STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525539	A. Building B. Wing	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint Johns on the Lake	1858 N Prospect Ave Milwaukee, WI 53202

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 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 a resident who uses a psychotropic PRN (as needed) drug had an order limited to 14 days for 1 (R6) of 5 residents reviewed for unnecessary medications. R6 had an order for PRN Ativan with a start date of 5/17/2025 and no end date. Findings include: The facility policy and procedure titled, Psychotropic Medication Use and last revised 1/2025, documents, in part: Policy Statement Residents will not receive medications that are not clinically indicated to treat a specific condition. Policy Interpretation and Implementation 1. A psychotropic medication is any medication that affects brain activity associated with mental processes and behavior . 12. Psychotropic medications are not prescribed or given on a PRN basis unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. 4. PRN orders for psychotropic medications are limited to 14 days. 1. For psychotropic medications that are NOT antipsychotic's: If the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, he or she will document the rationale for extending the use and include the duration for the PRN order. 2. For psychotropic medications that ARE antipsychotic's: PRN orders cannot be renewed unless the attending physician or prescriber evaluates the resident and documents the appropriateness of the medication . (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525539	A. Building B. Wing	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint Johns on the Lake	1858 N Prospect Ave Milwaukee, WI 53202

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R6 was admitted to the facility on [DATE] with pertinent diagnoses that include dementia (a syndrome that can be caused by a number of diseases which over time destroy nerve cells and damage the brain, typically leading to deterioration in cognitive function (i.e. the ability to process thought) beyond what might be expected from the usual consequences of biological ageing), depression (a mental health condition characterized by persistent sadness, loss of interest or pleasure in activities, and other symptoms that significantly affect daily life), and insomnia (common sleep disorder that can make it hard to fall asleep or stay asleep). R6's Quarterly Minimum Data Set (MDS) with an assessment reference date of 4/1/25, documents a Brief Interview for Mental Status score of 03 (severe cognitive impairment). R6 has an activated Power of Attorney for decision making. R6's MDS documents a patient depression questionnaire (PHQ-9) score of 01, indicating no depressive symptoms. R6's MDS documents that R6 is usually understood and usually understands others. R6 was documented as having no behaviors exhibited during the look back period. R6's care plan documents I have the potential for having a behavior problem related to dx (diagnosis) dementia aeb (as evidenced by) inappropriately touching others, inappropriate comments to others, attempts to kiss female staff, smears feces, revision on 1/22/2024. The pertinent intervention is administer medications as ordered. Monitor/document for side effects and effectiveness, date initiated: 12/12/2023. R6's physician order dated 5/17/25 documents Ativan Oral Tablet 0.5 MG (Lorazepam) Give 0.5 mg by mouth every 1 hours as needed for restlessness/anxiety. The Ativan had been administered to R6 in May on 5/20, 5/21, 5/26, 5/27, 5/30 and 5/31. Surveyor noted that the PRN order date was beyond 14 days and still active. Surveyor noted R6's medical record did not include documentation from the attending physician or the prescribing practitioner justifying the need for R6 to receive the medication beyond a 14 day timeframe. On 06/03/25, at 12:25 PM, Surveyor interviewed Director of Nursing (DON)-B regarding the PRN Ativan order for R6 not having a stop date. DON-B responded it was entered by a new to us nurse, the nurse needs some education. Usually, hospice has a 6-month extension they can write out for order. DON-B will look into issue and get back to Surveyor. On 06/03/25, at 12:38 PM, DON-B stated that the Ativan order was incorrectly put in and DON-B will need to provide education on entering a stop date to that nurse. Per DON-B the order has been discontinued. On 06/03/25, at 12:52 PM, Surveyor interviewed Register Nurse (RN) Nursing Supervisor-G and confirmed R6 would still be getting the Ativan as R6 was using it frequently PRN. Per RN Nursing Supervisor-G they had just called hospice for a reorder, R6 will not be without the order.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525539	A. Building B. Wing	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint Johns on the Lake	1858 N Prospect Ave Milwaukee, WI 53202

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 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 did not ensure for 1 (R16) of 1 residents reviewed for a level 1 and level 2 PASARR (Preadmission Screening and Resident Review) had the screenings completed as required. *R16 did not have a PASARR level 1 screen completed prior to admission to the facility. A level 1 screen was completed on the day of admission. Additionally, the facility did not ensure a level 2 screen was completed based upon the results of the level 1 screen. Findings include: The facility policy and procedure titled admission Criteria, dated January 2025 documents: policy statement. Our facility admits only resident who's medical and nursing care needs can be met. Policy interpretation and implementation. 9. All the admissions and readmissions are screened for mental disorders, intellectual disabilities or related disorders per the Medicaid preadmission screening and resident review process. 2. If the level I screen indicates that the individual may meet the criteria for a mental disorder, intellectual disability or related disorder he or she is referred to the state PASARR representative for the level II screening process. R16 was admitted to the facility on [DATE] and has diagnosis of Depression. R16 had a level 1 screen completed on 8/21/2024. There is no documentation found by surveyor of a level II screening following the completed level 1. On 8/21/2024, The Facility completed a level 1 pre-admission screen and resident review (PASARR) for R16. The form titled: Pre-admission Screen and Resident Review (PASARR) Level 1 Screen Summary, dated 8/21/2024, documents in part: Does the person have a major mental disorder? YES. Has this person received psychotropic medications to treat symptoms or behaviors of a major mental disorder? Yes. Surveyor noted, the box checked Yes for both questions. Surveyor noted in Section titled: screening result which documents, resident is suspected of having a serious mental illness. Provider response: AGREE On 6/2/2025, at 1:46 PM, Surveyor requested the Level 2 PASARR from Director of Nursing (DON)-B as the PASARR was not observed in R16's electronic record. On 6/2/2025, at 1:59 PM, Surveyor was informed by DON-B that the level 2 was not completed, that the level 1 was just sent out to the agency that completes the level 2. This was an oversight on our behalf. DON-B stated this was just sent out by us, it should have been completed 30 days after the level one.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525539	A. Building B. Wing	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint Johns on the Lake	1858 N Prospect Ave Milwaukee, WI 53202

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility did not store and prepare food in accordance with professional standards for food service safety potentially affecting all 20 residents that eat food prepared by the facility. *In the facility's main kitchen, observations of partially used and undated food were observed in the walk-in cooler. Open food was observed in the refrigerator in the resident floor main kitchen with no open or use by date. Findings include: The facility policy and procedure titled Food Storage, dated 5/29/2025 documents: Policy, Sufficient storage facilities are provided to keep foods safe, wholesome, and appetizing. Food is stored in an area that is clean, dry and free of contaminants. Food is stored, prepared, and transported at appropriate temperatures and by methods designed to prevent contamination or cross-contamination. 14. Refrigerated food storage: . All foods should be covered, labeled and dated. All foods will be checked to assure that foods left quotation mark including leftovers) patient [NAME] will be consumed by their safe use by dates, or frozen (where applicable), or discarded. 15. Frozen foods: . All foods should be covered, labeled and dated. All foods will be checked to assure that foods will be consumed by their safe use by dates or discarded. Food Storage Observations: On 5/29/2025, at 9:11 AM, Surveyor observed dinner rolls in the kitchen walk in freezer, not labeled or dated with an open or use by date. Surveyor observed the dinner roll package torn open on one side and wrapped with saran wrap, Surveyor informed Director of Dining-H of the concern. Director of Dining-H also observed that the package was open, and not dated. Director of Dining-H stated that the food is supposed to be dated after opening. Director of Dining-H pulled food from the freezer and asked staff to place a date on the dinner rolls. On 6/2/2025, at 7:57 AM, Surveyor observed sausage in the kitchen walk in freezer, not labeled or dated with an open or use by date. Surveyor observed the sausage package torn open on one side and wrapped with saran wrap, Surveyor informed Director of Dining-H, who observed that the package was open, and stated that the food is supposed to be dated after opening. Director of Dining-H pulled the sausage from the freezer and said it was supposed to be dated. On 6/2/2025, at 11:44 AM, Surveyor made observations of the resident's (main floor) refrigerator that was in the kitchenette located in the main dining area. Surveyor observed yogurt containers in the refrigerator that were not labeled or dated. Surveyor interviewed Kitchen Director-C, who stated that the yogurts will be getting tossed out and Kitchen Director-C stated that the dates may have been rubbed off. Director of Dining-H stated that the facility will now be labeling the dates on all yogurts, so this does not happen again. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525539	A. Building B. Wing	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint Johns on the Lake	1858 N Prospect Ave Milwaukee, WI 53202

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 06/3/2025, at 03:02 PM, Surveyor informed Director of Nursing (DON)-B, of the concerns with the food storage including items in the refrigerator and freezer not having dates on them.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525539	A. Building B. Wing	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint Johns on the Lake	1858 N Prospect Ave Milwaukee, WI 53202

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interview, and record review, the facility did not establish and maintain an infection prevention and control program based on current standards of practice, designed to provide a safe environment and to help prevent the development and transmission of communicable diseases and infections. This deficient practice has the potential to affect all 21 residents in the facility. *The facility's Water Management Plan (WMP) was not based on current standards of practice and did not: - Include the infection preventionist as part of the water management plan committee. - Identify corrective actions when control limits do not meet acceptable ranges of control limits (temperature ranges). *The facility does not monitor the dryer ventilation going to the outside of the facility from the facility dryers in the basement laundry room to make sure the vent remains clear and free of debris. Findings include: The facility policy titled Water Management Procedures: Legionella Prevention Procedures issued 5/2024 documents: 1. Water Management Program: a. [Facility name] has developed a water management plan (WMP) to: i. Identify ways to minimize growth and spread waterborne pathogens. ii. Conduct routine checks of control measures to monitor areas at risk. iii. Take corrective action if a problem is found. iv. Verify that a WMP is working as intended. b. The WMP is governed and directed by the organization's Safety Committee. The Safety Committee includes administrative and maintenance personnel who are knowledgeable about the facility's water system. On 5/29/2025, Surveyor reviewed the facility's WMP binder. Surveyor noted that the WMP/ safety committee did not list the employees that participated in the meetings. Surveyor also noted that the facility did not identify what actions are to be taken when the facility's control limits were not met according to the acceptable ranges that were documented. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525539	A. Building B. Wing	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint Johns on the Lake	1858 N Prospect Ave Milwaukee, WI 53202

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/3/2025, at 9:18 AM, Surveyor interviewed the Director of Facilities (DoF)-E, who was recently employed about 30 days ago, along with the Facility and Maintenance Director- F who was recently promoted to the role about 3 months ago but employed with the facility in the maintenance department for about 9 years. Surveyor asked how often the WMP committee met and who attends the meetings. Maintenance Director- F stated that there are weekly operations meetings held with maintenance and laundry and that the water is discussed at times. Maintenance Director-F stated that the safety committee also has the option to participate in those meetings. Surveyor asked what staff make up the safety committee. Maintenance Director-F stated that it is campus wide and usually consists of someone from each department. Surveyor asked if the Infection Preventionist (IP) is included in any of the WMP discussions or safety committee. Maintenance Director-F stated that the IP is not included that they are aware of. Maintenance Director-F stated that the IP is not communicated with regarding the meetings or collaborated with regarding infection prevention concerns with the water systems. Maintenance Director-F stated that that the facility is trying to get the requirements worked out. Surveyor asked what protocols are in place when the control limits (for example water temperatures) are not within the control limits. Maintenance Director-F stated they are alerted and will try to find out what the cause is. Surveyor asked if there are any protocols in place to do extra testing or stop use of water etc. Maintenance Director-F stated that administration would be contacted, but not sure if further requirements are needed. Maintenance Director-F stated that they would need to check into that and again stated they know the facility is trying to get the requirements worked out. On 6/3/2025, at 12:47 PM, Surveyor interviewed Infection Preventionist (IP)-D who stated IP-D is not part of the WMP or anything that discusses the water risks. IP-D stated that the maintenance department is in charge of the water flushes and monitoring but not aware if there is a committee or not. Surveyor shared importance of the IP involvement with the WMP because any concerns of legionella or other water borne pathogens can affect the residents and IP should have involvement to assist in the safety of the residents with whomever is managing the WMP. IP-D stated they are aware of the importance and would love to be part of it, if the facility developed one, but currently not aware of anything. Surveyor asked if there is a process in place if the facility had a positive legionella case or other water borne pathogen concern. IP-D stated they would follow any guidance from the centers of disease control (CDC), but had no specifics at current time, just would look online. On 6/3/2025, at 2:00 PM, Director of Nursing (DON)-B was made aware of Surveyors concerns that the WMP did not Include the infection preventionist as part of the water management committee and the facility did not identify corrective actions when control limits do not meet acceptable ranges of control limits (temperature ranges). DON-B acknowledged Surveyor's concerns. On 6/3/2025, at 9:18 AM, Surveyor toured the basement laundry room with Director of Facilities (DoF)-E and Maintenance Director- F. Surveyor asked about the vent leading from the facility dryers to the outside of the building and how often that is checked. Maintenance Director-F stated they do not check that vent. Surveyor asked if Maintenance Director-F knew where it vented out to. Maintenance Director-F stated somewhere above and on the side. Maintenance Director-F stated that the facility has a company come in to monitor all the vents from the facility to the outside, but does not think the dryer vent is on the list for the company to inspect. Surveyor asked if it is known if there is any build up or debris around the vent. Maintenance Director-F stated no but would reach out to the company to see if that is one of the vents the company looks at. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525539	A. Building B. Wing	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint Johns on the Lake	1858 N Prospect Ave Milwaukee, WI 53202

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/3/2025, at 2:00 PM, Director of Nursing (DON)-B was made aware of Surveyors concerns that the facility does not monitor the dryer ventilation going to the outside of the facility from the facility dryers in the basement laundry room to make sure the vent remains clear and free of debris. DON-B acknowledged Surveyor's concern.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525539	A. Building B. Wing	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint Johns on the Lake	1858 N Prospect Ave Milwaukee, WI 53202

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility did not include 1 (R15) of 2 residents reviewed for antibiotic stewardship on the facility line listing to ensure antibiotic use was monitored per facility protocols and ensure the antibiotic administration was included as part of the overall facility infection prevention and control program. *R15 was receiving an intravenous (IV) Antibiotic (ABT) and was not added to the antibiotic/infection control line list. The line list is part of the antibiotic stewardship program which allows the facility to monitor and track antibiotic use and infections. Findings include: The facility policy and procedure titled Antibiotic Stewardship - Review and Surveillance of Antibiotic Use and Outcomes, dated January 2025 documents: Policy. Antibiotic usage and outcome data will be collected and documented using a facility approved antibiotic surveillance tracking form. The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility wide antibiotic stewardship. Implementation: . 4. All resident antibiotic regimens will be documented on the facility approved antibiotic surveillance tracking form. The information gathered will include: A. Resident name and medical record number; B. Unit and room number; C. Date symptoms appeared; D. Name of antibiotic. R15 was admitted to the facility on [DATE] with diagnosis of atrial fibrillation, dementia. Surveyor reviewed R15's discharge paperwork from the hospital dated: 4/2/2025 which documented, IV antibiotic orders for discharge: diagnosis: right wrist presumptive septic arthritis, no culture able to be obtained. Prescription: Ceftriaxone 2 grams, IV daily duration 2 weeks. The discharge diagnoses documented as sepsis without acute organ dysfunction, due to unspecified organism. Surveyor reviewed R15's medication administration record (MAR) from April 2025. The order for Ceftriaxone Sodium 2 grams, IV infusion to administer over 10 minutes, was documented as administered on 4/3/2025 through 4/13/2025. On 6/03/2025, at 12:54 PM, Surveyor interviewed Infection Preventionist- D, who stated that all residents receiving antibiotics will be added to the line list for the antibiotic stewardship program. Infection Preventionist- D stated, even if the resident's antibiotic was started at the hospital, they are still added to the facility line list. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525539	A. Building B. Wing	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint Johns on the Lake	1858 N Prospect Ave Milwaukee, WI 53202

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/03/2025, at 1:11 PM, Surveyor and Infection Preventionist- D both reviewed the antibiotic stewardship binder for the month of April 2025. Surveyor noted R15 was not on the line list. Infection Preventionist- D stated R15 should have been added to the antibiotic stewardship program and most likely R15 wasn't added because she was presumptive (The administration of antibiotics when an infection is suspected but not yet confirmed.) for use. Infection Preventionist- D indicated even if presumptive, R15 still should have been added to the list for the antibiotic stewardship program. On 6/3/2025, at 2:00 PM, Surveyor informed Director of Nursing (DON)-B, of the concern with R15 not being added to the line list of the antibiotic stewardship program.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525539	A. Building B. Wing	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint Johns on the Lake	1858 N Prospect Ave Milwaukee, WI 53202

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based upon observation, interview and record review the facility did not ensure they had a system in place to ensure monitoring of and maintaining of laundry vents that extended up from the laundry room to the outside. This has the potential to effect all 21 Residents residing in the facility. *The facility does not monitor the dryer ventilation going to the outside of the facility from the facility dryers in the basement laundry room to make sure the vent remains clear and free of debris. Findings include: On 6/3/2025, at 9:18 AM, Surveyor toured the basement laundry room with Director of Facilities (DoF)-E and Maintenance Director- F. Surveyor asked about the vent leading from the facility dryers to the outside of the building and how often that is checked. Maintenance Director-F stated they do not check that vent. Surveyor asked if Maintenance Director-F knew where it vented out to. Maintenance Director-F stated somewhere above and on the side. Maintenance Director-F stated that the facility has a company come in to monitor all the vents from the facility to the outside, but does not think the dryer vent is on the list for the company to inspect. Surveyor asked if it is known if there is any build up or debris around the vent. Maintenance Director-F stated no but would reach out to the company to see if that is one of the vents the company looks at. On 6/3/2025, at 2:00 PM, Director of Nursing (DON)-B was made aware of Surveyors concerns that the facility does not monitor the dryer ventilation going to the outside of the facility from the facility dryers in the basement laundry room to make sure the vent remains clear and free of debris. DON-B acknowledged Surveyor's concern.