STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012345	A. BUILDING: _____ B. WING _____	R-C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANNES HOME FOR THE ELDERLY CBRF	3800 N 92ND ST MILWAUKEE, WI 53222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 000}	Initial Comments On 11/04/2025 with information gathered through 11/05/2025, Surveyors conducted a complaint investigation and verification visit at St Anne's Home for the Elderly CBRF. The complaint was unsubstantiated. Two deficiencies were identified. Two of 2 deficiencies were repeat violations. See Statement of Deficiency (SOD) LF4Q11, dated 12/17/2024, and SOD 9BGI12, dated 10/08/2020) Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 40	{N 000}		
{N 352}	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure residents received all prescribed medications in the dosage and at intervals prescribed by a practitioner for 1 of 1 resident (Resident 3) reviewed. This requirement is being cited for the third time. See Statement of Deficiency (SOD) LF4Q11, dated 12/17/2024, and SOD 9BGI12, dated 10/08/2020. Findings include:	{N 352}		

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

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{N 352}	Continued From page 1 On 11/04/2025 at 8:45 AM, Surveyors toured the facility and observed Caregiver B administer medications. While Caregiver B was preparing Resident 3's medication, Surveyor observed Caregiver B put aside the medication card containing Resident 3's lisinopril and mark in the Medication Administration Record (MAR) that it was unavailable. Surveyor observed that the order in the MAR was for lisinopril 20 milligrams (mg) and the medication card had lisinopril 30 mg tablets. Caregiver B searched the medication cart for Resident 3's fluticasone nasal spray. Caregiver B could not locate the fluticasone nasal spray and reported s/he would be documenting it as unavailable. While in Resident 3's room, Surveyor noted the fluticasone nasal spray on the resident's bedside table. Caregiver B did not administer the medication and left the nasal spray in Resident 3's room. On 11/04/2025 at approximately 9:30 AM, Surveyors reviewed Resident 3's records. Resident 3 was admitted on 02/03/2024, with diagnoses that include essential hypertension, hyperlipidemia, and major depressive disorder. Resident 3's medication orders state resident should be receiving 20 mg of lisinopril daily in the morning. Resident 3's ISP, dated 08/05/2025, states staff administer and store all Resident 3's medications. On 11/04/2025 at 10:00 AM, Surveyors interviewed Nurse Supervisor (NS) A. NS A reviewed the medication orders and the medication card and confirmed they did not match. NS A stated they would reach out to the pharmacy regarding the lisinopril and resolve the issue. NS A stated the caregiver should have taken the nasal spray out of Resident 3's room	{N 352}		

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{N 352}	Continued From page 2 and stored it in the medication cart. Cross Reference N0415 DHS 83.37(2)(d) Documentation of Medication Administration	{N 352}		
{N 415}	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on observation record review and interview, the provider did not ensure each resident's medication administration record (MAR) was accurately maintained for 2 of 2 residents (Resident 3 and Resident 2) reviewed. Staff did not accurately document what medications Resident 3 had been administered and if Resident 2 had consumed their medications. This requirement is being cited for the third time. See Statement of Deficiency (SOD) LF4Q11, dated 12/17/2024, and SOD 9BGI12, dated 10/08/2020)	{N 415}		

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{N 415}	Continued From page 3 Findings include: On 11/04/2025 at 8:45 AM, Surveyors toured the facility and observed Caregiver B administer medications. Surveyor observed Resident 3's medication card for lisinopril 30 milligrams (mg) tablets. Twelve tablets remained in the medication card that originally contained 31 tablets. Surveyor observed a medication cup in Resident 2's room which contained 8 yellow tablets (later found to be naltrexone 50 mg tablets). On 11/04/2025 at approximately 9:30 AM, Surveyors reviewed Resident 3's and Resident 2' records. The following as identified: Resident 3 was admitted on 02/03/2024, with diagnoses that include essential hypertension, Hyperlipidemia, and major depressive disorder. Resident 3's Individual Service Plan (ISP), dated 08/05/2025, identified Resident 3 required staff assistance for all medication administration. Resident 3's MAR for October 2025 showed lisinopril 20 mg signed out 30 out of 31 days. On 11/04/2025 at 4:00 PM, surveyor interviewed Pharmacy Tech (PT) C by phone, PT C confirmed pharmacy has been sending lisinopril 30mg tablets to the facility. Resident 2 was admitted on 10/17/2019, with diagnoses that include alcohol dependence in remission, essential hypertension and hyperlipidemia. Resident 2's ISP, dated 08/18/2025, identified Resident 2 required staff assistance for all medication administration. Resident 2's MAR for October 2025 documented Naltrexone as refused 6 times and administered 25 times. There was a notation on the MAR for	{N 415}		

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{N 415}	Continued From page 4 Resident 2's naltrexone stating "must watch resident take med." On 11/04/2025 at approximately 9:45 AM, Surveyors interviewed Resident 2. Resident 2 stated /she did not take the naltrexone as it gave them loose stools. On 11/04/2025 at 10:00 AM, Surveyors interviewed Nurse Supervisor (NS) A. NS A confirmed the documentation for Resident 3 was incorrect as the dose on the MAR and the dose sent by the pharmacy were not the same. NS A stated they would reach out to the pharmacy to fix the issue. NS A confirmed caregivers should be watching Resident 2 swallow his/her medication, and if the medication is being refused that NS A should be updated. NS A stated they would inform the Resident 2's physician s/he has not been receiving the prescribed medication consistently. Cross Reference: N0352 DHS 83.32(3)(h) Rights of Resident: Receive Medication	{N 415}		