STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525731	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Ann Health and Rehabilitation Center	2020 S Muskego Ave Milwaukee, WI 53204

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, record review, and facility document review, the facility failed to ensure known resident behaviors of kicking, hitting, grabbing, rejection of care, et cetera (etc., other similar things) were addressed, to include the development and implementation of interventions, for 1 (Resident #2) of 5 sampled residents reviewed for behaviors. Findings included:An admission Record revealed the facility initially admitted Resident #2 on 04/09/2024 and most recently admitted the resident on 10/31/2024. According to the admission Record, the resident had a medical history that included diagnoses of encephalopathy (disease in which the functioning of the brain is affected); epilepsy (seizure disorder); hemiplegia (complete paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting the left non-dominant side; unspecified dementia, moderate, with other behavioral disturbance anxiety disorder; insomnia; and need for assistance with personal care. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/16/2025, revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment. The MDS indicated the resident exhibited physical and verbal behavioral symptoms directed towards others, other behavioral symptoms not directed towards others, and rejection of care during one to three days of the seven-day assessment look-back period. Per the MDS, Resident #2 was dependent upon staff for rolling left and right in bed. A quarterly MDS, with an ARD of 07/17/2025, revealed Resident #2 had a BIMS score of 4, which indicated the resident had severe cognitive impairment. The MDS indicated the resident exhibited physical and verbal behavioral symptoms directed towards others during four to six days of the seven-day assessment look-back period and other behavioral symptoms not directed towards others during one to three days of the seven-day assessment look-back period. Per the MDS, Resident #2 was dependent upon staff for rolling left and right in bed. Behavior Symptoms documentation for the timeframe from 07/02/2025 through 07/31/2025 revealed Resident #2 exhibited yelling/screaming during 15 out of 30 days, kicking/hitting during 11 out of 30 days, grabbing during 15 out of 30 days, and rejection of care during seven out of 30 days.Resident #2's Care Plan revealed a focus area addressing the potential for Resident #2 to be physically aggressive was not initiated until 07/19/2025. In addition, interventions directing staff how to respond should the resident become agitated were not initiated until 07/19/2025. A Nurses Note, documented by Licensed Practical Nurse (LPN) B with an effective date of 07/19/2025 at 2:59 PM, indicated LPN B was called to Resident #2's room during the morning by a certified nursing assistant (CNA). Per the note, the CNA reported that while turning the resident, the resident's head hit the wall. The note indicated the resident's right eye was swollen, and there was a 1-centimeter (cm) laceration above the resident's right eye. Documentation of an interview conducted by the facility with CNA A and copies of text message communications between the CNA and Administrator, dated 07/19/2025, revealed CNA A reported that while trying to provide care to Resident #2, the resident became combative and punched her. CNA A reported the resident was fighting and was in a rage, and when CNA A turned the resident on their side, the resident's face hit the wall.On 08/01/2025 at 8:02 AM, 9:11 AM, and 2:49 PM, the surveyor attempted to conduct a telephone interview with CNA A; a voicemail message was left, and no return call was received. During an interview on 07/31/2025 at 4:46 PM, the Administrator stated Resident #2 had anxiety and required one-person assistance prior to the incident on 07/19/2025. During a follow-up interview on 07/31/2025 at 5:39 PM, the Administrator stated the root cause analysis conducted as a result of the 07/19/2025 incident revealed Resident #2 was being aggressive. The Administrator further stated Resident #2's behaviors were hit or miss and were mostly related to the resident's diagnosis of anxiety. During a phone interview on 08/01/2025 at 12:21 PM, the Director of Nursing (DON) stated her expectation was that CNA A should have walked away and gotten help.During an interview on 08/01/2025 at 12:23 PM, the Administrator stated if the resident was agitated, her expectation was that staff would remove themselves and reapproach the resident to give the resident space to calm down.Resident #2's care plan focus area addressing the potential for physically aggressive behaviors, initiated 07/19/2025, was not updated to include an intervention that directed staff to walk calmly away, and approach later when the resident became aggressive until after this incident on 07/19/2025.