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	03/26/2026

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 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** Based on observation, interview, and record review, the facility did not ensure residents at risk of pressure injuries received necessary treatment and services consistent with professional standards of practice to prevent the development of pressure injuries for 1 (R34) of 1 resident reviewed. *R34 was admitted to the facility 2/23/26 without any pressure injuries, and the facility assessed R34 to be at high risk for the development of pressure injuries. R34 developed two avoidable facility acquired, unstageable pressure injuries to the right and left legs on 3/22/26. The facility did not implement person centered interventions to prevent pressure injuries from developing, did not accurately assess the pressure injuries upon discovery, did not identify the root cause of the pressure injuries to allow the facility to identify person centered interventions to promote healing and prevent new pressure injuries from developing. Findings include:The facility's policy and procedure titled, Pressure Injury Prevention and Managing Skin Integrity with initial approval date 2/8/17 and reviewed date 5/8/25 documents . I. Policy: prevention measures are put in place to reduce the occurrence of pressure injuries. II. Procedure:Risk Assessment . Upon admission: Braden Scale will be completed to evaluate individual's risk for developing a pressure injury at admission, and weekly for four weeks for all new admissions. Re-evaluation: Braden Scale will be completed upon change of condition and quarterly. 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 and Care Plan . 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 . Care Plan . In developing a plan of care, the following will be considered: . Individual pressure injury history . risk for pressure ulcer development (Braden Scale) . Skin Checks . Skin check will be done upon admission, readmission or as clinically indicated. While providing routine care, a licensed nurse is to monitor the skin condition of each individual weekly and document the Skin Check in the medical record. 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 (PCP) (Primary Care Physician) with any decline in wound appearance, or as necessary . Update the Care Plan with any new interventions as applicable . Update Individual Representative as indicated.The National Pressure Injury Advisory Panel (NPIAP) document titled, NPIAP Staging for Lightly Pigmented Skin dated 2/14/2020 defines a pressure injury as localized damage to the skin and underlying soft tissue usually over a bony prominence . the injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The document defines the following stages:Stage 2: partial-thickness skin loss with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar (hard, dead scab or crust of tissue) are not present. Stage 3: full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and (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 0686 Level of Harm - Actual harm Residents Affected - Few	epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location . if slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.Unstageable Pressure Injury: full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. R34 was admitted to the facility on [DATE] with diagnoses including other sequelae (long-term effects) of cerebral infarction (stroke).R34's admission skin evaluation dated 2/23/26 documents bruising at the left and right antecubital (front of the elbow) regions and an abrasion to the left elbow. R34's significant change Minimal Data Set (MDS) dated [DATE] documents no current pressure injuries or skin conditions, and R34 is assessed to be at risk for developing pressure injuries. The MDS documents R34 has a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS documents R34 requires moderate assistance from staff for rolling in bed and R34 is dependent on staff for activities of daily living (ADLs), transfers in and out of bed, transfers in and out of a wheelchair, and is unable to walk. R34's Care Area Assessment (CAA) for pressure injuries dated 3/16/26 documents the CAA triggered for potential pressure ulcer due to need for assistance with bed mobility . further complicated by incontinent of urine and bowel, utilizes brief daily to manage. [R34] does not currently have a pressure ulcer or history of pressure ulcers . [R34] is at risk for skin breakdown . will proceed to plan of care with goal to maintain skin integrity. R34's Braden Scale assessment dated [DATE] documents a score of 11, indicating high risk for pressure injury development.R34's care plan documents [R34] has potential for impairment to skin integrity r/t (related to) decreased ambulation. Date initiated:3/2/26, revision on 3/2/26. Interventions include:-[R34] will maintain clean and intact skin by the review date.-The resident will maintain clean or develop clean and intact skin by the review date.-Follow facility protocols for treatment of injury. -[R34] needs pressure relieving/reducing cushion to protect the skin while up in chair. -The resident needs (Specify: pressure relieving/reducing mattress, pillow, sheepskin padding etc. (etcetera)) to protect the skin while up in chair. Surveyor notes the facility did not identify resident specific interventions to prevent pressure injuries from developing including what type of cushion R34 required while up in a chair. In an interview with R34 on 3/23/26 at 1:52 PM, R34 was unable to state what happened to R34's legs. Surveyor observed a wound dressing on both R34's right and left lower legs dated 3/23. R34's legs were observed to not be resting on the Broda chair and a roho cushion was in place. Surveyor reviewed R34's electronic health record (EHR) and located a nursing progress note written by Registered Nurse (RN)-K dated 3/22/26 at 1:59 PM, which documents two new open areas to [R34]'s knees: the right lateral (outer) knee showed no drainage, and the surrounding skin was pink and intact. The left lateral knee also had no drainage, with the surrounding skin being pink and intact. The areas were cleaned with wound cleaner, f/b (followed by) bordered foam dressing. The resident denies pain in the area. POA (Power of Attorney), DON (Director of Nursing) and ADON (Assistant Director of Nursing) and [name of hospice company] RN (Registered Nurse) were made aware of the above. R34's EHR documents a skin care form dated 3/22/26 which documents Skin color WNL (within normal limits). New skin issue. Location: Front right knee. Laterality. Tissue type: Open lesion. Progress: New wound. Wound acquired in-house. It is unknown how long the wound has been present. Signs and symptoms of infection: None. Painful: No. Staged by: in-house nursing. Length (cm): 0.5, Width (cm) 2.5, Depth (cm) 0.1, Undermining: No. Tunnelling: No. Periwound: epithelization. Periwound: Rolled ddge (sic) (Epibole). Surrounding tissue: Fragile. Surrounding tissue: Intact. Induration: Induration (the localized hardening or firming of soft tissue surrounding a wound) < 2cm around the wound. Edema: No swelling or edema. Periwound temperature: Normal. Dressing appearance: Intact. Dressing saturation: 0%. Cleansing solution: None. Primary Dressing: foam. Secondary dressing: No secondary dressing applied. Modalities: None. Frequency of treatment: Clean wound with wound cleaner f/b bordered foam dressing 3x (times) week. New skin issue. Location: Front left knee. Laterality/orientation: Left. Laterality/orientation: Lateral. Issue (sic) type: Open (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Lesion. Progress: New wound. Wound acquired in-house. It is unknown how long the wound has been present. Signs and symptoms of infections: None. Painful: No. Staged by: In-house nursing. Length (cm):1, Width (cm): 1, Depth (cm) 0.1. Undermining: No. Tunnelling: No. Granulation: 0%. Slough: 0%. Exudate type: None. Odor after cleaning: None. Periwound: Rolled ddge (sic) (Epibole). Surrounding tissue: Intact. Surrounding tissue: Erythema. Induration: Induration (the localized hardening or firming of soft tissue surrounding a wound) < 2cm around the wound. Edema: No swelling or edema. Periwound temperature: Normal. Dressing appearance: Intact. Dressing saturation: 0%. Cleansing solution: None. Primary Dressing: foam. Secondary dressing: No secondary dressing applied. Modalities: None. Frequency of treatment: Clean wound with wound cleaner f/b bordered foam dressing 3x (times) week. On 3/25/26 at 2:33 PM, Surveyor interviewed RN-K via phone call. RN-K confirmed a certified nursing assistant (CNA) discovered R34's wounds on 3/22/26 and alerted RN-K. RN-K confirmed an assessment was completed 3/22/26 for R34's new wounds and RN-K confirmed the wounds were documented as open lesions. RN-K stated R34's wounds looked like maybe a blister had opened and RN-K was unsure of the etiology. Surveyor asked why RN-K categorized the wounds as open lesions and RN-K stated RN-K was not sure what to categorize the wounds as and did not think the wounds were due to pressure and RN-K didn't know if it was shearing or a blister. RN-K stated R34 does tend to cross R34's legs when sitting in the wheelchair, so maybe the wounds developed from shearing when R34 was crossing their legs. RN-K stated R34 usually wears socks and takes them off and moves around a lot. RN-K stated they (RN-K) have done a lot of wound care but did not necessarily receive education from the facility. RN-K stated there is an area on the form (facility skin care form) to document root cause. RN-K stated unknown should have been documented, wound bed newly granulating, 0% granulation since it was brand new, no slough or exudate was observed. Surveyor notes the facility did not implement care plan interventions to promote healing to address possible shearing when R34 crosses their legs. On 3/24/26 at 7:37 AM, Surveyor observed R34's wound care performed by RN-F. Surveyor asked RN-F how R34's wounds may have developed. RN-F stated R34 appears to have a curvature to the lower legs on both sides where the wounds developed, and the wounds are over a prominent area, so they could have developed due to the curvature of R34's legs. Surveyor notes the facility did not implement interventions to address R34's leg curvature as a possible cause of R34's pressure injuries. On 3/24/26 at 8:50 AM, Surveyor went with Director of Nursing-B and Wound Nurse Practitioner (Wound NP)-J to R34's room. DON-B and Wound NP-J stated 3/24/26 is the first date R34's wounds are being assessed by DON-B and Wound NP-J. Wound NP-J observed R34's wounds and stated the wounds are over a very prominent area on R34's lower legs so the wounds would be considered pressure injuries. Wound NP-J stated the right lower leg wound is a full thickness wound measuring 0.5 cm in length, 0.5 cm in width, and unable to determine (UTD) depth with 80% granular tissue and 20% slough with small serous drainage, no signs of infection. Wound NP-J stated the left lower leg wound is a full thickness wound measuring 1.0 cm in length, 2.0 cm in width, and UTD depth with 20% granular tissue and 80% slough with small serous drainage, no signs of infection. Wound NP-J stated both wounds are considered unstageable pressure injuries since slough is present in both wounds. Wound NP-J stated the wounds may have developed from R34's mattress from resting on the scoops on the edge of the mattress. Surveyor notes the scoops on the edge of the mattress are located only at the head and foot of the mattress. The Wound Care Initial Evaluation in R34's EHR dated 3/24/26 at 12:36 PM, written by Wound NP-J documents etiology of wounds is unclear, however [R34] needs full assistance with cares. Air mattress to be ordered, continue to reposition, avoid laying on either side for more than two hours at a time while in bed. On 3/24/26 at 12:52 PM, Surveyor observed R34 lying in bed on R34's left side with both lower legs off of the mattress and resting directly on an extra mattress next to R34's bed. Surveyor asked RN-F why there is an extra mattress next to R34 and RN-F stated the extra mattress is a fall intervention because R34 has had previous falls out of bed. RN-F stated R34 likes to lay in this position. Surveyor notes the facility did not implement pressure injury preventative interventions to address R34's (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	preference to lay with his legs off the bed and resting directly on the extra mattress next to the bed. On 3/25/26 at 8:20 AM, Surveyor interviewed CNA-L and CNA-M who stated R34 does cross R34's legs a lot in the wheelchair and when lying in bed. CNA-L demonstrated to Surveyor how CNA-L observes R34 cross the legs and Surveyor notes the heel is demonstrated to be resting on the opposite leg in the same area of R34's wounds. CNA-L and CNA-M stated they have observed R34 cross R34's legs in this manner since R34 was admitted to the facility. R34's impairment to skin integrity care plan was revised 3/25/26 (3 days after the pressure injuries were identified) and documents the following interventions:-alternating pressure mattress (initiated 3/25/26)-avoid laying on either side for greater than 2 hours when in bed (initiated 3/24/26)-every 2 hours turn and reposition schedule on even hours when in bed (initiated 3/25/26)-monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs/symptoms of infection, maceration etcetera (initiated 3/24/26)-weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations (initiated 3/24/26)Surveyor notes no interventions were added to reduce pressure to R34's legs while R34 is up in the wheelchair, to reduce pressure/shearing when R34 crosses R34's legs, to address the curvature of R34's legs, or 34's preference to lay with legs off the bed all of which facility staff have identified as a possible causes for the pressure injuries. On 3/25/26 at 2:46 PM, Surveyor shared concern with Nursing Home Administrator (NHA)-A, DON-B, Assistant Director of Nursing (ADON)-C and Regional Nurse Consultant-D that R34 admitted to the facility on [DATE] without any pressure injuries and was assessed to be at high risk for the development of pressure injuries, and developed two unstageable pressure injuries to the right and left lower legs on 3/22/26. Surveyor shared additional concern R34's care plan was not revised to address the staff identified causes for the pressure injury development. On 3/26/26 at 8:00 AM, NHA-A provided Surveyor with a document titled New Wound for R34. Surveyor notes DON-B documented in the notes section dated 3/24/26 [R34] was seen on Tuesday with normal rounds, wound assessed and addressed by Wound NP. [R34] has had multiple falls with behaviors of crawling around which has been care planned . initial wound assessment was done by floor nurse who is uncertified in wound care. Floor nurse description of wound bed and measurements was not accurate. On 3/26/26 at 12:09 PM, NHA-A provided initial pictures of R34's wounds taken on 3/22/26 by RN-K to the survey team. Surveyor notes the pictures show slough tissue in both wounds upon discovery. On 3/26/26 at 8:25 AM, Surveyor interviewed DON-B regarding the pictures of R34's pressure injuries. DON-B confirmed the pictures indicate slough was present in R34's wounds when the wounds were first discovered, so the wounds should have been categorized as unstageable pressure injuries. Surveyor shared concern with DON-B that R34's wounds were not accurately staged or described as unstageable pressure injuries when they were discovered. DON-B expressed understanding. No additional information was provided.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. This has the potential to affect all residents that reside at the facility. *Registered Nurse (RN)-F did not properly disinfect a glucometer that is shared between residents. This deficient practice has the potential to affect 5 residents that require blood sugar testing on the first floor. *The facility had a COVID-19 outbreak in February 2025 and did not provide evidence that the outbreak was reported to the local public health authority. This deficient practice had the potential to affect all residents residing in the facility during the February 2025 outbreak. Findings include: The facility policy titled Infection Prevention and Control Program with approval date 6/14/17 and review date 8/29/25 documents: the facility will report to the public health department according to the Centers for Disease Control (CDC) and state guidelines. The State of Wisconsin Memo BCD 2023-05 dated 9/29/2023 documents outbreaks of any communicable disease, including COVID-19, remain a category 1 reportable condition. The State of Wisconsin Chapter DHS (Department of Health Services) 145 Appendix A, titled Communicable Diseases and Other Notifiable Conditions documents category 1 conditions include: Outbreaks, confirmed or suspected: other acute illnesses. The disease shall be reported by telephone to the patient's local health officer or to the local health officer's designee upon identification of a case or suspected case. In addition to the immediate report, complete and fax, mail or electronically report an Acute and Communicable Diseases Case report to the address on the form, or enter the date into the Wisconsin electronic Disease Surveillance System, within 24 hours. On 3/24/26 at 11:34 PM, Assistant Director of Nursing (ADON)-C confirmed ADON-C is the Infection Preventionist (IP) at the facility and provided Surveyor with two infection control binders. ADON/IP-C stated one binder is for information about the IP program from January 2026 to current and the other binder is information about the IP program from January 2025 to December 2025. ADON/IP-C stated ADON/IP-C started the IP role in August 2025 and was not sure who the IP for the facility was prior to then. Surveyor noted documentation of a COVID-19 outbreak between the dates of 1/26/25 to 2/25/25 which affected 12 residents and 3 staff members. Surveyor was unable to locate evidence that the facility reported the outbreak to the local health officer. Surveyor did not note any other outbreaks documented in the facility between January 2025 to current. On 3/25/26 at 1:52 PM, ADON/IP-C stated the information available in the binder that was provided to Surveyor is all the information ADON/IP-C has regarding the COVID-19 outbreak and no additional information is available. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/25/26 at 2:46 PM, Surveyor shared concern with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, ADON/IP-C and Regional Nurse Consultant-D that there is no evidence the facility reported the COVID-19 outbreak to the local health officer in February 2025. Regional Nurse Consultant-D confirmed no additional information was located and all information regarding the COVID-19 outbreak in February 2025 the facility has was provided in the binder. 2.) On 3/24/26 at 8:10 AM, Surveyor observed Registered Nurse (RN)-F prepare medications for R17. Surveyor observed a glucometer resting on a white wipe on the medication cart. RN-F picked up the glucometer and removed a wipe from a container with blue top labeled Sani hands instant hand sanitizing wipe. RN-F wiped the glucometer for 15 seconds and placed it on top of the wipe. Approximately 1 minute later, RN-F sanitized his hands, put on gloves and entered R17's room to obtain her blood sugar. After obtaining R17's blood sugar, RN-F walked back to the medication cart, removed his gloves and sanitized his hands. RN-F applied gloves, obtained a wipe from the same container and wiped the glucometer for 15 seconds before placing it on a clean glove on the medication cart. Upon completion of R17's medication pass, Surveyor asked if residents have their own glucometers or if they are shared between residents. RN-F stated, On this floor it is shared, upstairs they have their own each in a plastic bag with their name. Surveyor asked RN-F if he had any other blood sugars to do. RN-F stated, Yes, one more. Surveyor asked RN-F if any other residents' blood sugars have been done. RN-F stated, Yes, room [room number] and room [room number]. Surveyor verified those residents as R24 and R29. Surveyor asked how the glucometer is cleaned between residents. RN-F stated, I use this wipe (showed Surveyor the instant hand sanitizing wipe container) and wipe it down, some of these have instructions to keep it wet for a while, so that's why I wipe it down and leave it wet to air dry. On 3/24/26 at 8:25 AM, Surveyor asked RN-F if there were any other wipes in the medication cart to clean the glucometer. RN-F checked the drawers and stated, No, but after thinking about it, I realize now that I didn't use the right wipe, I think it's supposed to be the purple top. Surveyor advised RN-F of concern he cleaned the glucometer using a hand sanitizing wipe. RN-F reported he would obtain the proper wipe to clean the glucometer. On 3/24/26 at 8:30 AM, Surveyor asked Nursing Home Administrator (NHA)-A and Consultant-D what the expectation is for cleaning glucometers. NHA-A said, I think an alcohol wipe, I'm not sure. Consultant-D corrected her, stating No, we use the germicidal wipe. Surveyor observed a container with a purple top on the table labeled Super Sani Cloth germicidal disposable wipe. Consultant-D confirmed this is the wipe to be used. Surveyor asked for a copy of the facility policy and procedure for cleaning glucometers. On 3/24/26 at 8:45 AM, NHA-A advised Surveyor the facility does not have a policy and procedure on cleaning glucometers, We would follow the manufacturer recommendations on the container. I assume you're asking because (RN-F) used the wrong wipe, the one with the blue top. Surveyor advised NHA-A of concern the glucometer was cleaned with a hand sanitizing wipe. NHA-A stated, We spoke with him, did education and gave him the correct wipe with the purple top. Surveyor asked NHA-A for evidence of how many residents on the unit require blood sugar testing and if any residents have bloodborne pathogens. Surveyor was provided with a list of residents requiring blood sugar testing on the first floor to be: R10, R17, R21, R24 and R29. Surveyor verified none of the residents had bloodborne pathogens. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The blue top Instant hand sanitizing wipes container label documents: Cleans and sanitizes hands. Kills 99.9% of many common bacteria. Safe to use before eating and drinking. Contains moisturizing aloe and vitamin E. Active ingredient: Ethyl alcohol 70% by volume - antiseptic. Use: To decrease bacteria on the skin. The purple top Super Sani-Cloth germicidal disposable wipe container label documents: Effective against: Bacteria, multi-drug-resistant bacteria, viruses, bloodborne pathogens, mycobacterium (TB), pathogenic fungi. Kills HIV-1(Human Immunodeficiency Virus), Hepatitis B and Hepatitis C on the environmental surface/object within 2 minutes. Contact time: Allow surface to remain wet for 2 minutes, let air dry. The Assure Prism glucometer manufacturer recommendations document: To minimize the risk of transmission of blood-borne pathogens, the cleaning and disinfection procedure should be performed as recommended in the instructions below. After disinfection, users should remove gloves and wash hands before testing the next patient. Cleaning and disinfecting: The cleaning procedure is needed to clean dirt as well as blood and other body fluids on the exterior of the meter and lancing device before performing the disinfection procedure. The disinfection procedure is needed to prevent transmission of blood-borne pathogens. The meter should be cleaned and disinfected after use on each patient. This blood glucose monitoring system may only be used for testing multiple patients when standard precautions and the manufacturer's disinfection procedures are followed. We have validated Super Sani-cloth germicidal disposable wipe for disinfecting the assure prism multi meter. It has been shown to be safe for use with the meter. On 3/34/26 at approximately 10:00 AM, NHA-A and Consultant D were advised of the above concern. No additional information was provided.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on record review and staff interview, the facility did not ensure the Infection Preventionist (IP) had specialized training in infection prevention and control. This has the potential to affect all 36 residents in the facility. *The Assistant Director of Nursing (ADON)-C began the IP role in August 2025 and did not provide evidence of completing specialized training in infection prevention and control prior to assuming the role of the IP. Findings include:The facility policy titled Infection Prevention and Control Program with review date 8/29/25 documents: the IP will maintain current knowledge in the filed of infectious disease and epidemiology through training provided through the Centers for Disease Control (CDC) in collaboration with Centers for Medicare and Medicaid (CMS). On 3/24/26 at 11:34 AM, Surveyor met with ADON/IP-C to discuss the facility's infection control program. During this meeting, Surveyor asked ADON/IP-C if ADON/IP-C has specialized training in infection prevention and control with evidence of a certificate. ADON/IP-C stated ADON/IP-C does not have any certification or specialized training and has not completed training through the CDC. ADON/IP-C stated ADON/IP-C took over the role of IP for the facility in August 2025. Surveyor shared concern with ADON/IP-C that ADON/IP-C has been the IP for the facility since August 2025 without completing specialized training. ADON/IP-C understood the concern. Surveyor reviewed the facility infection control program information provided by ADON/IP-C from January 2025 to March 2026 and did not note any documented outbreaks in the facility between August 2025 to March 2026 when ADON/IP-C served as the facility's IP.In an interview on 3/25/26 at 1:52 PM, ADON/IP-C informed Surveyor that the facility enrolled ADON/IP-C in the infection prevention and control program on 3/24/26, after it was brought to the facility's attention. During the interview, Surveyor asked ADON/IP-C if ADON/IP-C participates in the facility's water management program. ADON/IP-C stated ADON/IP-C has not participated in the water management program and was not aware of what the IP role in the facility's water management program would be. On 3/25/26 at 2:46 PM, Surveyor shared concerns with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, and regional nurse consultant-D that ADON/IP-C did not have evidence of completing specialized training in infection prevention and control prior to assuming the role of IP in August 2025, and there is no evidence this training has been completed as of 3/25/26. Regional nurse consultant-D confirmed ADON/IP-C was enrolled in the CDC infection preventionist training course on 3/24/26 but ADON/IP-C has not yet completed the course. In an interview on 3/26/26 at 12:19 PM, regional nurse consultant-D stated regional nurse consultant-D does have the CDC certification for infection prevention and control and will continue monitoring and assisting ADON/IP-C with the infection control program until ADON/IP-C has completed the certification course. Surveyor requested regional nurse consultant-D's evidence of specialized training completion, but regional nurse consultant-D was unable to locate the certificate. On 3/26/26 at 5:26 PM, NHA-A sent additional information to Surveyor with a certificate for nurse consultant-O documenting completion of the CDC course Nursing Home Infection Preventionist Training Course dated 7/16/2024. NHA-A stated in the email that nurse consultant-O also assists the facility with the infection control program.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 5 (R5, R6, R30, R37, and R1) of 8 resident's reviewed for hospitalization received the proper notice of transfer and bed-hold to include; date and reason for transfer, location of transfer, duration of bed hold, reserve bed hold payment, appeal rights, and name and address, and telephone number of the Office of the State Long-Term Care Ombudsman. *R5 transferred and admitted to the hospital on the following dates, 6/14/25, 7/2/25 and 12/4/25 while residing in the facility and evidence was not provided R5 or their representative were notified in writing of the reason for the transfer/discharge to the hospital and the facility policy for bed hold. *R6 transferred and admitted to the hospital on the following dates, 11/21/25 and 2/19/26 while residing in the facility and evidence was not provided R6 or their representative were notified in writing of the reason for the transfer/discharge to the hospital and the facility policy for bed hold. *R30 transferred and admitted to the hospital on the following dates, 1/31/26 and 2/24/26 while residing in the facility and evidence was not provided R30 or their representative were notified in writing of the reason for the transfer/discharge to the hospital and the facility policy for bed hold. *R37 transferred and admitted to the hospital on the following dates, 12/3/25, 1/4/26 and 3/13/26 while residing in the facility and evidence was not provided R37 or their representative were notified in writing of the reason for the transfer/discharge to the hospital and the facility policy for bed hold. *R1 transferred and admitted to the hospital on [DATE] while residing in the facility and evidence was not provided R1 or their representative were notified in writing of the reason for the transfer/discharge to the hospital and the facility policy for bed hold. Findings include: The facility policy, entitled Individual Bed Hold, dated 5/8/91 with most recent review dated 3/3/26, documents, in part . Policy: The individual, guardian, and/or individual representative will be informed upon admission and/or hospital/therapeutic leave of their bed hold options at the facility. Procedure: .B. Upon transfer to hospital and/or therapeutic leave. 1. Individual will be informed and receive a copy of the bed hold procedure and letter. 2. Options will be given for a decision to be made regarding bed hold status. 3. If individual is unable to make preference known, designee will contact guardian and/or individual representative to determine preference. 4. Response will be documented. 5. Life Coach, or designee, will contact the individual representative on the next working day to ensure that the representative understands the bed hold and return to facility information. 6. Life Coach, or designee will make periodic contact with the individual and/or representative during the individual's absence. C. Bed Hold Parameters. 1. For Private Pay Individuals: An individual's bed will be held and the individual will be billed the day (sic) rate for each day he or she is away from the entity. The individual and/or individual representative may request that he or she does not want the bed held. 2. For Medical Assistance Individuals and Managed Care Individuals: Medical Assistance and Managed Care will pay to hold the bed for 15 days. The individual, guardian, and/or individual representative may choose to pay privately on the 16th day after the leave to hold the bed. If the bed hold is not desired, the individual may be offered the next available bed at the entity for admission. 3. For Medicare and/or other Insured Individuals: An individual's bed will be held and the individual will be billed the day (sic) rate for each day he or she is away from the entity. Medicare does not cover the cost of a bed hold during hospitalization or therapeutic leave. The individual, guardian, and/or individual representative may request that he or she does not want the bed held. 1.) R5 was admitted (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to the facility on [DATE]. R5 has an activated Power of Attorney (POA) effective 6/14/25. R5's Nurses Note, dated 6/14/25 at 8:02 AM, documents, Resident assessed by writer @ (at) 0645 (6:45 AM) R/T (related to) decline in condition. Resident weak. Not changing position in bed. More confused than usual. Lethargic and not accepting fluids. Skin turgor poor with tenting. A (alert) & O (oriented) X (times) 1 only. T (temperature)-99.0 P (pulse)-78 R (respiration)-18. B.P. (blood pressure)130/70. STAT (immediately, instantly or without delay) labs and STAT urine not obtained 6-13-25 per writer conversation with PM (second shift) nurse. Writer called POA on above and states she wants her to be sent to the ER (emergency room). NP (Nurse Practitioner) called and updated states to send Resident out to [hospital name] ER per ambulance. Ambulance called to transport. All papers sent with [name of company] ambulance when transported @ 0715 (7:15 AM).[Hospital name] ER called and ER RN (Registered Nurse) updated on Resident transfer and condition. 2nd floor cell phone number provided to ER nurse to call with any questions. R5's Nurses Notes, dated 6/14/2025 at 12:11PM, documents, Resident admitted with DX (diagnosis) Hypokalemia (lower than normal level of potassium in the blood) and elevated WBC (white blood count). R5's Discharge/Transfer Note, dated 6/16/2025 at 8:48AM documents, Bed hold completed, the residents bed will be held according to the facility bed hold policy. R5's Nurses Note, dated 6/24/2025 at 5:29 PM, documents, Resident follow up readmit, slept through the night, no complaints of pain or discomfort, none reported. R5's Nurses Note, dated 7/2/2025 at 13:38 (1:38 PM) documents, Resident working with PT (Physical Therapy) when writer was called to her room as Resident was unresponsive. Resident unresponsive and sitting on the toilet. Eyes closed and body limp. 911 called by writer and Resident monitored continually until ALS (Advanced Life Support) in room. Writer was instructed not to move Resident and keep her NPO (nothing by mouth). Resident with shallow breathing and PT stated she was unresponsive about a minute. Resident became responsive when ALS arrived. Resident slow to respond @ first. Resident transported to [hospital name] ER per stretcher. POA called and updated on above. POA thanked writer for sending her to [hospital name] as Resident has a CVA/T.I.A. (stroke/transient ischemic attack) HX (history). R5's Nurses Note, dated 12/4/2025 at 06:22 AM, documents, Patient had coffee brown emesis x1 on shift, BP 174/106, RR 20, HR 85, and Spo2 96%. [Physician service] updated, voicemail left to POAs. Resident sent to ER to get eval and to treat. On 03/24/2026 at 12:11 PM Surveyor requested from Nurse Consultant-D, the Bed Hold and Transfer notices for R5's hospitalizations that occurred on 6/14/25, 7/2/25 and 12/4/25. On 03/24/2026 at 12:30 PM, Nursing Home Administrator (NHA)-A provided Surveyor a copy of R5's Bed Hold confirmation upon Transfer from the Skilled Nursing Facility for hospitalization on 6/14/25 and a copy of R5's Notice of Transfer and Bed Hold Form for hospitalization on 12/4/25. NHA-A confirmed there is no evidence of R5's bed hold or transfer notice for hospitalization on 7/2/25. R5's Bed Hold Confirmation upon Transfer from the Skilled Nursing Facility form, dated 6/14/25, documents, R5's name, physician, date of transfer, location of transfer, payor source as Medicaid, 15 day bed hold, appeal rights, and name and address with the telephone number of the Office of the State Long-Term Care Ombudsman but did not document R5's reason for transfer, reserve bed hold payment daily rate and does not have R5's signature or representative signature nor documentation if a verbal notification was provided. R5's Notice of Transfer and Bed Hold Form dated 12/03/25 documents R5's name, physician, date of transfer, location of transfer, reason for transfer, payor source as Medicare, reserve bed hold payment (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	daily rate, appeal rights, and name and address with the telephone number of the Office of the State Long-Term Care Ombudsman but did not document R5's POA was informed of bed hold and transfer notice. Surveyor notes, R5's Notice of Transfer and Bed Hold Form dated 12/03/25, for actual hospitalization on 12/4/25, documents incorrect payor source of Medicare when it should be Medicaid and a 15-day bed hold was not indicated. On 03/24/2026 at 2:58 PM, Surveyor informed NHA-A, Director of Nursing (DON)-B, Assistant Director of Nursing (ADON)-C, and Nurse Consultant-D of missing or incomplete/inaccurate bed hold and transfer notices for the R5. NHA-A expressed understanding. 2.) R6 was admitted to the facility on [DATE]. R6 was appointed legal guardianship effective 12/6/24. R6's Progress Note, dated 11/21/2025 at 10:45 AM documents, Resident c/o (complained of) non-radiating stabbing chest pain (8/10). VS (Vital Signs) WNL (Within Normal Limits) SPO2 (oxygen level) 96% RA (room air). Resident request to go to ER (emergency room) for evaluation. 911 called. Aspirin 324mg (milligrams) administered order by 911. Resident maintained NPO (nothing by mouth). 1110 (11:10 AM) 911 on the unit. EKG (electrocardiogram) (teste that measures the heart's electrical activity) completed; negative. Chest pain continues at 8/10. Resident request ER evaluation. POA (Power of Attorney) called; agrees to send resident to [name of hospital] Hospital for evaluation and treatment. R6's Progress Note, dated 2/19/2026 at 21:08 (9:08 PM), documents, Resident presents with red-tinged projectile vomiting x (times) 2. 97.1 80 139/82 17 94% RA BS 398. [Physician service] notified; ordered to send to Hospital for evaluation and treatment. DON (Director of Nursing) and POA notified. 911 called. On 03/24/2026 at 8:34 AM, Surveyor requested from NHA-A, R6's bed hold and transfer notices for hospitalizations on 11/21/25 and 2/19/26. On 03/24/2026 at 10:38 AM, NHA-A stated the facility used to have a full time Admissions Coordinator and when this person vacated the position, job duties were split between two other staff members and somehow the bed hold and transfer notices fell between the cracks and the documents are no longer being completed. NHA-A confirmed there is no evidence of R6's bed hold and transfer notices for hospitalizations on 11/21/25 and 2/19/26. 3.) R30 was admitted to the facility on [DATE]. R30 makes his/her own health care decisions. R30's Nurses Note, dated 1/31/2026 at 10:42 AM, documents, Writer called in the room by CNA (Certified Nursing Assistant) who stated the resident was on the floor when she entered the room. When writer entered the room, the resident was lying on R30's right side with his face against the nightstand in R30's room walker was under R30, and the resident had bowel movement on the floor behind R30. Writer asked the resident how did R30 fall and R30 stated that R30 was trying to go to the bathroom. call light was not on gripper socks on. writer asked the resident did R30 hit head R30 stated I don't know writer completed a full assessment and the resident was able to move all extremities. The CNA helped hoyer him into the bed. during neuro check the resident became confused and asked where am I? who are you? spo2 (oxygen level) dropped to 75%. writer placed 2L (liters) of 02 (oxygen) on the resident and called Ambulance for transport to the hospital. BP 132/65 pulse 104 respirations 25 temp 97.8. POA, DON and on call NP all notified. R30's Nurses Note, dated 2/24/2026 at 9:47 AM, documents, Resident c/o (complained of) sob (shortness of breath) refused prn (as needed) breathing treatment. edema noted to upper and lower extremities NP (Nurse Practitioner) notified. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R30's Nurses Note, dated 2/24/2026 at 10:28 AM, documents, Resident sent out to hospital via Bell ambulance NP updated. On 03/24/2026 at 8:34 AM, Surveyor requested from Nursing Home Administrator (NHA)-A, R30's bed hold and transfer notices for hospitalizations on 1/31/26 and 2/24/26. On 03/24/2026 at 10:38 AM, NHA-A provided R30's Notice of Transfer and Bed Hold Form for hospitalization on 1/31/26 and confirmed there is no evidence of bed hold and transfer notice for R30's 2/24/26 hospitalization. R30's Notice of Transfer and Bed Hold Form dated 1/31/26, documents name, physician, date of transfer, location of transfer, reason for transfer, payor source as Medicare, appeal rights, and name and address with the telephone number of the Office of the State Long-Term Care Ombudsman but did not document R30's reserve bed hold payment daily rate. On 03/24/2026 at 2:58 PM, Surveyor informed NHA-A, Director of Nursing (DON)-B, Assistant Director of Nursing (ADON)-C, and Nurse Consultant-D of missing or incomplete/inaccurate bed hold and transfer notices for the R30. NHA-A expressed understanding. 4.) R37 was admitted to the facility on [DATE]. R37 makes his/her own health care decisions. R37's Progress Note, dated 12/3/2025 at 8:30 AM, documents in part .Patient is seen today for vomiting and diarrhea. Nursing reported patient had vomiting and diarrhea overnight. Provider attempted to see patient – R37 was laying in bed, extremely pale, fatigued, and asleep. R37 appeared extremely comfortable. Provider stepped out to see another patient. When nurse went to take vitals, blood pressure was 80/50. Patient was sent to the emergency department for ongoing workup and fluids. R37's Nurses Note, dated 1/4/2026 at 10:37 AM, documents, Resident being sent out to [name of hospital]. reported trouble breathing. very loud wheezing/rhonchi, using accessory muscles. inhaler provided, PO2 (oxygen level) 88%. placed on O2, saturation increased to 92%. EMT (Emergency Medical Technician) provided breathing treatment. w/ (with) no improvement to wheeze or accessory muscle use. resident requested to go to [name of hospital]. writer requested prn (as needed) neb (nebulizer) (breathing treatment) treatment order. R37's Nurses Note, dated 3/13/2026 at 11:28 AM, documents, Resident with increased S.O.B. (shortness of breath) PO2 80 % on room air. O2 applied @ L per N/C.PO2 up to 92%. Audible wheezing noted. T-98.2 P-100 R-26 B.P.158/80. Resident wn (sic) person and Full Code Status. Resident alert and able to make needs known. Resident stated that she wants to go out to ER. [Name of physician service] updated by secure message. Ambulance called and transporting to [hospital] ER. On 03/24/2026 at 12:11 PM Surveyor requested from Nursing Home Administrator (NHA)-A, R37's bed hold and transfer notices for 12/3/25, 1/4/26 and 3/13/26 transfers. On 03/24/2026 at 12:30 PM, NHA-A confirmed there is no evidence of bed hold and transfer notices for R37's hospitalizations on 12/3/25, 1/4/26, and 3/13/26. On 03/24/2026 at 2:58 PM, Surveyor informed NHA-A, Director of Nursing (DON)-B, Assistant Director of Nursing (ADON)-C, and Nurse Consultant-D of missing or incomplete/inaccurate bed hold and transfer notices for the R5, R6, R30 and R37. NHA-A expressed understanding. 5.) R1 admitted to the facility on [DATE]. R1 was hospitalized for a change in condition on 10/6/25. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R1's progress note dated 10/6/25 at 7:48 AM, documents nurses note: Called to Residents room by Med Tech stating that Residents PO2 (oxygen saturation) was 32%. Resident stated he was S.O.B. (short of breath). O2 applied per N/C (nasal cannula) at 2 liters. Resident A & O (alert and oriented) X 4. Stated he was just relaxing. T (temperature) 98.2 P (pulse) 116 R (respirations) 22 B.P. (blood pressure)152/85. PO2 98%.PO2 level fluctuating down to 92%. Expiratory wheezing noted using chest muscles with respirations. Medical provider updated. N.O.R. (new order received) Send to ER (emergency room) for Eval & TX (evaluation and treatment). Ambulance called to transport. Resident updated. Writer continually monitoring resident condition until ambulance here and transports. R1 was subsequently admitted to the hospital and readmitted to the facility on [DATE] with diagnoses acute mixed respiratory failure, CHF (congestive heart failure), fluid overload. Surveyor found no evidence transfer and bed hold notice was provided to R1 or his Power of Attorney. On 3/24/26 at 1:46 PM, Surveyor asked Nursing Home Administrator (NHA)-A and Consultant-D for evidence transfer and bed hold notice was provided. Surveyor was told No, neither was provided. No additional information was provided.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review ,the facility did not ensure the medical record reflected the advanced directive wishes for 1 (R40) of 3 residents reviewed.*R40 was readmitted on [DATE]. R40's Hospital Discharge summary dated [DATE] documents R40's code status was changed to DNR (do not resuscitate). On 4/29/26, R40 was observed wearing a purple DNI (do not intubate)/DNR bracelet on R40's right wrist. Despite this, R40's physician orders, code status by R40's picture in the electronic medical record and care plan continued to document full code until 4/29/26.Findings include:The facility's policy titled, Code Status and last reviewed 4/9/26 under Policy documents Facilities will discover, maintain, and execute a individual's code status by following the documented wishes of each individual. Under Procedure A. Discovery: 1. Upon admission, a designated staff member will discover any current code status directives that a individual may have in place. 2. The designated staff member will review the current code status for accuracy with the individual and/or individual representative. 3. If an individual does not have any code status directives in place, the staff member will provide materials to individual and/or individual representative. B. Maintenance: 2. Do-Not-Resuscitate a. If an induvial wishes to be a DNR, the individual's wishes will be maintained: i. Provider signed DNR order. ii. Within the medical record. iii. On a State DNR Form. iv. By wearing a facility approved DNR bracelet, until the state DNR bracelet is acquired.R40 was readmitted to the facility on [DATE]. R40 has an activated power of attorney and receives hospice services.R40's diagnoses includes dementia (loss of cognitive function that interferes with a person's daily life and activities), congestive heart failure (heart doesn't pump enough blood to meet the body's needs), neurocognitive disorder with Lewy bodies (progressive dementia that destroys brain cells, leading to cognitive decline, unpredictable fluctuating alertness, visual hallucinations, and motor issues), anxiety (emotional response involving feelings of worry, dread, and tension often accompanied by physical symptoms like a racing heart or sweating), and hypertensive heart disease with heart failure (prolonged high blood pressure that leads to the hearts inability to pump blood effectively.R40's physician orders dated 10/18/2023 documents Full Code.R40's physician orders dated 4/8/26 documents send to [Hospital Name] ER (emergency room) per POA (power of attorney) request, Full code status, continued decline in condition.R40's hospital discharge summary for date of discharge: [DATE] documents code status at discharge: DNI/DNR (do not intubate/do not resuscitate).R40's nurses note dated 4/27/26 at 14:30 (2:30 p.m.) written by Registered Nurse (RN)-H includes documentation of readmitted [R40's name] 84/F (female) 11/24/41 from [Hospital initials] DNI/DNR, Hospice.R40's progress note dated 4/28/26, at 11:13 a.m., written by Life Coach/Social Worker (LC/SW)-J documents [R40's first name] is a [AGE] year old female who readmitted to St. [NAME] on 4/27 following her stay at [hospital initials]. [R40's first name] readmits with a primary diagnosis of pressure ulcer of sacral region. [R40's first name] has a past medical history of, but not limited too; arthritis, hypertension, and hallucinations. Per hospital documents upon discharge, [R40's first name] was alert and oriented x4. [R40's first name] readmitted to her room on the long term care unit where it is expected she will remain to reside. Writer to meet with resident to conduct readmit assessments and schedule care conference. Writer will continue to follow and support resident while on campus.On 4/29/26, at 9:42 a.m., RN-F informed Surveyor the med tech is still doing med pass and then she will give R40 morphine and Ativan. RN-F explained R40 has Lewy body dementia. R40 is full code and the daughter is not ready to let mom go.On 4/29/26 from 10:30 a.m. to 11:00 a.m. Surveyor observed R40's sacrum pressure injury treatment with RN-F and Med Tech-E & Certified Nursing Assistant (CNA)-G. During this observation Surveyor observed R40 was wearing a purple DNI/DNR bracelet on R40's right wrist.On 4/29/26, at 11:15 a.m., Surveyor noted R40's electronic medical record by R40's picture documents Code status (Advanced Directive) full code. R40's physician orders (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	still includes Full code.On 4/29/26, at 12:17 p.m., Surveyor reviewed R40's resolved care plans and noted [R40] code status is full code initiated 10/23/23 and revised & resolved 4/29/26. Intervention documents Social Worker will follow up with resident and family as needed or as requested by resident or family. Initiated 10/23/23 and revised & resolved 4/29/26.Surveyor reviewed R40's current care plans and noted the facility did not develop an advanced directive care plan for DNR after R40's full code care plan was resolved.Surveyor reviewed R40's progress notes from date of readmission until 4/29/26. Surveyor was unable to locate any progress notes regarding facility staff contacting R40's power of attorney to discuss the change of code status since returning from the hospital until 4/29/26 at 11:32 a.m. R40's progress note dated 4/29/26, at 11:32 a.m. written by Regional Nurse Consultant (RNC)-C documents Review acute care hospital records - full code status deactivated 4/14/26 and initiated DNR no resuscitation no intubation for resident. Verified by DON (Director of Nursing) with daughter/POA [first name] with writer as verbal witness. Code status changed to DNR in HER (electronic health record). Hospice cares to continue as ordered, end of life cares being provided.On 4/29/26, at 12:24 p.m. Surveyor asked RN-F when a resident is readmitted from the hospital who reviews the hospital records. RN-F informed Surveyor the floor nurse. Surveyor asked who checks to see if the resident code status has changed. RN-F replied the nurse, admitting nurse. Surveyor asked RN-F if social services have anything to do with code status. RN-F explained to Surveyor they used to years ago now pretty much it's nursing. Surveyor asked RN-F if she is aware R40's code status changed to DNR. RN-F replied no. Surveyor informed RN-F when Surveyor reviewed R40's medical record today her code status still documented full code. RN-F informed Surveyor she wasn't here when R40 was admitted . R40 came in on Tuesday and the nurse had two admissions. RN-F informed Surveyor she hasn't looked at her record. Surveyor showed RN-F code status which documents full code. RN-F informed Surveyor when a resident is readmitted , they don't have two nurses checking it only one person which is not ideal.On 4/29/26, at 12:39 p.m., Surveyor asked RNC-C what prompted her to review R40's code status and write the progress note today. RNC-C informed R40 is their only wound in house for the facility's verification visit and was reviewing her record. Surveyor asked RNC-C who reviews hospital records for code status. RNC-C informed Surveyor she didn't know. Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B were also in the office with RNC-C. NHA-A informed Surveyor they were aware R40's code status changed to DNR when she returned from the hospital, but they didn't have the state form, and their policy is until they have this form so they kept her as full code. DON-B informed Surveyor she has spoken to R40's POA trying to get the paperwork. Surveyor asked DON-B who reviews paperwork when a resident is readmitted . DON-B replied the floor nurses. Surveyor asked if this would also be for code status. DON-B replied yes, explaining they get the paperwork from the ambulance when they come back. Surveyor informed facility staff there is no documentation in R40's record regarding speaking with R40's POA and hospital documentation reveals the code status was changed to DNR which is not reflected in R40's medical record.On 4/29/26, at 1:03 p.m., Surveyor asked RNC-C, NHA-A, and DON-B who were in NHA-A's office when the facility changed R40's code status today to DNR did they have a signed DNR paper. NHA-A informed Surveyor admissions are trying to get it from Epic. Surveyor asked again if there was a signed DNR paper. RNC-C replied no explaining they have a difference of opinion regarding their policy.On 4/29/26, at 1:15 p.m., met with RNC-C, NHA-A, and DON-B. NHA-A informed Surveyor the social worker meets with the resident regarding advanced directives. Surveyor asked if a residents advance directives change who is responsible for the paper work. NHA-A informed Surveyor our social worker. On 4/29/26, at 1:30 p.m., Surveyor asked NHA-A who the name of the facility's social worker. NHA-A explained their social worker is on medical leave and [name of] LC/SW-J from their sister facility is covering.On 4/29/26, at 1:40 p.m., Surveyor telephoned LC/SW-J and left a message requesting a return call. LC/SW-J did not return Surveyor's telephone call.No additional information was provided.

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	525524	A. Building B. Wing	03/26/2026

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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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure residents receiving psychotropic medications as needed (PRN) have an order limited to fourteen (14) days for 3 (R9, R6, and R34) of 7 residents reviewed for unnecessary medications: *R9 Clonazepam 0.5mg- 1 tablet every 12 hours as needed for increased agitation with no end date. *R6 has an order for Clonazepam 2mg- 1 tablet every 6 hours as needed for anxiety with no end date. *R34 Lorazepam 0.5 mg- 1 tablet every 3 hours as needed for anxiety with no end date. Findings include: The facility policy titled Standard Psychoactive Medication Protocol with no initiation or revision date documents: Problem: Individual is prescribed a psychotropic medication. Goal: Individual will have minimized side effects of psychotropic drug use. Nursing: . psychoactive team is to review for gradual dose reduction as indicated. All: offer non-pharmacologic approaches. 1.) R9 was admitted to the facility on [DATE] and has diagnoses that include Alzheimer's disease, Dementia with anxiety and mood disturbance, major depressive disorder, and anxiety disorder. R9's quarterly minimum data set (MDS) dated [DATE] indicated R9 has severely impaired cognition with a Brief Interview for Mental Status (BIMS) score of 5. Nursing assessed R9 and indicated R9 did not have behavior concerns. R9 has an activated power of attorney (POA) for healthcare decisions. R9 care plan documents uses Clonazepam (benzodiazepine medication acts as a central nervous system depressant calming overactive nerves in the brain) due to dementia and anxiety disorder, initiated on 3/9/2025 with the following interventions:- Administer ANTI-ANXIETY medications as ordered by physician. Monitor for side effects and effectiveness EVERY SHIFT.- Monitor/ document/ report PRN any adverse reactions to ANTI-ANXIETY therapy: . and UNEXPECTED SIDE EFFECTS: . R9's physician order dated 1/6/2026 documents Clonazepam Oral Tablet 0.5mg- Give 1 tablet by mouth every twelve (12) hours as needed for increased agitation. Surveyor noted the PRN Clonazepam 0.5mg order date was beyond 14 days and still active. R9's medical record/ physician order did not include documentation from the attending physician or the prescribing practitioner justifying the need for R9 to receive Clonazepam 0.5mg PRN beyond the 14 day timeframe. Surveyor reviewed R9's 3/2026 medication administration record (MAR) and noted facility staff documented administering Clonazepam 0.5mg to R9 on:-3/3/2026, 3/6/2026, 3/9/2026, 3/11/2026, 3/12/2026, 3/14/2026, 3/16/2026, 3/20/2026, 3/22/2026, and 3/23/2026 in the morning and 3/9/2026 in the evening. On 3/26/2026, at 12:02 PM, Surveyor interviewed director of nursing (DON)-B who stated pharmacy will review residents' medications monthly and notify DON-B what medications need end dates or other recommendations. DON-B stated medications also get reviewed in the psychoactive medication (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and behavior committee meetings and medications get discussed at those times as well. Surveyor shared concern R9's PRN Clonazepam 0.5mg medication did not have an ordered 14 day stop date or an indication for requiring the medication longer. DON-B stated it must have been overlooked during the meetings and on medication reviews. No further information was provided at the time of this write up. 2.) R6 was admitted to the facility on [DATE] and has diagnoses that include paranoid schizophrenia, major depressive disorder, generalized anxiety disorder, and dementia. R6's Minimum Data Set (MDS) annual assessment dated [DATE] documents R6 has a Brief Interview for Mental Status (BIMS) score of 6, indicating severe cognitive impairment. The MDS indicates R6's use of antipsychotic and antianxiety medications. R6's Physician Orders, dated 1/30/26, documents, clonazePAM Oral Tablet 1 MG (milligram) (Clonazepam) Give 1 mg by mouth three times a day for Anxiety. Pharmacy Active 1/30/2026. R6's Physician Orders, dated 1/29/26, documents, ClonazePAM Tablet 2 MG Give 1 tablet by mouth every 6 hours as needed for Anxiety. Pharmacy Active 1/29/2026 1/29/2026 (sic). R6's Medication Administration Record, documents R6 received PRN doses of ClonazePAM Tablet 2 MG on 3/5/26 and 3/21/26 Surveyor notes, R6's PRN Clonazepam 2 MG tablet order date is beyond 14 days since ordered on 1/29/26 and remains an active order. R6's medical record or physician order provides do not provide evidence the physician or the prescribing practitioner's justification for R6 to receive Clonazepam 2 MG beyond 14-day timeframe. On 3/26/2026, at 12:02 PM, Surveyor interviewed director of nursing (DON)-B who stated pharmacy will review residents' medications monthly and notify DON-B what medications need end dates or other recommendations. DON-B stated medications also get reviewed in the psychoactive medication and behavior committee meetings and medications get discussed at those times as well. Surveyor shared concern R6's PRN Clonazepam 2 MG medication did not have a 14 day stop date or an indication for requiring the medication longer. No further information was provided at the time of this write up. 3.) R34 was admitted to the facility on [DATE] with diagnoses including other sequelae (long-term effects) of cerebral infarction (stroke), and other chronic pain. R34's significant change Minimal Data Set (MDS) dated [DATE] documents R34 has a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition and R34 did not have behavior concerns. The MDS documents R34 takes an antianxiety medication. R34 has an activated power of attorney (POA) for healthcare decisions. R34's Care Area Assessment (CAA) for psychotropic drug use dated 3/16/26 documents CAA triggered for psychotropic drug use due to antianxiety medication use due to recent enrollment onto hospice for end-of-life cares. R34's physician order dated 3/20/26 documents Lorazepam Oral Tablet 0.5 mg (milligrams)- give 1 tablet by mouth every 3 hours as needed (PRN) for anxiety, restlessness, dyspnea (difficulty breathing), nausea. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Drugs.com documents Lorazepam belongs to a class of medications called benzodiazepines, which work by enhancing the activity of certain neurotransmitters in the brain. Surveyor notes the physician order for Lorazepam is still active with no stop date documented. Surveyor reviewed R34's electronic health record (EHR) and did not locate any documentation from R34's prescribing practitioner with a rationale R34 requires PRN Lorazepam beyond 14 days. Surveyor reviewed R34's 3/2026 medication administration record (MAR) and noted facility staff documented administering Lorazepam 0.5mg to R34 on 3/23/26 and 3/24/26. On 3/26/2026, at 12:02 PM, Surveyor interviewed director of nursing (DON)-B who stated pharmacy will review residents' medications monthly and notify DON-B what medications need end dates or other recommendations. DON-B stated medications also get reviewed in the psychoactive medication and behavior committee meetings and medications get discussed at those times as well. Surveyor shared concern R34's PRN Lorazepam 0.5mg medication did not have an ordered 14 day stop date or an indication for requiring the medication longer. DON-B stated it must have been overlooked during the meetings and on medication reviews. No further information was provided at the time of this write up.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to perform preadmission screening for individuals with a mental disorder for 1 (R17) of 1 resident reviewed for Pre-admission Screen and Resident Review (PASARR) Level II completion. *R17 had a positive Level I PASARR dated [DATE] and was identified to have a major mental disorder and, unspecified intellectual disabilities. The facility did not submit the positive Level 1 screen to the State mental health authority to complete a PASARR Level II evaluation after the initial 30-day hospital discharge exemption had expired. Findings Include:The facility policy titled admission Criteria/Requirements with an initial approval date [DATE] and reviewed date [DATE] documents: Residents diagnosed with serious mental illness or developmental disabilities will be screened prior to admission utilizing Preadmission Screen and Resident Review (PASARR). PASARR will contribute to individual's plan of care. PASARR Level 2 screen may be utilized to determine the facility's ability to manage the individual need. R17 was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder (a mental health condition combining schizophrenia symptoms, such as hallucinations and delusions, and mood disorder episodes, such as depression or mania), unspecified dementia with other behavioral disturbance, anxiety disorder, and unspecified intellectual disabilities. On [DATE] at 12:01 PM, Surveyor reviewed R17's electronic health record (EHR) and located a PASARR Level I with effective date documented as [DATE]. Surveyor notes the PASARR Level I Screen Summary does not have the date the screen was completed documented. The Level I Screen Summary documents yes to the questions: Does the person have a major mental disorder, has the person displayed any symptoms that may suggest the presence of a major mental illness, and has this person received psychotropic medication(s) to treat symptoms or behaviors of a major mental disorder and documents R17 received Seroquel (an antipsychotic medication used to treat schizophrenia). The provider response to the screening result resident is suspected of having a serious mental illness is documented as agree. The Level I Screen Summary documents yes for hospital discharge exemption- 30 day maximum. Surveyor reviewed R17's EHR and noted R17 receives psychiatry services at the facility on a monthly basis. On [DATE] at 1:59 PM, Surveyor interviewed Director of Admissions-N via phone call. Director of Admissions-N stated Director of Admissions-N completes the PASARR Level I screen on admission and the social worker would assist with a Level II screen if indicated. Director of Admissions-N stated a Level II screen would be required if a resident has a mental illness such as depression or anxiety. Director of Admissions-N stated the Level II would be completed right away after the Level I unless there is a hospital discharge exemption. Director of Admissions-N stated if the resident is still at the facility after the 30-day maximum for a hospital discharge exemption, then the Level II would be completed. Director of Admissions-N confirmed R17 should have had a PASARR Level II completed since R17 was on Seroquel on admission and had a major mental illness. Director of Admissions-N confirmed no PASARR Level II is in R17's EHR, which it would be if it were completed. On [DATE] at 2:20 PM, Nursing Home Administrator (NHA)-A informed Surveyor the social worker for the facility was not available for interview due to being out on leave. On [DATE] at 3:03 PM, Surveyor shared concern with NHA-A, Director of Nursing (DON)-B, Assistant Director of Nursing (ADON)-C, and regional nurse consultant-D that no PASARR Level II screen was completed for R17 after the 30-day maximum exemption period expired and the PASARR Level I screen was positive for major mental illness and prescribed psychotropic mediation. On [DATE] at 10:26 AM, NHA-A provided Surveyor with documentation a new PASARR Level I screen was completed by Director of Admissions-N for R17 dated [DATE]. NHA-A also provided Surveyor with an email printout dated [DATE] at 10:25 AM, which documents Director of Admissions-N requested the PASARR Level II screen for R17. NHA-A stated the previous admissions coordinator left around [DATE] and the PASARR Level II screens have not been completed since then. No additional information was provided as to why a PASARR Level II screen was not completed for R17 after the 30-day maximum exemption period.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure 1 (R9) of 12 resident's care plans reviewed were revised.R9's care plan was not revised after R9 was diagnosed with a right shoulder dislocation.Findings include:The facility policy titled Comprehensive Person Centered Care Plan last reviewed 5/8/2025 documents: I. Policy: The comprehensive person centered care plan will reflect the individual's needs and preferences to facilitate care. II. Procedure: . C. Care plan shall be reviewed and revised quarterly, upon change of condition, and/or as needed.*R9 was admitted to the facility on [DATE] and has diagnoses that include Alzheimer's disease, and Dementia with anxiety. R9's quarterly minimum data set (MDS) dated [DATE] indicated R9 has severely impaired cognition with a Brief Interview for Mental Status (BIMS) score of 5. R9 has an activated power of attorney (POA) for healthcare decisions. R9's care plan documents chronic pain related to history of fractured left humerus, initiated on 2/27/2025 with the following interventions:- Administer medication per medical doctor (MD) order.- Anticipate (R9's) need for pain relief and respond immediately to any complaint of pain.On 3/2/2026, at 12:57 PM, in the progress notes registered nurse (RN)-G documented (R9) got x-ray to right arm and right shoulder due to (R9) guarding right arm at times.On 3/3/2023, at 7:36 AM, in the progress notes RN-G documented (R9's) x-ray results for right shoulder/right arm x-rays document an anterior subluxation was noted across the glenohumeral joint space (dislocation of the right shoulder). Order received to send R9 out for further evaluation and treatment.On 3/3/2023, at 12:55 PM, in the progress notes nursing documented . (R9's) shoulder was reduced back into place . (R9) will be returning to the facility with and order for a sling and follow up orthopedic appointment.Surveyor reviewed R9's medical record and noted the following physician order:-Sling to right arm and shoulder area. Monitor for placement every shift and document refusals every shift for post shoulder reduction. Start date: 3/4/2026.Surveyor noted R9's care plan was not revised to indicate R9's need for a right shoulder/arm sling or how often to keep R9's sling in place. Surveyor reviewed R9's certified nursing assistant (CNA) care card and noted no interventions documenting R9 had a sling in place to the right arm/shoulder.Surveyor reviewed R9's progress notes and noted nursing staff documenting R9's refusals to wear the right shoulder/arm sling. Surveyor noted there were no care plan revisions regarding R9 refusing the right shoulder/arm sling or interventions to be implemented in place of R9's right shoulder/arm sling.On 3/24/2026, at 10:33 AM, Surveyor observed R9 sitting in in a recliner without R9's right shoulder/arm sling. Surveyor asked R9 if R9's right arm hurt and if R9 wanted R9's right arm sling on. R9 shook R9's head back and forth indicating a ?No gesture. On 3/24/2025, at 10:34 AM, Surveyor interviewed RN-H who stated R9 refused to wear the right arm sling at times. RN-H stated R9 had the right arm sling on earlier in the morning when staff assisted with getting R9 dressed, but then later in the morning R9 removed the right arm sling and refused to put the right arm sling back on. Surveyor asked if the physician was aware or if there were other interventions implemented when R9 does not want to wear the right arm sling but still has protection for R9's right shoulder. RN-H stated they were not aware of other interventions other than monitoring and assessing pain. RN-H was not sure if R9's physician was aware R9's refuses to wear the right arm sling at times however it is documented in progress notes and the physicians read progress notes. Surveyor asked who would update care plans with revisions to reflect current care needs for residents. RN-H stated the interdisciplinary team (IDT) meets in the mornings and reviews the care plans.On 3/24/2026, at 3:12 PM, Surveyor interviewed licensed practical nurse (LPN)-I who stated LPN-I did not update care plans with revisions. LPN-I stated management updates care plans and makes revisions for residents. Surveyor asked how management knows when to update residents care plans to show the most up to date care needs for residents. LPN-I stated LPN-I believes management reviews resident progress notes to see what is happening with residents.On 3/25/2026, (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 3:17 PM, Surveyor asked nursing home administrator (NHA)-A and director of nursing (DON)-B process for revising care plans. DON-B replied care plans can be revised by nursing staff when needed to have the most up to date interventions for resident needs. DON-B stated care plans are reviewed in morning meetings. Surveyor shared concern R9's care plan was not revised when R9 right should was found to be dislocated on 3/2/2026 and on 3/3/2026 when R9 returned from the hospital after having R9's right shoulder put back into place and had an order for a right arm sling. Surveyor shared concern nursing staff documented right arm sling refusals for R9 but no care plan revisions were made to indicate R9's refusals or if new interventions were to be implemented to prevent further injury to R9's right shoulder. No further information was provided to Surveyor at the time of this write up.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure each resident was offered the COVID-19 vaccine when available to the facility for 1 (R21) of 5 residents reviewed for immunizations. *R21 did not have evidence of being offered the COVD-19 vaccine upon admission to the facility on 1/9/26. Findings include:The facility policy titled Individual Immunizations with approval date 10/9/17 and review date 8/29/25 documents: . Prophylactic immunizations will be offered to individuals to promote the absence of Health Care Acquired Infections . upon admission, the organization will verify the individual's immunization status, update Primary Care Provider (PCP) as indicated, and administer immunizations as ordered. Individual will be offered immunizations based upon the Center for Disease Control (CDC) recommendations and guidelines . Immunization consent and or refusal shall be documented within the Electronic Medical Record (EMR). On 3/26/26 at 8:26 AM, regional nurse consultant-D provided Surveyor with the CDC vaccine and immunization guidelines the facility utilizes for resident vaccines. Surveyor notes for COVID-19, the CDC recommends adults over the age of 65 receive 2 or more doses of 2025-2026 vaccine. R21 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease with acute exacerbation (a sudden worsening of chronic respiratory symptoms such as shortness of breath), chronic respiratory failure with hypoxia (a long-term condition where the lungs cannot adequately transfer oxygen in the blood), and acute bronchitis (temporary swelling in the airways and lungs), unspecified asthma (inflammation of the airways). R21 had an activated power of attorney (POA) for healthcare decisions effective 1/24/26. On 3/23/26, Surveyor reviewed R21's EMR and located a tab titled immunizations. Surveyor noted no documentation of R21's POA consent or refusal to the COVID-19 vaccine, and no documentation of the last time R21 received the COVID-19 vaccine. On 3/25/26 at 2:19 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-C. ADON-C confirmed ADON-C is the Infection Preventionist (IP) at the facility. ADON-C confirmed as the IP, ADON-C is responsible for resident vaccinations, which are reviewed and offered upon resident admission to the facility. ADON-C stated if a resident has an activated POA, ADON-C will call the POA to get verbal consent for the vaccines and then document that verbal consent was obtained from the POA in the immunizations section in the resident's EMR. Surveyor shared concern with ADON-C there is no evidence R21 was offered the COVID-19 vaccine upon admission to the facility 1/9/26 in the immunizations section in R21's EMR. ADON-C responded ADON-C would look into it. On 3/25/26 at 2:46 PM, Surveyor shared concern with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, ADON-C and Regional Nurse Consultant-D there is no evidence the COVID-19 vaccine was offered to R21 upon admission. On 3/26/26 at 9:56 AM, ADON-C informed Surveyor ADON-C realized R21 was not offered the COVID-19 vaccine upon admission, so ADON-C obtained consent from R21's POA on 3/26/26 to administer the COVID-19 vaccine, and ADON-C administered the vaccine to R21 on 3/26/26. ADON-C stated ADON-C must have forgot to offer R21 the COVID-19 vaccine upon admission. No additional information was provided.