STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525635	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milwaukee Catholic Home	2330 N Prospect Ave Milwaukee, WI 53211

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure each resident received adequate supervision and assistance to prevent accidents for 1 (R4) of 6 sampled residents reviewed for transfers.*R4 was assessed and care planned to transfer with a sit to stand mechanical lift (EZ stand) and assist of 2 staff. Surveyor observed Certified Nursing Assistant (CNA)-C transfer R4 with the sit to stand mechanical lift without the assistance of another staff member.Findings include:The facility policy titled, Transfer of a resident with the Sit to Stand dated 10/2025 documents: Policy: The safe transfer of a resident who is able to bear weight can be done with the Sit to Stand and the assist of one or two staff per plan of care (POC). Procedure: .4. Place sling under the arms of the resident with the padding next to resident. Be sure sling fits snugly. Adjust accordingly. R4 was admitted to the facility on [DATE] with diagnoses that included Spinal Stenosis- Lumbar region, Type 2 Diabetes Mellitus with Diabetic Foot Ulcer and Neuropathy, Weakness, history of falls, and . Sciatica on the right side.R4's Quarterly Minimum Data Set (MDS) dated [DATE] documented that R4 was assessed as having moderately impaired cognition with a Brief Interview for Mental Status (BIMS) score of 12. The MDS assessed R4 as needing maximal assistance for transfers and total assistance with toileting hygiene. The MDS documents that R4 is frequently incontinent of bladder and occasionally incontinent of bowel and that R4 transferred using a sit to stand mechanical lift.R4's risk for falls and history of falls care plan initiated on 11/14/2022 documents the following interventions:- Provide reassurance during transfers and ensure leg-strap is in place (Effective: 3/19/2026).- EZ Stand (sit to stand mechanical device) with 2 assist for all transfers (Effective: 5/16/2026).R4's alteration in comfort related to spinal stenosis, neuropathy, scoliosis, . care plan was initiated on 11/14/2022 with the following interventions: -EZ Stand with one assistSurveyor noted R4 has 2 different transfer statuses with the EZ stand that are currently active, with one care plan documenting a transfer status of an assist of 2 staff and the other with an assist of 1 staff.R4's resident summary (CNA care card) has the following interventions: - Transfer/ Positioning: EZ-Stand with assist of 2 for all transfers. Provide Reassurance during transfers and ensure leg-strap is in place.- Transfers: 2+ person weight bearing help (move/support/hold), EZ- Stand with 2 assist for all transfers.- Toileting: 2+ person weight bearing help (move/support/hold). On 5/19/2026, at 9:52 AM, Surveyor observed CNA-C in R4's bedroom getting ready to transfer R4 to the toilet from R4's electric wheelchair. Surveyor observed CNA-C transfer R4 from R4's electric wheelchair to the bathroom toilet using a sit to stand mechanical device and assist of 1 staff member. Surveyor noted the chest strap around R4 was loose and above R4's chest area. R4 had a grimacing facial expression during the transfer. CNA-C walked out of R4's bedroom to grab more washcloths and towels. Surveyor asked R4 if R4 was in pain from the transfer. R4 stated the transfer was uncomfortable and felt like R4 was hanging from the strap and R4 pulled at the strap around R4's chest area. On 5/19/2026, at 9:56 AM, CNA-C came back to R4's room and raised the sit to stand mechanical device up so CNA-C could provide peri cares to R4. CNA-C finished providing cares to R4 and applied a clean protective brief and pulled up R4's pants. On 5/19/2026, at 10:00 AM, CNA-D came into R4's room and assisted CNA-C (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with transferring R4 from the bathroom to R4's electric wheelchair.On 5/20/2026, at 9:07 AM, Surveyor interviewed CNA-C. Surveyor asked CNA-C to clarify R4's transfer status. CNA-C stated R4 was a transfer using an EZ Stand with 2 staff. Surveyor asked CNA-C why CNA-C transferred R4 alone on 5/19/2026. CNA-C stated R4 is not CNA-C's normal patient and when CNA-C answered R4's call light on 5/19/2026, CNA-C was helping CNA-D and stated that CNA-C decided to assist CNA-D and take R4 to the toilet. CNA-C stated R4 wanted to use the toilet right away, so CNA-C just transferred R4 alone. CNA-C stated R4 was initially a transfer with 1 staff member, but a few weeks ago R4 changed to needing 2 staff members with transfers. Surveyor asked CNA-C how staff are made aware of changes to a resident's care plan. CNA-C stated the resident summary is updated and nursing tells staff regarding the changes.On 5/20/2026, at 9:44 AM, Surveyor interviewed Registered Nurse Unit Manager (RNUM)-E. Surveyor asked RNUM-E to clarify R4's transfer status. RNUM-E stated R4 was changed to assist of 2 with an EZ Stand because it was no longer safe for R4 to be transferred with 1 staff member. Surveyor showed RNUM-E R4's care plan and the conflicting transfer statuses in 2 different sections of R4's care plan. RNUM-E confirmed R4 should be an EZ-Stand with assist of 2.RNUM-E was not sure why R4's transfer status was different in 2 separate sections of R4's care plan. RNUM-E stated staff should follow a residents care plan, resident summary or the CNA care card, and nursing staff and the managers with verbally update staff as well of any changes to resident's plan of care. Surveyor shared observation of CNA-C transferring R4 from R4's electric wheelchair to the bathroom alone. RNUM-E stated R4 can be impatient at times, but staff still need to follow R4's plan of care. Surveyor shared observation of strap not positioned correctly on R4's chest area and R4 stated it felt like R4 was hanging. RNUM-E confirmed the chest strap should sit below the resident chest snugly so avoid residents from slipping out of it. On 5/20/2026, at 10:04 AM, Surveyor shared observations with Director of Nursing (DON)-B of CNA-C transferring R4 from R4's electric wheelchair to the bathroom alone and the chest strap around R4 was loose. Surveyor shared R4's care plan had conflicting transfer statuses for R4. DON-B stated if staff see that, staff must report the discrepancy and follow the status with the most assistance until further clarification is received. DON-B was not sure why R4 had a transfer status in the pain section of the care plan.No additional information was provided.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility did not maintain an infection prevention and control program designed to reduce the transmission of disease and infection for 1 (R4) of 1 sampled residents observed for incontinence cares. *Staff was observed not wearing appropriate personal protective equipment (PPE) while providing personal to R4. R4 was on Enhanced Barrier Precautions (EBP).Findings include:The facility policy titled Enhanced Barrier Precautions dated 4/2025 documents: Policy: Multidrug-resistant organism (MDRO) transmission is common in skilled nursing facilities, contributing to significant morbidity and mortality for residents and increased cost for the health care system. This policy will target gown and glove use during high contact resident care activities and is designated to reduce transmission of MDRO's. Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of MDRO's that employs targeted gown and glove use during high contact resident care activities.Procedure: 1. Upon identification of . or at risk resident, a sign indicating EBP will be placed on the door and a cart with supplies outside of room.4. Put on (DON) PPE. Gown and gloves will be utilized for all high contact activities which include: .c. Transferringd. Providing hygiene .f. Changing brief or assisting with toileting.R4 was admitted to the facility on [DATE]with diagnoses that include Type 2 Diabetes Mellitus with diabetic foot ulcer and Chronic Osteomyelitis, and history of Urinary Tract Infections. R4's Quarterly Minimum Data Set (MDS) dated [DATE] documented that R4 was assessed as having moderately impaired cognition with a Brief Interview for Mental Status (BIMS) score of 12. The MDS assessed R4 as needing maximal assistance with 1-2 staff members for activities of daily living (ADL's) and assessed R4 as being frequently incontinent of bladder and occasionally incontinent of bowel. The MDS documents that R4 was receiving hospice services and on was on EBPs.On 5/19/2026, at 9:52 AM, Surveyor observed an EBP sign hanging on R4's doorway and a bin with 3 drawers that had PPE (gowns, gloves) in the drawers. Surveyor observed Certified Nursing Assistant (CNA)-C take R4 to the bathroom to use the toilet. CNA-C did not put on appropriate PPE and wore only gloves on both hands while providing incontinence cares for R4. Surveyor observed CNA-C remove a soiled protective brief and put it in the garbage. Surveyor then observed CNA-C take off CNA-C's gloves and walk out of the room. Surveyor did not observe CNA-C wash CNA-C's hands in R4's bedroom before exiting R4's bedroom.On 5/19/2026, at 9:56 AM, CNA-C re-entered R4's room with gloves on and no gown. Surveyor observed CNA-C provide perineal cares for R4. On 5/19/2026, 10:04 AM, CNA-D walked into R4's bedroom wearing only gloves and no gown and assisted CNA-C transferring R4 back into R4's electric wheelchair. Surveyor asked when staff have to wear PPE if someone is on EBP. CNA-C stated R4 is no longer on precautions. CNA-C stated R4 was on precautions but had recently cleared. Surveyor showed CNA-C R4's EBP sign on R4's bedroom door. CNA-C and CNA-D stated R4 is not on any precautions, and the nurse has to take the sign down.Surveyor noted the EBP sign posted on R4's door documented: EBP: EVERYONE MUST: clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following High-Contact Resident Care Activities:- Dressing- Bathing/ Showering- Transferring- Changing Linens- Providing Hygiene- Changing briefs or assisting with toileting- Device care use: .- Wound Care: any skin opening requiring a dressing.R4's impaired skin related to immobility, diabetes mellitus, history of skin breakdown and diabetic ulcers on the right foot . care plan was initiated on 11/15/2022 and revised on 5/20/2025 with the following intervention:-Contact Isolation (effective 5/20/2025 - current)R4's resident summary/CNA care card has the following interventions documented:- EBPs .- Contact IsolationOn 5/19/2026, at 12:38 PM and 2:07 PM, Surveyor observed the EBP sign on R4's door and bin with available PPE by R4's doorway.On 5/20/2026, at 9:07 AM, Surveyor observed the EBP sign on R4's door and a bin with available PPE by R4's doorway. Surveyor asked CNA-C if R4 was supposed to be on any transmission (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	based precautions (ex: contact isolation) or EBP because R4 still had the RBP sign outside R4's doorway. CNA-C stated R4 is not on any precautions and does not wear any PPE when provided cares for R4. CNA-C stated the nurse has not taken down R4's sign or taken away the PPE yet.On 5/20/2026, at 9:23 AM, Surveyor interviewed Registered Nurse/ Infection Preventionist (RN/IP)-F, Director of Nursing (DON)-B was also present for the interview. RN/IP-F stated R4 was on contact isolation due to R4's wounds and history of having Multidrug-Resistant Organism (MDRO) infections, but currently R4 is on EBP and will always be on EBP due to R4's comorbidities (medical conditions).Surveyor asked RN/IP-F if staff should don PPE when toileting and providing peri cares for R4. RN/IP-F stated staff should don PPE when toileting and providing peri cares for R4. Surveyor shared observations with DON-B and RN/IP-F of CNA-C and CNA-D not wearing appropriate PPE when providing incontinent cares and transferring R4. No additional information was provided.