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	01/07/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility did not ensure that residents' environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents for 1 of 1 (R2) residents reviewed for accidents. R2 sustained an avoidable fall from bed during cares. R2 was assessed as being dependent for bed mobility as assessed and documented on their significant change and most recent quarterly Minimum Data Set. An assessment code of 01 dependent indicates the need for two staff assistance. R2 was also assessed by therapy as being dependent on staff for bed mobility with the number of staff assistance needed not specified. R3's care plan dated 8/9/23 indicated R2 requires the assistance of 1 staff for bed mobility and was not reflective of current assessments or level of assist needed by R2. During the fall, 1 staff provided cares and assistance to R2 while in bed. The Certified Nursing Assistant (CNA) rolled R2 away from themselves and onto R2's side affected by hemiplegia. The CNA did not maintain control of R2 when the CNA reached for a towel and R2 fell from bed requiring hospitalization, sutures to repair a head laceration and questionable rib fracture.Findings include:R2 admitted to the facility on [DATE] and had diagnoses that include hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, syringomyelia (neurological disorder of the brainstem and spinal cord), anemia, chronic obstructive pulmonary disease, depression, anxiety disorder, hypertension and chronic respiratory failure.The facility policy and procedure titled Comprehensive Person-Centered Care Plan documents (in part) . I. Policy: The comprehensive person-centered care plan will reflect the individual's needs and preferences to facilitate care.II. Procedure:A. Within 48 hours after admission a baseline care plan will be completed and reviewed with individual and/or individual representative.B. Within 21 consecutive days after admission, and in correlation with the Minimum Data Set (MDS), a comprehensive assessment will be completed and a written are plan will be developed based on the individual's history, preferences, and assessments from appropriate disciplines and the physician's evaluation and orders.C. Care plan shall be reviewed and revised quarterly, upon change of condition, and/or as needed.R2's significant change MDS dated [DATE] section GG - Functional Abilities documents (in part) . Roll left and right: The ability to roll from lying on back to left and right side and return to lying on back on the bed as Dependent - helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity.R2's quarterly MDS submitted and accepted on 10/3/25 also identifies R2 was assessed as being dependent on staff for rolling left and right in bed.According to the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.20.1 dated October of 2025 for section GG0130: Self-Care and GG170 Mobility: Code 01, Dependent: (is assessed/coded) if the helper does ALL of the effort. Resident does none of the effort to complete the activity; or the assistance of two or more helpers is required to complete the activity. Code 01 Dependent: (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 0689 Level of Harm - Actual harm Residents Affected - Few	if two helpers are required for safe completion of an activity, even if the second helper provides supervision/stand-by assist only and does not end up needing to provide hands-on assistance. Code 01, dependent: if a resident requires the assistance of two helpers to complete an activity (one to provide support to the resident and a second to manage the necessary equipment to allow the activity to be completed.R2's care plan documents: (R2) has an ADL (activity of daily living) self-care performance deficit r/t (related to) hemiplegia - date initiated 8/9/23. Interventions include Bed mobility: Assist of 1. Uses 1/2 bed rails bilaterally for repositioning and bed mobility - initiated 8/9/23.R2's Side Rail Assessment and Risk Screen dated 5/2/25 documents: Which type would be beneficial (choices half side rail or bed bar). Bed bar was checked. Summary of evaluation: Enabler bars indicated.Review of R2's therapy documentation includes reference in therapy notes for dates 2/11/25 - 5/11/25 R2 is dependent in all bed mobility. Surveyor noted there is no documentation to specify R2 requires the assistance of only 1 staff for bed mobility and/or the determination of dependent would differ from the definition of dependent as defined by the RAI Manual.On 6/10/25 at 5:30 AM, R2 sustained a fall from bed. The facility investigation interview with the Certified Nursing Assistant (CNA) involved documents: She stated she was getting (R2) prepared for a shower but needed to do peri care as he was incontinent of stool first. She stated the height of the bed was up as she was doing cares. The bed was slightly angled per resident preference. She stated that he does have arm spasms from time to time and did have one while she had turned him onto his right side, however it did stop. At this time, she noted that she needed the towel and reached for the towel which was located on his w/c (wheelchair) which was next to her. While she did this, she noticed that he continued to roll and slid out of bed onto the floor. She was unable to stop him from rolling out of bed towards that other side. Immediately called for help and 911 was called. Surveyor noted documentation of the facility interview with the involved CNA indicates R2 was rolled away from the CNA during cares creating a safety risk.According to https://www.pioneernetwork.org/wp-content/uploads/2018/07/Restorative-Transfers.pdf: Dependent Roll - Set-up - Make sure that the resident has plenty of room on the side direction he/she wishes to roll. Pre-roll Positioning - The person assisting positions him/herself on the side of the bed toward which the resident is to roll. Cross the lower leg farthest away from you over the extremity closest to you. Cross the arm farthest away from you over the chest, supporting the arm as necessary. Place one hand on the back of the pelvis and one hand on the shoulder blade. Roll - Gently roll the resident toward you onto his/her side. Encourage the resident to turn his/her head in the direction of the roll. Position arms and legs with pillows as needed. Encourage the resident to assist in the following ways: Flexing the opposite hip and knee, placing the foot flat and aiding the roll by reaching forward with the pelvis. Turn the resident's head in the direction of the roll. If the roll is toward the affected side, have the resident place his/her unaffected arm in the direction of the roll. If the roll is toward the unaffected side, have the resident clasp his/her hands together (as in praying), and reach with both arms in the direction of the roll.Facility investigation Summary documents: After review and investigation of the findings of the fall, this facility determined that the care plan was not violated in reference to any interventions. This was (R2's) first fall in the facility since admission. The CNA was unable to stop him from rolling as stated it happened so fast. The locks on the bed were in proper working order.Surveyor was advised by Nursing Home Administrator (NHA)-A that a self-report was not submitted because it didn't meet the criteria, and the care plan was followed.The hospital Discharge summary dated [DATE] documented: Presented to ED (Emergency Department) after patient fell out of bed when he was being turned by a CNA. Landed face down. Post fall c/o (complained of) pain to face, right chest, right shoulder and left sided (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	pain from left shoulder to left foot. Does have history chronic pain on multi-modal pain regimen. Pan-scan on arrival was notable for questionable right anterior 3rd rib fracture, correlation with physical exam is recommended, prominent left periorbital subcutaneous hematoma with small blood products extending along the lateral post septal left orbit, no acute intracranial findings. Sustained laceration above left eye which was repaired in ED with 6 absorbable sutures.On 1/7/26 at 10:38 AM, Surveyor spoke with Registered Nurse (RN)/MDS-D about R2's significant change MDS dated [DATE]. Surveyor noted R2 was coded as dependent for bed mobility and asked what that meant. RN/MDS-D stated, That staff do everything for them, the resident does not participate. If they're marked as dependent, they require 2-person assist. Per CMS guidelines, the definition of dependent is 2-person assist. RN/MDS-D added, If the care plan indicated he was 1 person assist, then the care plan is not updated or correct. RN/MDS-D reported she does her MDS entry strictly by nursing documentation and is not involved with the care plan.On 1/7/26 at 11:00 AM, Surveyor spoke with Director of Nursing (DON)-B. Surveyor asked about the side rail assessment completed on 5/2/25. DON-B reported she did not do the assessment, that it was completed by therapy and Physical Therapy Assistant (PTA)-F could walk Surveyor through the process. Surveyor advised DON-B that documentation in R2's annual MDS, assessments and documentation in the medical record indicates R2 was dependent for bed mobility. DON-B stated, He was limited, he could not turn or reposition himself, he was dependent for bed mobility. Surveyor shared the MDS nurse during interview stated dependent for bed mobility requires 2 assist and asked why R2's care plan documented 1 assist with bed mobility. DON-B stated, Because that's what therapy determined, that he was 1 assist for bed mobility. Surveyor advised therapy notes for dates 2/11/25 - 5/11/25 document R2 is dependent in all bed mobility and does not specify 1 assist. DON-B stated, He was very top heavy, and we think he just rolled out of the bed. Surveyor advised the fall investigation documented R2 was turned on his right side and he has left sided hemiparesis, so he wouldn't have been able to use the grab bar with his left hand. Surveyor asked DON-B did she think it was safe to turn R2 with 1 person assist. DON-B stated, That's what therapy determined. Surveyor advised all documentation indicated he was dependent for bed mobility and was providing care in bed with 1 person was safe. DON-B stated, I'm not really sure.On 1/7/26 at 11:30 AM, Surveyor spoke with Physical Therapy Assistant (PTA)-F. He reported he did not help R2 out of bed, but did exercises on his back. PTA-F stated, He could not roll himself at all. He was dependent for bed mobility which means he would require 2 assist.On 1/7/26 at 12:00 PM, Surveyor asked CNA-H about R2's bed mobility. CNA-H stated, He could not turn himself at all, we had to roll him over. I'd roll him onto his side, and he would just like stay there, it's hard to explain, but he would just stay there. CNA-H reported she would roll R2 by herself, but after he came back from the hospital following the fall he was always 2-person assist. On 1/7/26 at 1:10 PM, Surveyor spoke with Assistant Director of Nursing (ADON)-E. Surveyor reviewed education titled Ensuring resident safety while providing cares in bed which was provided to staff on 12/4/25 following a fall from bed involving a different resident. Surveyor asked if this education was in place prior. ADON-E stated, Yes, this is always the expectation. We just did re-education after that one resident fell. The education provided documents (in part) .To ensure resident safety and preventing falls from bed while using proper mechanics and positioning techniques when performing cares - such as perineal care, brief changes, skin checks and/or repositioning.1. Prepare the environment first. Before touching the resident, ensure the environment is safe: Lock the bed wheels - no exceptions. Ensure adequate lighting so you can see what you're doing. Keep the call light within reach if you momentarily step away. Gather all supplies first; avoid leaving the resident to retrieve items.3. Follow side rail policies correctly. If side rails are not allowed, stand (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	firmly on the side the resident could roll toward.4. Maintain control of resident positioning. Hands-on safety is the #1 fall prevention method during cares in bed. Keep one hand on the resident while they are turned.7. Never leave resident unattended on a raised bed. If the bed is up at working height and you must step away - even for a second - lower the bed first. If you cannot lower the bed (e.g. in the middle of turning), call for help instead of leaving.9. Use proper body mechanics to maintain control. Stand close to the bed - don't lean over far. Work from one side at a time instead of stretching across the bed. If the resident is large or cannot assist, ask another caregiver for assistance.Quick safety checklist for cares in bed: Bed wheels locked. Supplies ready. One-hand contact during turning. Resident not left alone on raised bed. Bed lowered before leaving bedside.On 1/7/26 at 2:22 PM, Surveyor spoke with NHA-A and shared concern R2's nursing documentation, MDS assessments and interview with RN/MDS-D documents R2 was dependent for bed mobility which requires 2-person assist and R2's care plan documented 1 person assist. NHA-A reported the definition of dependent does not specify 2-person assist is required and reviewed definition with Surveyor. Surveyor shared concern not only related to care plan, concern that R2 was dependent for bed mobility and was rolled away from the CNA during cares onto his right side leaving his affected left (hemiplegia) side exposed. The CNA reached for a towel and did not maintain control of R2, which resulted in the fall from bed requiring hospitalization, sutures to repair a head laceration and questionable rib fracture.On 1/7/26 at 2:50 PM, Surveyor asked NHA-A what the difference between 1/2 side rail, bed bar and enabler bar is. Surveyor was advised the facility does not use side rails or 1/2 side rails, and enabler bar and bed bar are the same thing - it is small a horseshoe shaped grab bar. Surveyor advised NHA-A of the facility reported expectation and training to staff which indicates if side rails are not allowed, a staff person is to stand firmly on the side that the resident could roll toward. No additional information was provided at time of survey exit.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not ensure 1 (R1) of 1 resident reviewed for adequate monitoring and indications for use with a medication was administered the medication in accordance with physician ordered parameters. R1 was transferred to the hospital on [DATE] following a fall and returned to the facility the same day. While in the emergency department R1 was diagnosed with atrial fibrillation (A Fib). On 11/27/25 Metoprolol Tartrate 25 mg (milligrams) once daily for heart failure and A Fib was ordered. This order was not implemented until 12/1/25. R1's Metoprolol Tartrate 25 mg orders included parameters to hold the medication for heart rate less than 60 or systolic blood pressure under 100. R1 received Metoprolol Tartrate 25 mg when this medication should have been held on 12/2/25, 12/9/25, 12/14/25, & 12/19/25.Findings include:R1's diagnoses include congestive heart failure) (heart doesn't pump enough blood to meet the body's needs, hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side) following cerebral infarction (type of stroke) affecting left nondominant side, hypertension (high blood pressure), and Atrial Fibrillation (irregular and rapid heartbeat).R1's hospital ED (emergency department) notes dated 11/26/25 includes documentation of Given the fact that the patient was on hospice, we engaged in extensive shared decision making with the patient and her daughter on how to proceed with workup and final disposition. It was ultimately decided to not proceed with imaging as this would likely not change intervention given her hospice status which the patient wished to stay on. She was additionally noted to be in atrial fibrillation with RVR (rapid ventricular response) likely secondary to fluid overload. We discussed attempting treatment with oral metoprolol with the patient and her hospice team as well as the patient's daughter. We did attempt to rate control the patient with oral metoprolol in the ED. We additionally provided pain control, and she stated that her pain was adequately controlled throughout ED course. After discussion with hospice team, patient and her daughter we ultimately discharged the patient back to her nursing [NAME] to continue her hospice care.R1's nurses note dated 11/27/25, at 0426 (4:26 a.m.), written by Licensed Practical Nurse (LPN)-I documents Resident returned from hospital at 1600 (4:00 p.m.) following post fall in stable condition. Resident alert and oriented x (times) 3. Hospice visited at 1700 (5:00 p.m.). VSS (vital signs stable). No new injury noted. Needs met, call light within reach.R1's physician verbal order dated 11/27/25 documents Metoprolol Tartrate 25 mg (milligram) oral tablet; Take 1 tab(s) oral once daily for heart failure and fib (A Fib) (Atrial Fibrillation).R1's nurses note dated 11/27/25, at 09:49 (9:49 a.m.), written by Registered Nurse (RN)-J documents Resident is resting. Vs (vital signs) 101/65, hr (heart rate): 56, O2 (oxygen): 91% ra (room air), RR (respiratory rate): 16 using accessory muscles. C/o (complained of) lethargy. No c/o pain or discomfort will continue to monitor. Grandson present and concerned about breathing. [Name] hospice notified. New orders provided by MD (medical doctor) and faxed to pharmacy. PRN (as needed) O2 applied.R1's nurses note dated 11/28/25, at 12:06 p.m., written by Hospice RN-K documents Pt (patient) today sleeping in bed when I arrived. I was able to wake her up easily. She responded saying my name and asking if we are having our study today. I said we will do it next week and that I wasn't sure how she felt after this fall. Pt has short periods of labored breathing lasting about 20 seconds and then her respirations will be non-labored and regular. She denies any SOB (shortness of breath). Respirations range from 14-20 per minute. Pt is on 3 liters of oxygen, decreased it to 2 liters. Pt sating at 92-93%, BP (blood pressure) 84/66, HR (heart rate) 108. Writer faxed over new order for metoprolol 25 mg (milligrams) once daily to control her afibb (sic) since patient was in afibb (sic) with RVR (rapid ventricular response) in the emergency room on 11/26. Hospice RN will see patient tomorrow (Saturday) for this COC (change (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of condition) regarding her need for oxygen and afibb (sic).R1's nurses note dated 12/1/25, at 13:39 (1:39 p.m.), written by Hospice-K documents Pt today sitting in bed with lunch in front of her. Pt is not eating and reports she doesn't have an appetite. She drinks her chocolate milk though. Pt seems to be back to baseline, alert, oriented x (times) 2-3. Pt is able to answer questions appropriately but does not really keep the conversation going or ask me questions. She was happy to know I was ordering her a bigger bed after this fall. New order for metoprolol that I ordered last week was not in [Name of electronic charting system], so I refaxed it again and they are putting the order in. Pt will need to get a dose of her metoprolol today since she is still in afibb (sic) 115-130's. Pt is asymptomatic, denies SOB. Oxygen 95% on 1 liter of oxygen. Writer decreased her oxygen to 1 liter from 2 liters. BP 11/73-HR 111. Writer told facility nurse to give metoprolol dose today. Writer ordered a bariatric bed and mattress for patient safety reasons after her fall out of bed last week. Should be delivered within 24 hours.R1's nurses note dated, 12/1/25 at 13:13 (1:13 p.m.), written by RN-C documents N.O.R. (new order received) per [Name] RN [Name] hospice for Metoprolol Tartrate 25 mg q (every) AM (morning).Medical Doctor (MD)-L's progress note dated 12/8/25 under assessment and plan includes documentation of *I48.91 - Unspecified atrial fibrillation*: Patient was found to have atrial fibrillation with rapid ventricular response during emergency department visit on 11/26/2025 for fall from bed with head strike. Heart rate was 248 in ED and was treated with metoprolol tartrate 25 mg for rate control. Metoprolol tartrate 25 mg daily was ordered on 12/1/2025 for tachycardia. Heart rate has improved, ranging 56-92 over the past week (12/1/2025-12/7/2025). Patient remains on hospice care with focus on comfort measures. Metoprolol tartrate is being increased to 25 mg twice daily for improved rate control. Will monitor heart rate.Surveyor reviewed R1's November 2025 MAR (medication administration record) and noted Metoprolol 25 mg once daily is not included on this MAR.Surveyor reviewed R1's December 2025 MAR and noted the following:Metoprolol Tartrate Oral Tablet 25 MG (Metoprolol Tartrate) Give 1 tablet by mouth in the morning related to Hypertensive Heart Disease with Heart Failure (I11.0) hold medication for heart rate less than 60 or systolic B.P. (blood pressure) under 100. Start date 12/2/25 and discontinued 12/8/25.Metoprolol Tartrate Oral Tablet 25 MG (Metoprolol Tartrate) Give 1 tablet by mouth two times a day related to Hypertensive Heart Disease with Heart Failure (I11.0) hold medication for heart rate less than 60 or systolic B.P. (blood pressure) under 100. Start date 12/9/25.Physician orders were not followed for holding Metoprolol Tartrate 25 mg when R1's heart rate is less than 60 or systolic blood pressure is under 100 on 12/2/25 when R1's pulse was documented as 60. The morning dose on 12/9/25 when R1's pulse was 49, the morning dose on 12/14/25 when R1's systolic blood pressure was 98 & pulse was 50 and the morning dose on 12/19/25 when R1's systolic blood pressure was 79.On 1/7/26, at 11:05 a.m., Surveyor asked Director of Nursing (DON)-B who reviews paperwork from the hospital when a resident returns. DON-B informed Surveyor the floor nurse gets the paperwork and reviews this paperwork. Surveyor asked DON-B who Surveyor should speak with regarding R1 when R1 returned from the hospital on [DATE]. DON-B informed Surveyor she should speak with RN-C as RN-C is the main nurse and possible may have the answer.On 1/7/26, at 11:34 a.m., Surveyor asked RN-C who is responsible for reviewing a resident's hospital paperwork when they return from the hospital. RN-C informed Surveyor the nurse doing the admission. Surveyor asked how they are aware if hospice orders a medication. RN-C informed Surveyor hospice should let the nurse know if they don't there is a disconnect. Surveyor asked RN-C if she reviews hospice notes in a resident's medical record. RN-C informed Surveyor hospice is supposed to talk with the nurse, and she doesn't review hospice notes. Surveyor asked RN-C if there are parameters when to hold a medication should these parameters be followed. RN-C replied yes.On 1/7/26, at 12:20 p.m., Surveyor asked (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON-B if hospice writes an order how is the nurse on the floor aware. DON-B informed Surveyor hospice typically sends the order over the fax. Surveyor asked DON-B when a medication is ordered by hospice who ensure the order is implemented. DON-B informed Surveyor hospice orders go upstairs so the nurse on the floor would get the order and put the order in the system. Surveyor asked DON-B if the physician orders parameters when to hold medication should the nurse follow the physician orders for holding the medication. DON-B replied yes. Surveyor informed DON-B there is a telephone order dated 11/27/25 for Metoprolol 25 mg once daily for R1. On 11/28/25 there is a hospice note for R1 which includes writer fax over new order for Metoprolol 25 mg daily and a hospice note dated 12/1/25 which indicated new order for Metoprolol 25 ordered last week was not in system. Surveyor informed DON-B R1 did not receive Metoprolol 25 mg according to physician orders. Surveyor also informed DON-B R1 should not have received Metoprolol 25 mg on 12/2/25, 12/9/25, 12/14/25, and 12/19/25 as R1's pulse and/or systolic heart rate was below the parameters for which the medication should be administered.