

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525477	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/01/2025
NAME OF PROVIDER OR SUPPLIER  St Francis Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE  1915 E Tripoli Ave Saint Francis, WI 53235	

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)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on record review, interview, review of the Misconduct Incident Report, and facility policy review, the facility failed to ensure that a thorough investigation was documented regarding a potential visitor-to-resident altercation for one (R1) resident out of a sample of 14 residents reviewed for abuse.</p> <p>Findings include:</p> <p>Review of facility policy titled Abuse, Neglect and Exploitation, revised 07/15/22, revealed, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property .V. Investigation of Alleged Abuse, Neglect and Exploitation .B. Written procedures for investigations include .4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegation(s).</p> <p>Review of the Misconduct Incident Report (final report) provided by the facility dated 05/07/25 revealed On 05/01/25 R1 reported to staff at [name of the facility] that she was not happy with her friend and care giver from the community [name of the friend]. R1 stated she no longer wanted to have any contact with this person. R1 stated she no longer wants [name of the friend] to provide care for her at home when she discharges after rehab, and she does not want [name of the friend] to visit her here in the nursing home. The social worker inquired as to why and asked what had occurred and R1 stated that [name of the friend] came to visit her the previous weekend and was not nice to her. R1 said that [name of the friend] yelled at her and shook her by her arms. She [meaning R1] also made an indication that money may have been taken from her by [name of the friend] previously when living in the community. R1 was very upset with [name of the friend] interaction with her on the previous weekend yelling at her and shaking her. R1 said she is afraid of her and does not want [name of the friend] to be close to her. R1 said that she feels very safe being at the facility and if [name of the friend] is not allowed to visit her, she feels fine with the situation. She has been eating normal meals and socializing in the dining room. She [meaning R1] remains participatory in therapy and activities of her choice. She [meaning R1] continues to have a pleasant demeanor and is not having any ill effects from the incident. R1 does not have a roommate, and there were no witnesses to the incident. Upon initial report of the concern, the facility initiated an investigation. The investigation included interviews with R1, and the [name of the city] police department was also contacted and came out to take her statement. Notification to staff posted telling them not to let [name of the friend] visit R1 if she is to come into the building. There was no evidence of staff being interviewed regarding the abuse allegation.</p> <p>(continued on next page)</p>

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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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/30/25 at 1:45 PM with the Administrator, she said that since this incident did not involve the facility staff, the staff at the facility were not interviewed. The Administrator stated that the facility staff were informed not to let the friend visit and the police were contacted. At 3:30 PM, the Administrator stated that R1 was assessed after the incident and did not have any marks on her bilateral arms.</p> <p>During an interview on 07/01/25 at 3:47 PM with the Social Services Director (SSD), she said that an unknown Certificated Nursing Assistant (CNA) came to her and stated that R1 was upset that her friend visited over the weekend. The SSD stated that she and the CNA went and spoke with R1 who said that her friend was upset with her and shook her arms/hands. The SSD said she reported this incident to the Administrator and R1 was interviewed. R1 stated that her friend asked for her bank card and R1 stated no, and R1's friend became upset and shook her. R1 was upset that the police were contacted because she did not want to press any charges. The SSD confirmed that no residents were interviewed during the investigation The SSD stated that the incident occurred in R1's bedroom and that R1 did not have a roommate and there were no witnesses to the alleged incident.</p>		