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 06/18/2026

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 06/18/2026, Surveyor concluded a standard survey, verification visit and four complaint intakes at St Anne's Home for the Elderly. Three complaints were unsubstantiated. One complaint was substantiated. Three deficiencies were identified. Two of 3 deficiencies were repeat violations (see SOD LF4Q11, dated 12/17/2024, and SOD LF4Q12, dated 11/05/2025). Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 45	{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 6) reviewed. This requirement is being cited for the third time. See Statement of Deficiency (SOD) LF4Q11, dated 12/17/2024, and SOD LF4Q12, dated	{N 352}		

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
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{N 352}	Continued From page 1 11/05/2025. Findings include: On 06/17/2026, Surveyor reviewed Resident 6's record and identified the following: Resident 6 was admitted on 01/26/2024 and had diagnoses including hypertensive heart disease with heart failure, atherosclerosis, and reflux disease. Resident 6 needed assistance with medication administration from staff. Resident 6's, June 2026 Medication Administration Record (MAR), dated 06/01/2026 to 06/17/2026, had a chart code entry, on the following dates: - 06/11/2026, Eliquis tablet 2.5 milligrams evening pass, chart code 16 defined as, "Medication unavailable-pharmacy contacted." - 06/12/2026, marked as given. - 06/13/2026, Eliquis tablet 2.5 milligrams evening pass, chart code 9 defined as, "Other. See progress notes." - 06/14/2026, marked as given. - 06/15/2026, marked as given. - 06/16/2026, marked as given. On 06/13/2026, Certified Nursing Assistant (CNA) H documented in Resident 6's progress note, "Needs refill." Resident 6's physician order summary report stated Resident 6 was prescribed the following	{N 352}		

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{N 352}	Continued From page 2	{N 352}		

medications:

-Eliquis tablet 2.5 milligrams (MG). One tablet by mouth twice daily. Indications for use: Anticoagulation. Order date: 08/07/2024. Start Date: 08/07/2024. End Date: Blank.

On 06/17/2026, at 8:50 a.m., Surveyor interviewed Resident 6, who stated his/her nighttime medications had been coming inconsistently for the past week or so. Resident 6 stated, "I had to get a hold of [Nurse Supervisor (RNS) A]. Sometimes I received my medication and sometimes I did not." Resident 6 stated the medication was the blood thinner for him/her. Resident 6 stated, "That's very important for me."

On 06/17/2026, at 9:25 a.m., Surveyor interviewed Medication Passer (Med Pass) F, who confirmed Resident 6 received two pills in the evening. Resident 6 received Eliquis and acetaminophen. Med Pass F and Surveyor reviewed electronic MAR and observed 06/11/2026, Eliquis tablet 2.5 milligrams evening pass, chart coded as medication unavailable; pharmacy contacted and 06/13/2026, Eliquis tablet 2.5 milligrams evening pass, chart coded as other; see progress notes.

On 06/17/2026, at 9:30 a.m., Surveyor requested to review the medication cards. Med Pass F looked through the medication cart and could not find Resident 6's evening medication cards. Med Pass F stated, "This is the perfect example of when the resident does not have their pills, because clearly, [Resident 6] does not have them. They appear to be reordered, but I cannot find them."

On 06/17/2026, at 9:50 a.m., Surveyor

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{N 352}	Continued From page 3 interviewed Executive Director (ED) E, who stated s/he found the medication cards in the medication cart. They were not where they were supposed to be. ED E and Surveyor reviewed the medication card and the MARs. The following was identified: - 06/11/2026: Marked as chart code 16, "Medication unavailable-pharmacy contacted." Observed medication still in medication card. - 06/12/2026: Marked as given. Observed medication still in medication card. - 06/13/2026: Marked as chart code 9, "Other. See progress notes." Observed medication still in medication card. - 06/14/2026: Marked as given. - 06/15/2026: Marked as given. Observed medication still in medication card. - 06/16/2026: Marked as given. On 06/17/2026, at 10:08 a.m., ED E confirmed medication was still in medication card. ED E stated, "I spoke with Medication Passer (Med Pass) G, who stated s/he ordered the medication and borrowed from the morning medication for the evening medication on 06/12/2026." Resident 6 did not receive his/her prescribed Eliquis medication on 06/11/2026, 06/12/2026, 06/13/2026, and 06/15/2026. On 06/17/2026, at 10:08 a.m., Surveyor interviewed ED E and Med Pass F. Surveyor asked Med Pass F if borrowing medication from another date/time is part of the medication policy. Med Pass F stated it was not.	{N 352}		

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{N 352}	Continued From page 4 On 06/17/2026, at 5:00 p.m., Surveyor interviewed ED E, who stated they had been working very hard at medications. RNS A was watching the dashboard daily, watching for any issues. S/He must have missed this situation. ED E explained s/he was disappointed and will continue to educate staff. Cross Reference N0415 DHS 83.37(2)(d) Documentation of Medication Administration	{N 352}		
N 355	83.32(3)(k) Rights of Residents: Self-determination In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Self-determination. Make decisions relating to care, activities, daily routines and other aspects of life which enhance the resident ' s self reliance and support the resident ' s autonomy and decision making. This Rule is not met as evidenced by: Based on interviews, record review, and observation, the provider did not ensure residents had the ability to make decisions relating to activities, other aspects of life which enhance the resident's self-reliance, and support the resident's autonomy. Resident 5 moved into the facility with his/her items in plastic bags and boxes. Resident 5 did not have ample space to unpack his/her items and chose to leave his/her personal items alongside his/her apartment wall, in his/her bags and boxes. Executive Director (ED) E unpacked and organized Resident 5's items without Resident 5's consent.	N 355		

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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

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N 355	Continued From page 5 Findings include: On 09/05/2023, the Department received a complaint alleging Resident 5 had items missing during his/her move from one facility into current facility. On 06/17/2026, Surveyor reviewed Resident 5's record and identified the following: Resident 5 was admitted on 11/10/2025 and had diagnoses including 2 diabetes mellitus, paraplegia, hypertensive heart disease and instability/muscle weakness. Resident 5 was his/her own person. Resident 5 was enrolled in services with a managed care organization (MCO) and was assigned case managers. Resident 5's individualized service plan (ISP) had a revision date of 05/14/2026. Resident 5 and his/her MCO case managers signed the document on 05/14/2026. Surveyor did not observe any indication that Resident 5 required staff assistance with putting clothing away or rearranging personal items. Under Laundry, it stated, "requires assistance with laundry on scheduled days by staff." On 06/17/2026 at 10:50 a.m., Surveyor interviewed Medication Passer (Med Pass) G, who stated, "I hope I don't get in trouble for telling you this." Med Pass G explained Resident 5 moved in with his/her things in boxes and bags. After Resident 5 had been at the facility for a while, ED E and Housekeeper (HK) I went into Resident 5's room and began rearranging and cleaning his/her room, without Resident 5's consent. Med Pass G stated, "[Resident 5] was mad. S/He kept telling [ED E] not to touch his/her things because s/he knew where everything was	N 355		

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N 355	Continued From page 6	N 355		

in his/her bags and boxes." Med Pass G stated Resident 5 was his/her own person and was, "sharp as a tack." Med Pass G stated Resident 5 would get out of his/her bed on his/her own time and work on putting away the items in the bags and boxes; s/he was slowly unpacking the items.

On 06/17/2026 at 11:43 a.m., Surveyor observed Resident 5's apartment. Along the wall, Surveyor observed a laundry basket with small grocery bags of unidentified personal items, a large gift bag with a white plastic bag of items, five large brown boxes, 4 small, see-through totes with covers, a walker, 3 large packages of adult undergarments and 2 medium totes with covers.

On 06/17/2026 at 11:45 a.m., Surveyor interviewed Resident 5, who stated s/he could not stand or walk very well. When s/he moved in, all s/he had was a small, 3 drawer dresser and a nightstand to put his/her personal items in. S/he also stated s/he had ample closet space, but most of his/her items belonged in dresser drawers. Resident 5 explained in January 2026, ED E and HK I came into his/her room and began looking through his/her bags, sorting through his/her things, putting his/her things where they thought the items should go and then removed things. Resident 5 stated s/he had not seen several of those items since that day. Resident 5 stated, "[ED E] had no reason to be in my apartment. [HK I] wanted to mop the floor and was bothered that s/he could not do the whole floor because of my things." Resident 5 explained s/he told ED E to stop what s/he was doing. Resident 5 asked ED E multiple times, to get out of his/her apartment. ED E told Resident 5, "I'm sorry. We cannot have these items on the floor." Resident 5 stated s/he has been unable to find certain, important paperwork since the incident.

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N 355	Continued From page 7	N 355		

Resident 5 confirmed s/he was able to move freely around his/her apartment: to the bathroom, window and to the front door with no concern of a trip hazard.

On 06/17/2026 at 12:15 p.m., Surveyor interviewed HK I, who stated s/he and ED E went into Resident 5's room and cleaned. HK I confirmed Resident 5 did not request assistance with his/her bags and boxes. HK I stated, "[Resident 5] did not want us to remove the bags. S/He was mad."

On 06/17/2026 at 1:20 p.m., Surveyor interviewed Resident 5's Family J, who stated Resident 5 had called him/her and explained someone from the facility had come into Resident 5's room and unpacked his/her bags and boxes. Family J stated Resident 5 had paperwork for old student loans that disappeared the day ED E unpacked his/her things. Resident 5 told family J s/he had very little shelving to put his/her personal items on.

On 06/17/2026 at 3:05 p.m., Surveyor interviewed ED E and asked when Resident 5 provided him/her consent to rearrange and clean Resident 5's room. ED E stated Resident 5 did not provide consent. However, Resident 5 kept telling ED E his/her family would come to assist with the items. ED E placed a telephone call to the family, who lived out of state, and they confirmed that they would not be coming to assist Resident 5's bags and boxes. ED E stated, "The family told me to just go ahead and help [Resident 5]." ED E confirmed the family member was not a guardian or activated power of attorney. ED E stated s/he spoke with the local ombudsman, who told ED E if s/he felt like it was a safety issue, s/he could do something about it. Surveyor requested evidence

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N 355	Continued From page 8 of the apartment being a health and safety issue. ED E stated s/he did not take photographs of the apartment before s/he began cleaning it.	N 355		
{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 1 of 1 resident (Resident 6) reviewed. Staff did not accurately document what medications Resident 6 had been administered and when Resident 6's medication was missing from the medication cart. This requirement is being cited for the third time. See Statement of Deficiency (SOD) LF4Q11, dated 12/17/2024, and SOD LF4Q12, dated 11/05/2025. Findings include:	{N 415}		

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{N 415}	Continued From page 9 On 06/17/2026, Surveyor reviewed Resident 6's record and identified the following: Resident 6 was admitted on 01/26/2024 and had diagnoses including hypertensive heart disease with heart failure, atherosclerosis, and reflux disease. Resident 6 needed assistance with medication administration from staff. Resident 6's, June 2026 Medication Administration Record (MAR), dated 06/01/2026 to 06/17/2026, had a chart code entry, on the following dates: - 06/11/2026, Eliquis tablet 2.5 milligrams evening pass, chart code 16 defined as, "Medication unavailable-pharmacy contacted." - 06/12/2026, marked as given. - 06/13/2026, Eliquis tablet 2.5 milligrams evening pass, chart code 9 defined as, "Other. See progress notes." - 06/14/2026, marked as given. - 06/15/2026, marked as given. - 06/16/2026, marked as given. On 06/13/2026, Certified Nursing Assistant (CNA) H documented in Resident 6's progress note, "Needs refill." Resident 6's physician order summary report stated Resident 6 was prescribed the following medications: -Eliquis tablet 2.5 milligrams (MG). One tablet by mouth twice daily. Indications for use:	{N 415}		

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{N 415}	Continued From page 10 Anticoagulation. Order date: 08/07/2024. Start Date: 08/07/2024. End Date: Blank. On 06/17/2026, at 9:50 a.m., Surveyor and Executive Director (ED) E, reviewed Resident 6's 8:00 p.m. medication card and his/her June MARs. The following was identified: - 06/11/2026: Marked as chart code 16, "Medication unavailable-pharmacy contacted." Observed medication still in medication card. - 06/12/2026: Marked as given. Observed medication still in medication card. - 06/13/2026: Marked as chart code 9, "Other. See progress notes." Observed medication still in medication card. - 06/14/2026: Marked as given. - 06/15/2026: Marked as given. Observed medication still in medication card. - 06/16/2026: Marked as given. On 06/17/2026, at 10:08 a.m., ED E confirmed medication was still in medication card. ED E stated, "I spoke with Medication Passer (Med Pass) G, who stated s/he ordered the medication and borrowed from the morning medication for the evening medication on 06/12/2026." On 06/17/2026, at 5:00 p.m., Surveyor interviewed ED E, who stated they had been working very hard at medications. RNS A was watching the dashboard daily, watching for any issues. S/He must have missed this situation. ED E explained s/he was disappointed and will continue to educate staff.	{N 415}		

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{N 415}	Continued From page 11 Cross Reference: N0352 DHS 83.32(3)(h) Rights of Resident: Receive Medication	{N 415}		