informed ADON-E that R5's care plan was not updated with an intervention after R5 developed the heel pressure injury and after NP-G recommended a Prevalon boot. ADON-E stated, I remember, it was there. On [DATE] at 8108 AM, Surveyor interviewed DON-B. Surveyor about R5's right heel pressure injury. Surveyor asked if interventions that the wound NP recommends should be added to R5's care plan. DON-B stated that repositioning and floating of heels should have been added to R5's care plan. DON-B indicated that after the heel injury developed, the Prevalon boot should have been added to R5's care plan as directed by NP-G. R5's Wound Evaluation completed by NP-G, dated [DATE] documents, in part: Coccyx (stage 2 pressure ulcer). Partial thickness wound with 100% smooth pink tissue at the base. Wound measuring 0.8 x 1.8 x 0.1 cm . Status: deteriorating . Continue offloading measures. Right lateral heel (DTI). Absorbing fluid filled blood blister measuring 5 x 5.5 x UTD cm . Prevalon boot to be worn whenever in bed. Avoid use of shoes. Surveyor noted R5's coccyx pressure injury deteriorated. Surveyor noted the treatment remained the same and no additional offloading interventions like turning or repositioning were added to R5's care plan. Surveyor noted R5's right lateral heel pressure injury improved. Surveyor noted NP-G added that R5 should avoid the use of shoes. Surveyor reviewed R5's care plan and noted that this intervention was not added to R5's care plan. R5 had wound evaluations completed on [DATE] and [DATE]. Surveyor noted both of R5's pressure injuries were documented as improving. R5's Wound Evaluation completed by NP-G, dated [DATE] documents, in part: Coccyx (stage 2 pressure ulcer). Partial thickness wound with 100% smooth pink tissue at the base. Wound measuring 1.0 x 0.3 x 0.1 cm . Status: deterioration . Continue offloading measures. Right lateral heel (DTI). Blood blister evolved to an eschar measuring 3.8 x 4.2 x UTD cm. Eschar is intact/adherent and without fluctuance . Plan: Apply betadine daily, leave [Open to air]. Prevalon boot to be worn whenever in bed. Avoid use of shoes. Surveyor noted R5's coccyx pressure injury deteriorated. Surveyor noted the treatment remained the same and no additional offloading interventions like turning or repositioning were added to R5's care plan. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Surveyor noted R5's right lateral heel pressure injury improved. Surveyor noted Prevalon boots and that R5 should avoid use of shoes was documented again by NP-G. Surveyor noted that neither of these interventions were added to R5's care plan. R5's progress note dated [DATE] at 12:49 PM documents, in part: . wound NP was not in house today, but this writer did see resident's wound and did treatments. treatment in place in [electronic medical record], staff will continue to follow [plan of care]. On [DATE] at 10:41 AM, Surveyor interviewed ADON-E about wound rounds on [DATE]. ADON-E stated that it was over Labor Day weekend an ADON-E completed the assessments on R5. Surveyor informed ADON-E that Surveyor could not find any documentation in R5's medical record indicating the measurements and assessment of R5's pressure injuries. ADON-E stated that ADON-E has the assessment on paper in ADON-E's office. ADON-E returned to Surveyor with a one-page spreadsheet of all the wounds that ADON-E assessed on [DATE]. ADON-E's documentation of R5's pressure injuries dated [DATE] documents: Coccyx 1.5 x 1.8. Right heel 2. 8 x 2. Surveyor noted ADON-E's documentation did not include a comprehensive assessment on R5's pressure injuries. Surveyor noted both the coccyx pressure injury and the right lateral heel pressure injury deteriorated. Surveyor noted the treatment remained the same to both areas and R5's care plan was not updated with new interventions. R5's Wound Evaluation completed by NP-G, dated [DATE] documents, in part: Coccyx (stage 2 pressure ulcer evolved to unstageable). Full thickness wound with 100% slough at the base. Wound measuring 2.5 x 1. 5 x UTD cm . Status: deterioration. Plan: Cleanse with [Normal Saline] or wound cleanser, then apply skin prep to the peri wound medihoney to the base of the wound followed by Alginate and cover with bordered foam, change daily and [As needed]. Continue offloading measures. Right lateral heel (DTI). 100% eschar measuring 5 x 6 x UTD cm . Eschar is intact/adherent and without fluctuance . Prevalon boot to be worn whenever in bed or use of heels up cushion. Avoid use of shoes. Surveyor noted the coccyx pressure injury deteriorated and was staged as unstageable. Surveyor noted the treatment to the coccyx was changed and a new MD order for treatment was placed in R5's electronic medical record. Surveyor noted no additional offloading interventions like turning or repositioning were added to R5's care plan. Surveyor noted R5's right lateral heel pressure injury treatment remained the same. Surveyor noted that NP-G's documentation included Prevalon boot or the use of heels up cushion and that R5 should avoid the use of shoes. Surveyor noted that none of these interventions were added to R5's care plan. R5's Wound Evaluation completed by NP-G, dated [DATE] documents, in part: Coccyx (stage 2 pressure ulcer evolved to unstageable). Full thickness wound with 100% slough at the base. Wound measuring 2.5 x 2. 0 x UTD cm . Status: deterioration. Continue offloading measures. Right lateral heel (DTI). 100% eschar measuring 5 x 6 x UTD cm. Eschar is intact/adherent with slight lifting at the margins, without fluctuance. Prevalon boot to be worn whenever in bed or use of heels up cushion. Avoid use of shoes. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Surveyor noted that R5's Coccyx pressure injury deteriorated, and the treatment remained the same. Surveyor noted no additional offloading interventions like turning or repositioning were added to R5's care plan. Surveyor noted R5's right lateral heel pressure injury treatment remained the same. Surveyor noted that NP-G's documentation included Prevalon boot or the use of heels up cushion and that R5 should avoid the use of shoes. Surveyor noted that none of these interventions were added to R5's care plan. R5's Wound Evaluation completed by NP-G, dated [DATE] documents, in part: Coccyx (stage 2 pressure ulcer evolved to unstageable). Full thickness wound with 100% soft light brown necrotic tissue at the base. Wound measuring 7 x 4.0 x UTD cm . Continue offloading measures. Right lateral heel (DTI). 100% eschar measuring 4 x 6 x UTD cm. Eschar is intact/adherent with slight lifting at the margins, without fluctuance . Prevalon boot to be worn whenever in bed or use of heels up cushion. Avoid use of shoes. Surveyor noted R5's Coccyx pressure injury deteriorated from 2.5 x 2 to 7 x 4 in one week. The treatment remained the same and no additional offloading interventions like turning or repositioning were added to R5's care plan. Surveyor noted R5's right lateral heel pressure injury treatment remained the same. Surveyor noted that NP-G's documentation included Prevalon boot or the use of heels up cushion and that R5 should avoid the use of shoes. Surveyor noted that none of these interventions were added to R5's care plan. R5's progress note dated [DATE] at 12:02 PM documents, in part: [By mouth] intake has decreased to ~25%. At the time of last nutrition assessment 3 months ago, PO intake was 38% on average. R5's progress note dated [DATE] at 3:33 PM documents: Resident was transferred to [name of local hospital] today via ambulance accompanied by EMT due to lethargy, poor appetite, and critical labs. The ADON and family updated. R5 was admitted to the hospital from [DATE] through [DATE] with Severe sepsis in setting of bilateral parotitis. While hospitalized , R5 had an x-ray completed of R5's right lower extremity and Vascular Surgery visited R5. R5's X-ray results dated [DATE] documents a final result of: suspicious for osteomyelitis given overlying wound. R5's Vascular Surgery Consult dated [DATE] documents, in part: [R5] with functional decline and poor [by mouth] intake in the past 4 months who is bed/wheelchair bound at this point . The heel wound appears to be a pressure wound . The eschar is hard and well adhered to the heel. Given these findings of the heel wound, no surgical debridement is recommended . Suggestion of osteomyelitis on [x-ray]- it is highly unlikely that this is contributing to [R5's] [altered mental status] and overall deconditioning . Given the patient's age, multiple co-morbidities and her current altered status with sepsis that is being treated, no surgical intervention is recommended . Recommend heel off-loading shoe. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Surveyor noted Vascular Surgery signed off on R5's care and noted that R5 should have a heel off-loading shoe. R5 was readmitted to the facility on [DATE] with hospice care. R5's progress note dated [DATE] 2:34 PM documents, Hospice will take over wound care for resident [related to] hospice services. On [DATE], R5's potential impairment to skin integrity care plan focus was updated with Hospice will do all wound care on admission to hospice. Surveyor noted that a heel off-loading shoe was not placed as an intervention as recommended by the Vascular Surgery MD. Surveyor reviewed R5's electronic medical record and did not locate any measurements or assessments of R5's wound from [DATE] until [DATE]. R5's progress note dated [DATE] 10:15 PM documents, in part: An open area noted to resident [right] lateral leg. No bleeding noted. Dressing applied. No s/s of infection noted. ADON and hospice updated. Message left for family to call facility for update. Surveyor reviewed R5's electronic medical record and did not locate any further documentation of the new right lateral leg wound including measurements and a comprehensive wound bed assessment. R5's care plan was not updated with this new wound and a new interventions was not place. Surveyor noted a wound treatment with a start date of [DATE] was put in place for the right lateral leg wound and staff were completing treatments for this new wound. On [DATE] at 10:41 AM Surveyor interviewed Assistant Director of Nursing (ADON)-E. Surveyor asked what the plan was for R5's wound care after R5 returned to the facility on [DATE]. ADON-E stated that the hospice nurse, RN-J, told ADON-E that RN-J would complete all R5's wound care needs. ADON-E stated that RN-J would do all the dressing changes and assessments. If needed, the facility staff would fill in the gaps when RN-J was not in the facility on the weekends. Surveyor asked ADON-E if hospice was completing the assessments of R5's wounds. ADON-E stated that no assessments or measurements were in the electronic health record, but ADON-E reached out to the hospice company on [DATE] to get the documentation of the assessments. ADON-E stated that hospice did not have the documentation and stated that they did not document on the wounds. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 12:27 PM, Surveyor interviewed RN-J, the hospice nurse, regarding R5's wound care. RN-J stated that RN-J remembered having a conversation about completing R5's wound care with the Director of Nursing (DON)-B. RN-J stated that RN-J remembers saying that RN-J would complete the wound care treatments and take care of any MD orders associated with R5's wound care. RN-J stated that RN-J was not aware that RN-J was the only staff member who would be getting measurements of the wounds or assessing the wounds. RN-J stated that in other facilities, RN-J will work with the Wound Doctor or Nurse Practitioner. RN-J stated that during the conversation, RN-J recommended that DON-B follow up about having the facility Wound Nurse Practitioner (NP)-G continue to follow R5's wounds. Surveyor asked about the wound that developed on [DATE]. RN-J stated that the wound was not a pressure injury, but it was a laceration. Surveyor asked if it was a laceration, how the laceration occurred. RN-J stated that it could have happened from a transfer or from a pillow. RN-J was not sure how the injury happened but stated again that it was a laceration/skin tear not a pressure injury. RN-J stated that RN-J did get measurements of the laceration when she did an assessment on [DATE], but that was the first-time measurements were completed. Surveyor asked if hospice or the facility determined the cause of the new wound. RN-J was not sure if a cause was identified. Surveyor asked if any measurements or assessments were completed on R5's pressure injuries/wounds from [DATE] through [DATE]. RN-J gave the following assessment information from RN-J's notes: [DATE]- Coccyx unstageable pressure injury was not measured or assessed. Right heel pressure injury was unstageable and measured 7 x 5.5 cm. Wound had eschar and was moist with red, pink, and black areas. Small amount of drainage. Right lateral leg laceration measured 7 x 1.5. Wound had a small amount bloody drainage and was moist with red and pink wound bed. [DATE]- Coccyx unstageable pressure injury was not measured. Facility RN was doing wound care, so RN-J looked at the wound and documented the coccyx wound to be moist with red, pink, and yellow areas. Small amount serosanguineous drainage. Right heel unstageable pressure injury measured 7.5 x 4.5 cm. Moist, black with no drainage. Right lateral leg laceration measured 8 x 3.5. Wound was pink and yellow with a small amount of tan drainage. [DATE]- Coccyx unstageable pressure injury was not measured or assessed. Right heel unstageable pressure injury measured 7.5 x 4.5 cm. Dry. Black. No drainage. Right lateral leg laceration measured 8 x 3. 5 Clean. Wound was scabbed and edges were attached. No drainage was noted. Surveyor asked if there were any changes that were made to R5's MD orders regarding treatment of the pressure injuries. RN-J stated that R5 already had previous treatment orders in place before R5's hospitalization and those treatment orders continued the entire time RN-J cared for R5's wounds. RN-J stated that RN-J was more focused on R5's comfort. RN-J stated that R5 was not eating or drinking so the pressure injuries were not going to heal but RN-J wanted to make sure that R5 was comfortable. Surveyor asked what interventions were in place for R5's skin integrity. RN-J stated R5 had the following interventions on the hospice care plan: Air mattress. Incontinent care. Assess skin and pressure areas. SNF (skilled nursing facility) to perform wound care. Surveyor asked if RN-J's hospice care plan included any offloading measures for R5. RN-J stated that RN-J remembers R5 having a pillow offloading her coccyx area. RN-J stated that RN-J was not sure if R5 was turned every 2 hours because that would be the facility staff responsibility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525524	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Actual harm Residents Affected - Few	Surveyor noted that the facility communication of the wound care plan was not communicated clearly to RN-J. Surveyor noted that none of the wound measurements given to Surveyor in the interview with RN-J were located anywhere within R5's electronic medical record. Surveyor noted that without facility and hospice staff knowing the status of R5's wound, staff would not be able to tell if the wounds were deteriorating or not. Surveyor noted that the new wound on R5's Right lateral leg was designated a laceration by RN-J. Surveyor noted that a treatment was put in place but there was not a root cause analysis completed for the [DATE] wound. Surveyor noted that the right lateral leg wound was not thoroughly assessed or measured until 5 days after its development and was not thoroughly assessed or measured weekly. R5's care plan was not updated with a new intervention after the development of this new wound. Surveyor noted that R5's Coccyx pressure injury was not assessed or measured after R5 was placed on hospice. Surveyor noted that R5's Right heel pressure injury was not assessed on admission to the facility. The right heel was not assessed or measure from [DATE] through [DATE]. The [DATE] assessment completed by RN-J did not include a thorough wound bed assessment including the percentage of eschar, slough, or granulation tissue present. The right heel was not assessed or measured from [DATE] through [DATE]. The [DATE] and the [DATE] assessment completed by RN-J did not include a thorough wound bed assessment including the percentage of eschar, slough, or granulation tissue present. On [DATE] at 9:12 AM, Surveyor interviewed NP-G. NP-G stated that NP-G initially saw R5 after R5 developed a coccyx/sacral pressure injury and cared for R5 until R5 went on hospice. NP-G stated that R5's overall condition was declining and R5 was refusing oral intake. Surveyor asked if NP-G knew what interventions were in place to prevent a pressure injury from developing. NP-G stated that R5 was on an air mattress and believed that R5 had other offloading interventions as well. NP-G stated that NP-G did not expect R5's wounds to heal. NP-G stated that wounds do not heal with poor nutrition. NP-G stated that the facility and R5's family had discussions about hospice care, but the family did not agree to that. NP-G stated that NP-G talked to R5's family about Arterial studies and more aggressive care after R5 developed the Right heel pressure injury, but the family was not agreeable to an aggressive plan. NP-G stated that the goal was limit the risk of infection and continue with treatments on the pressure injury areas. NP-G stated on [DATE] when R5 was transferred to the hospital, R5 had taken a fast downward spiral. NP-G stated R5 was not acting like herself. NP-G stated when R5 returned to the facility NP-G was no longer involved in R5's care. Surveyor asked if R5's wound care and assessments schedule would need to change since R5 was on hospice. NP-G stated that taking care of R5's wound would be no different if R5 was on hospice or not. NP-G stated that you still need to do assessments and change treatments as needed while a resident is on hospice. NP-G stated that at other facilities, NP-G continues to care for resident's wounds even when the resident is put on hospice. NP-G did not know why the decision was made for hospice to care for R5's pressure injuries. On [DATE] at 11:08 AM, Surveyor interviewed Nursing Home Administrator about R5's wounds after R5 was placed on hospice. NHA-A indicated that NHA-A did not like that R5's wound care assessments and measurements were missed. NHA-A stated that NHA-A was not happy with the hospice care team. NHA-A indicated that NHA-A had spoken to t[TRUNCATED]

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38146 Based on interview and record review, the facility did not ensure that residents who are continent of bladder and bowel received services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain for 1 of 2 (R22) residents reviewed for bowel and bladder. R22 had a decline in bowel continence following admission to the facility. The facility did not comprehensively assess R22's decline and no new interventions were implemented. The facility was not documenting or monitoring R22's bowel movements. Findings include: R22 admitted to the facility on [DATE] and has diagnoses that include Diabetes Mellitus Type 2 with Chronic Kidney Disease, Atrial Fibrillation, Venous Insufficiency, Depression, Hypothyroidism, Urine Retention, Congestive Heart Failure, Peripheral Vascular Disease, Anemia, Acquired absence of left leg below knee and Atherosclerotic Heart Disease. R22 was hospitalized and readmitted several times while residing in the facility. The facility Policy and Procedure titled Bowel and Bladder Management reviewed 8/10/23 documents (in part) . .Policy: Prevention measures are put in place to promote bowel and bladder health. Procedure: A. Assessment: 1. Staff will assess newly admitted individuals for past and present bowel and bladder patterns which may include medication review, medical diagnoses, and/or diet. B. Care planning: 1. Staff will adopt a person-centered interdisciplinary care plan and implement interventions/approaches to bowel and bladder management to meet the goals of the individual. 2. Care plan will be reviewed quarterly, or as needed. C. Monitoring: 1. Staff will document bowel movements. 2. Care Plan will be reviewed quarterly, or as needed. 3. Abnormal bowel and bladder patterns will be reported to the nurse. (continued on next page)

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	525524	A. Building B. Wing	11/14/2024

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Staff will review individuals that do not have a recorded bowel movement within the past 3 days and provide appropriate interventions as needed. The facility form titled Standard Bowel/Bladder Protocol (not dated) documents (in part) . .Problem: Individual has potential for or identified bowel/bladder incontinence. Goal: Reduce skin breakdown, decrease episodes of incontinence as able, maintain regular bowel pattern, and minimize UTI (Urinary Tract Infection) signs and symptoms. RN (Registered Nurse): Bowel and bladder assessment upon admission, with COC (Change of Condition), annually and PRN (as needed). Determine and establish need for bowel/bladder training program and request order for OT (Occupational Therapy) to assist in process. Monitor bowel pattern, abdominal distension, bowel sounds, need for laxatives PRN. CNA (Certified Nursing Assistant): Provide toileting on demand or as otherwise requested/scheduled. If individual unable to express need, toilet or change every 2-3 hours. Monitor bowel consistency, odor, amount, color (red/black). Report concerns to licensed nurse. Therapy: OT consult as needed for bowel/bladder training. R22's Admission Continence Evaluation dated 1/29/24 documents: Does the resident have a history of bowel incontinence? NO Was the resident continent of bowel at the time of admission? YES Bowel continence - Select the one category that best describes the resident: Always continent Perception of need to defecate: Present R22's Admission Continence Evaluation dated 3/6/24 documents: Does the resident have a history of bowel incontinence? YES Was the resident continent of bowel at the time of admission? NO Bowel continence - Select the one category that best describes the resident: Always incontinent. R22's Quarterly Continence Evaluation dated 4/29/24 documents: Does the resident have a history of bowel incontinence? NO Was the resident continent of bowel at the time of admission? NO Bowel continence - Select the one category that best describes the resident: Always incontinent Perception of need to defecate: Diminished (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R22's Quarterly MDS (Minimum Data Set) dated 5/3/24 documents: Bowel continence - Select the one category that best describes the resident - Always incontinent. Is a toileting program currently being used to manage the resident's bowel continence? No Surveyor noted there was no evidence of an assessment regarding R22's decline in bowel continence and no evidence a toileting program was implemented to maintain bowel continence. R22's Annual MDS dated [DATE] documents a BIMS (Brief Interview for Mental Status) score of 14, indicating no cognitive impairment. Indwelling catheter (including suprapubic catheter and nephrostomy tube) - Yes Bowel continence - Select the one category that best describes the resident - not assessed. Is a toileting program currently being used to manage the resident's bowel continence? No Constipation present? No Surveyor review of POC (Point of Care) revealed there was no section or evidence of facility documentation of R22's bowel movements or continence. On 11/12/24 at 9:04 AM, Surveyor advised DON (Director of Nursing)-B of concern R22 admitted to the facility continent of bowel, and is now incontinent. Surveyor advised DON-B there is no evidence the facility is documenting or monitoring R22's bowel movements or continence, and there is no evidence the facility assessed R22's decline in bowel continence and no new interventions were implemented. On 11/13/24 at 9:00 AM, DON-B stated, Apparently it (recording of bowel movements) wasn't activated in POC to enter BM's (bowel movements). I don't know why, I thought it automatically activates. So we're not able to determine when or why he became incontinent of BM as there are no records. On 11/13/24 at 3:00 PM, the facility was advised of the following concern: R22's admission continence evaluation dated 1/29/24 indicated R22 was always continent of bowel. Subsequent continence evaluation dated 3/6/24 and Quarterly MDS dated [DATE] documents R22 as always incontinent. There is no evidence the facility recognized R22's decline in bowel continence and completed a comprehensive assessment or implemented a toileting program to maintain bowel continence. In addition, there is no evidence the facility is recording or documenting R22's bowel movements. No additional information was provided.

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	525524	A. Building B. Wing	11/14/2024

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 42037 Based on observation, interview, and record review, the facility did not ensure that sufficient nursing staff was provided to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Surveyors made observations of residents waiting for assistance with delayed call light wait responses. Residents were interviewed and expressed concerns to surveyors that the facility does not have sufficient staff, resulting in delayed call light responses. Surveyor reviewed last 30 days of facility nursing schedules and nurse staff postings. Surveyor noted that the facility did not designate a charge nurse for each tour of duty on each daily nursing schedule. This deficient practice has the potential to affect a pattern of all 43 residents residing in the facility. Findings include: Delayed call light response On 11/11/24 at 11:12 AM, during initial interview, R2 reported they still have trouble getting to the bathroom either before or after meals. R2 reported that no staff is left on the floor to take anyone to the bathroom and call lights don't get answered. On 11/11/24 at 11:25 AM, Surveyor observed R2's call light on the illuminated call light board. Surveyor confirmed with R2 that their call light is on because they need to go to the bathroom. On 11/11/24 at 11:53 AM, Surveyor noted the illuminated call light board. Surveyor noted R2's call light was on for over 28 minutes. On 11/11/24 at 12:00 PM, Surveyor observed a staff member in R2's room assisting with putting on her sweater. The staff member left the room with the sit to stand lift. R2 reported they had been taken to the bathroom. R2 stated they felt like she waited 45 minutes and that they had to go to the bathroom very badly and was barely able to hold it until staff came to help them. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/11/24 at 1:41 PM, Surveyor observed R1's call light on in their room. On 11/11/24 at 1:59 PM, Surveyor conducted interview with R1 about their call light. R1 stated they wanted to go back into bed and that's why they have their call light on. Surveyor asked how long they have been waiting for help. R1 stated that they have been waiting for quite a while and asked Surveyor to inform staff. On 11/11/24 at 2:00 PM, Surveyor exited R1's room. Surveyor noted at this time that R1's call light was no longer on. R1 told Surveyor that staff had turned off call light without speaking to R1. At this time, Surveyor informed 2 staff members at the nurses' station that R1 wanted to get back into bed. Staff left nurses' station and went to assist R1. On 11/12/24 at 11:15 AM, Surveyor conducted the Resident Council meeting. The residents informed Surveyor of the following staffing concerns: Residents stated that they did not feel like the facility had enough staff to help with their needs. Residents stated that call light wait times can be long. Surveyor asked how long they will need to wait for their call lights to be answered. Residents stated that it varies. Sometimes can be less than 5 minutes. Sometimes it can be much longer. R20 stated that R20 has asked CNAs (Certified Nursing Assistants) for help and has been told by CNAs the following: That is not my job or I am not your aide. R20 stated that any CNA should be able to help R20 if they need help. R27 stated that in the past R27 has had a CNA that is a floater, meaning that the CNA will work on both the first and second floor throughout their shift and does not have a designated unit that they are assigned to. R27 stated that it is frustrating when R27 has a floater because it takes even longer to get help. R27 stated that when their electric wheelchair is charged, R27 will go to the nurses' station, wait there for staff and continually ask staff for help until R27 gets the assistance that they need. R27 stated that it is the fastest way to get help because the call lights are not answered as timely as R27 would like. R27 stated that staff will tell R27 that they can start R27's cares but will not be able to finish the cares before the end of the shift. R27 stated their frustration with this, feeling like they should tell staff that they might as well not start the cares for them if they will not be able to finish them in a timely fashion. R27 stated, The CNAs here make me feel like I am just a job to them . R27 completed reporting their staffing concerns by stating, I'm really just an afterthought to these workers .please don't treat me like I am not a human being. Scheduler Interview On 11/12/24, Surveyor reviewed the last 30 days of facility nursing schedules and nurse staff postings from 10/14/24-11/11/24. Surveyor reviewed the Facility Assessment. Surveyor did not note any documentation in the Facility Assessment related to staffing levels or staff/resident ratios. Surveyor noted that the facility did not designate a charge nurse for each daily nursing schedule on the following dates: 10/19/24, 10/20/24, 10/26/24, 10/27/24, 11/2/24, 11/3/24, 11/9/24, and 11/10/24. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/13/24 at 1:35 PM, Surveyor conducted an interview with Scheduler-Y. Scheduler-Y told Surveyor that they utilize a staffing grid to determine staffing levels based off the facility's census. Scheduler-Y reported to Surveyor that the facility may assign one CNA downstairs on the first floor (rehabilitation unit) at times as the census on the second floor (long term care unit) is typically higher. Surveyor asked Scheduler-Y if they have had concerns brought forward to them about the current staffing levels at the facility. Scheduler-Y told Surveyor that the facility has recently hired a new medication technician to help with passing medications as well as resident cares to improve staffing situations. Surveyor asked Scheduler-Y if they are aware of the Facility Assessment document and whether or not it contains guidance for staffing ratios. Scheduler-Y told Surveyor that they have never heard of a Facility Assessment document and using it for guidance for staffing. Surveyor asked Scheduler-Y if they were aware that there was not a charge nurse designated on the facility's nursing schedules on 10/19/24, 10/20/24, 10/26/24, 10/27/24, 11/2/24, 11/3/24, 11/9/24, and 11/10/24. Scheduler-Y told Surveyor that they have, done this job for four years and that they have never in their life heard about having to denote who the facility's charge nurse is on a schedule. On 11/14/24 at 11:20 AM, Surveyor conducted an interview with NHA (Nursing Home Administrator)-A. Surveyor informed NHA-A of the concerns mentioned by the resident council group, including Surveyor's interviews with R1, R2, and R20 and about insufficient staffing levels and observations of prolonged call light wait times by surveyors. NHA-A stated that the facility has just hired a Medication Technician and has 3 new Medication Technician positions posted to help with staffing needs. Surveyor shared concern related to the Facility Assessment document which did not include any staffing information including staff to resident ratios. Surveyor shared concern related to facility's schedules not designating who the facility charge nurse would be on 10/19/24, 10/20/24, 10/26/24, 10/27/24, 11/2/24, 11/3/24, 11/9/24, and 11/10/24 as confirmed by interview with Scheduler-Y. The facility did not share any additional information at this time related to above concerns.