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	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Anne's Salvatorian Campus	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** Based on record review, staff interviews, and policy review, the facility failed to report an allegation of abuse to local law enforcement for one of one resident (Resident (R) 1) reviewed for abuse of six residents in the sample. This failure had the potential to increase a resident's risk of abuse throughout the facility. Findings include: Review of the facility's policy titled, Comprehensive Abuse, Neglect, Mistreatment and Misappropriation of Resident Property Program, revealed .Law Enforcement: All reports of suspected crime and/or alleged sexual abuse must be immediately reported to local law enforcement to be investigated. Facility staff will fully cooperate with the local law enforcement designee. A summary of the investigation will be submitted to the State agency within five working days of the initial report. Review of R1's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/03/25 revealed R1 was admitted to the facility on [DATE] with diagnoses that included joint replacement surgery, presence of left artificial shoulder joint, anxiety disorder, and depression. R1 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. R1 was discharged from the facility on 04/07/25. Review of Misconduct Incident Report, provided by the facility dated 05/06/25 revealed, At approximately 2:00 PM on 03/04/25 [R1] reported to the therapy director that she did not want [Physical Therapy Assistant (PTA) 1], the PTA seeing her anymore stating he made her feel uncomfortable. When asked why she said he patted her by the butt a while ago. Investigation begun immediately; [PTA1] was suspended pending investigation. Resident refused to have law enforcement notified. During an interview on 06/12/25 at 3:28 PM, the Occupational Therapist (OT) 1 stated she did not witness the event between R1 and PTA1. On 03/04/25, OT1 stated she was speaking with R1 when R1 stated she was not feeling comfortable with working with PTA1. OT1 stated R1 informed her that R1 found PTA1 creepy and that PTA1 had patted her bottom. OT1 stated she immediately informed the Social Worker (SW) 1 and the former Administrator 1. OT1 stated PTA1 did not recall touching R1 inappropriately or touching her in any way. OT1 stated R1 was unable to give details about when and how the incident occurred. (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 06/12/25 at 3:37 PM, PTA1 stated he was unsure of the date R1 alleged that he touched her. PTA1 stated his recollection was two or three days before the accusation. PTA1 stated R1 was lying in bed, and PTA1 got her out of bed, using a walker, into the wheelchair. He stated R1 stood up from the wheelchair for a minute or two, then sat down in the wheelchair, then transferred back to the bed. PTA1 stated according to his notes on that day, R1 did not need any physical assist and no physical contact from him at all. During an interview on 06/13/25 at 4:09 PM the Director of Nursing (DON) stated it was the previous Administrator 1 conducted the investigation into R1's allegation. During an interview on 06/13/25 at 5:00 PM the Corporate Senior Executive Director stated if he had been the one in charge, he would have called the police whether the resident wanted to or not, because he was aware it was the law. During an interview on 06/13/25 at 5:13 PM, the SW stated she recalled R1's allegation that PTA1 patted her butt. The SW stated she immediately informed the former Administrator and the facility conducted an investigation. The SW stated she did not recall if the police were called.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff interviews, and review of facility policy, the facility failed to ensure that staff discarded dispensed liquid medications that were not immediately administered to residents for one of two residents (Resident (R) 2) during medication administration for six residents in the sample. This failure had the potential to expose the resident to contamination in the medication. Findings include: Review of facility's undated policy titled, Preparation and General Guidelines: Equipment and Supplies for Administering Medications revealed, the facility maintains equipment and supplies necessary for the preparation and administration of medications to residents . Review of R2's annual Minimum Data Set (MDS) located under the MDS tab of the electronic medical record (EMR) with an Assessment Reference Date (ARD) of 03/07/25 revealed R2 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included nonalcoholic steatohepatitis (NASH), end stage renal disease, chronic kidney disease, cirrhosis of liver. R2 had a Brief Interview for Mental Status (BIMS) score of three out of 15, which indicated the resident was severely cognitively impaired. Review of physician's orders located under the orders tab of the EMR, revealed the following order: Lactulose Oral Solution 10 GM (milligram)/15ML (milliliter) (Lactulose). Give 45 ml orally four times a day for Constipation During an interview on 06/13/25 at 12:21 PM, Registered Nurse (RN) 2 stated that the 1:00 PM dose of Lactulose was signed out by the medication administration assistant (Med Tech) 1. During an interview on 06/13/25 at 12:23 PM, Med Tech1 stated she signed out the Lactulose at 12:00 PM and went to R2's room to give it. Med Tech1 stated R2 was asleep, so she did not give R2 the medication. During an observation on 06/13/25 at 12:40 PM, Med Tech1 walked to the nurse's station with a cup of liquid medication without her medication cart to R2's room. At 12:42 PM, Med Tech1 administered R2 the medication in a cup. During an interview on 06/13/25 at 12:46 PM, Med Tech1 stated when she first attempted to give the Lactulose, R2 was asleep, she returned the liquid medication to her medication cart. When asked if she returned an open cup of liquid uncovered to her cart, she stated she had two small medication cups with 30 mL and 14 mL each, and that she covered the smaller cups with a big cup and locked her cart. When asked if she had just administered the same medication that was pulled about 45 minutes ago that was stored in her cart in open cups, she stated, yes. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/13/25 at 12:50 PM, RN2 stated it was unacceptable for Med Tech1 to sign out a medication she had not yet given. It was also unacceptable that Med Tech1 returned the medication to the cart in open cups or at all. RN2 stated Med Tech1 should have discarded the medication, informed the nurse the medication was not given, and documented her actions. RN2 stated staff have been trained not to pre-sign medications that have not been given. During an interview on 06/13/25 at 4:09 PM, the Director of Nursing (DON) stated it was her expectation that Med Tech1 should have discarded the medication that was not given and documented it.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff interviews, and facility policy review, the facility failed to follow appropriate infection control practices for hand hygiene for one of one residents (Resident (R) 2) observed during medication administration of six residents in the sample. The failure had the potential for the spread of pathogens in the facility. Findings include: Review of the facility's policy titled Infection Control Hand Hygiene, dated 12/05/24 revealed I. Policy: The organization will promote clean hands as the single most important factor in preventing the spread of pathogens, antibiotic resistance, and incidence of infections. II. Procedure: A. Specific Indications for Hand Hygiene 1. Immediately before touching a patient .3. Before moving from work on a soiled body site to a clean body site on the same patient. 4. After touching a patient or the patient's immediate environment. 5. After contact with blood, body fluids, or contaminated surfaces .1. Wear gloves when in contact with blood, body fluids, or potentially other infectious materials. Review of R2's annual Minimum Data Set (MDS) located under the MDS tab of the electronic medical record (EMR) with an Assessment Reference Date (ARD) of 03/07/25 revealed R2 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included nonalcoholic steatohepatitis (NASH), acute respiratory failure, end stage renal disease, type two diabetes mellitus with diabetic chronic kidney disease, chronic diastolic (congestive) heart failure, other pancytopenia, cirrhosis of liver, epilepsy, without status epilepticus, and dementia. R2 had a Brief Interview for Mental Status (BIMS) score of three out of 15, which indicated the resident was severely cognitively impaired. Review of the EMR Orders tab revealed an order, Enhanced Barrier Precautions (EBP) for Wounds. Everyone must clean their hands, before entering and when leaving the room. Providers and staff providing high touch-contact care activities must wear gloves and gowns dated 04/23/25. During observation on 06/13/25 at 12:42 PM, Medication Administration Technician (Med Tech) 1 returned to R2's room, did not perform hand hygiene before entering R2's room, and wore no gloves. Med Tech1 held the cup of the liquid medication to R2's mouth with bare hands in multiple sips. Med Tech1 obtained a tissue and dabbed R2's mouth as some of the medication dribbled out. When done with the medication administration, Med Tech1 discarded the tissues and medication cup in the trash and touched the trash can lid. Med Tech1 attempted to perform hand hygiene with the wall alcohol hand rub dispenser in R2's room, but it was empty. Med Tech1 walked out of R2's room and across the hallway into another resident's room to use the wall alcohol dispenser in that room. During an interview on 06/13/25 at 12:46 PM Med Tech1 acknowledged she did not wear gloves or perform hand hygiene to give an oral liquid medication that spilled out of the resident's mouth and dabbed the resident's mouth with tissue using her bare hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/13/25 at 12:50 PM, Registered Nurse (RN)2 stated it was her expectation that Med Tech1 should have performed hand hygiene before entering R2's room. Furthermore, R2 was on EBP. RN2 stated that Med Tech1 should have worn gloves to give the medication to R2 since it involved possible contact with R2's bodily fluids. During an interview on 06/13/25 at 4:09 PM, the Director of Nursing (DON) stated it was her expectation that Med Tech1 should have worn gloves when giving the resident a medication to drink out of a cup and should have performed hand hygiene before entering a resident's room.