STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525526	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chi Franciscan Villa	3601 S Chicago Ave South Milwaukee, WI 53172

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21382 Based on observation, interview, record review, the facility did not ensure that 1 of 4 residents (R1) was free from verbal and mental abuse. Certified Nurse Aide (CNA) D intentionally moved R1's call light out of his reach and closed his door, thereby taking away R1's ability to summon assistance in the event of an emergency or need. CNA D reported her actions to RN E (Registered Nurse); however, RN E did not report the incident to the Administrator. This allowed CNA D to work 3 shifts at the facility following the incident before she was suspended. The facility's failure to ensure residents were free from abuse created a finding of immediate jeopardy that began on 10/19/24. Surveyor notified the Nursing Home Administrator (NHA) of the immediate jeopardy on 11/8/24 at 11:10 a.m. The immediate jeopardy was removed on 11/8/24, however continues at a scope/severity of D (potential for more than minimal harm/isolated) as the facility continues to implement its action plan. Findings include: Review of the facility's policy titled, Abuse, Neglect, Exploitation, dated 10/22/24, 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 .The facility will have written procedures that include: reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required and to all other required agencies (e.g. law enforcement when applicable) within specified timeframes: Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury . (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy titled, Compliance With Reporting Allegations of Abuse/Neglect/Misappropriation, revised 07/2021, revealed, It is the policy of this facility to report all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources and misappropriation of resident property are reported immediately to the Administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed timeframes . When suspicion of abuse/neglect/exploitation or reports of abuse/neglect/exploitation occur, the following procedure will be initiated: The Licensed Nurse will: a. Respond to the needs of the resident and protect him/her from further incident .Remove the accused employee from resident care areas .Notify the Director of Nursing and Administrator .Notify the attending physician, resident's family/legal representative, and Medical Director .Complete an incident report and initiate an investigation .Notify the appropriate agencies immediately: as soon as possible, but no later than 24 hours after discovery of the incident .Suspend the accused employee pending completion of the investigation . R1 was readmitted to the facility on [DATE] with diagnoses that included traumatic spinal cord dysfunction and quadriplegia. R1's Care Plan dated 02/01/23 stated, .Be sure puff call light is in reach . Review of R1's annual Minimum Data Set (MDS), dated [DATE], revealed R1 is cognitively intact. The MDS recorded R1 had functional limitations in range of motion on the upper and lower extremities bilaterally and was dependent on staff for all activities of daily living. Review of the facility's investigative file for the incident between R1 and CNA D revealed the following: A statement from LPN F (Licensed Practical Nurse) dated 10/24/24 stated, Resident stated that CNA D was mean to him, he asked her to change him, and she refused, and they started arguing, she then got mad at him removed his call light which he blows into, turned out the lights on him and shut the door. He also stated that she wouldn't even change him the next day because she didn't like him and that he could starve to death. A statement from DON B (Director of Nursing) stated, 10/24/24 LPN G reported to me that (R1) had reported to her that CNA D had taken his mouthpiece call light system out of his mouth to where he couldn't reach it then turned lights out and closed his door after having an argument. I went to see R1 to discuss his allegation. R1 stated that CNA D had taken his mouthpiece out of his mouth and moved it out his reach then left his room closing his door. Stated she had worked on Sunday, Monday and Wednesday. Stated this happened on Wednesday pm shift after having an argument with her. He also stated that she came into his room about 4:00 pm and he told her he had 'pooped' and needed changed but she left the room and never came back. R1 also stated that she said to him 'I don't need you, you need me.' I asked R1 who replaced your mouthpiece? He stated the nurse RN H replace it and opened his door .He is able to speak but no movement and uses mouthpiece for contacting staff for his needs . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A statement from RN E notes, 10/25/24 Re: Incident involving R1. Resident put his call light on, and CNA D went to answer it. A couple minutes later, I, RN, came down the hall, and noted resident's door closed, which was strange. I thought maybe he was getting cares. However, when I got to the nurses' station, I noted the CNA sitting there. I asked her why was R1's door closed, and she replied that she shut it, and took away his call light. She stated they had some words, both of them calling each other names. She stated she got angry, took away the call light and slammed the door closed. I told her that she can not [sic] do that, and that I gave him back his call light and opened the door. I told the CNA not to go back into the resident's room, that she would need to switch him with another CNA. After giving the resident back his call light and opening up his door; the resident stated he feels better and now safer. An undated statement from CNA notes, Hello [Administrator], On Sunday October 20th, I went to answer [R1]'s light. He [unknown] been upset already. I asked him if he needed something he started complaining about his [unknown] so I told him I would go get the nurse then he started yelling at me getting real disrespectful calling me fat bitches multiple times and threatened to slap me. I told him I'm not gonna be too many fat bitches and for him to go ahead and slap me. He then threatened to have someone come up to the job to fight me. So I told him go ahead. After that I left out his room. On Monday October 21 I didn't have much going on with him except he accused me of doing something to his food so he didn't want it. On Wednesday October 23rd I didn't have much going on with him. I told the other aide that worked with me that she would have to take him cause of our interaction. I thought she agreed to. At the end of shift the nurse did come ask all of us who had him. I told her I thought the other aide did but she said no so I said I'll go in his room only if someone else comes in there with me because I didn't want him saying I tried to do something to him. The nurse said no I don't want you going in there cause he won't let you touch him and so he doesn't say anything else to you so I didn't. Also, another aide did go in his room answer his light told him she would go get someone for him. He's just overall a hard person to deal with especially when things don't go his way. [unknown] of the other aides and nurses don't like to go in his room because he's too much . A statement from CNA I, dated 10/31/24, stated, On 10/23/24 I was standing outside R1's room talking to CNA D. I saw his light come on so I answered it. He told me that he needed to be changed and he had been waiting. I told him I was going to pass it to his aide. CNA D was standing outside the door. She was shaking her head no. I came out asked her why she not doing him [sic]. She told me because he called her a fat bitch and that he was going to slap her. And she can refuse to do him. I replied no you can't refused [sic] to do him, but he can refuse you as his aide. She told me I didn't know what I was talking about . Review of CNA D's Individual Timecard revealed she worked on 10/20/24, 10/21/24, and 10/23/24. The surveyor was unable to determine which hallway she had worked on. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/07/24 at 5:00 PM, RN E stated that on 10/19/24, she had stepped away from the unit and on returning to the unit about 9:20 PM, she noticed R1's door was closed which was not normal. She stated CNA D was observed seated at the nurses' desk, and when asked why the door was closed, CNA D stated R1 and she had words with each other, calling one another names about 9:00 PM. RN E stated CNA D reported that R1 called her a fat ass bitch. RN E stated CNA D further stated she had removed R1's puff activated call light from his reach and slammed his door shut. RN E stated she told CNA D what she did was not appropriate, and she went to his room. RN E stated she opened his door and returned his call light to him and asked if he was OK or scared of anyone including CNA D, and that R1 told her he was not afraid of anyone. RN E stated the problem started on Saturday 10/19/24, not on a weeknight. RN E stated she removed CNA D from R1's care around 9:20 PM, and that CNA D sat at the nurse's station until she clocked out at 9:58 PM on 10/19/24. RN E reported R1 was without his puff call light for 20 to 30 minutes. RN E confirmed she did not report the incident to the NHA A (Nursing Home Administrator). She stated she felt that she had handled the situation, and she was unaware she could call the Administrator, no matter what time it was. RN E stated she was unaware CNA D should have been suspended following the incident. During an interview on 11/07/24 at 9:45 AM, NHA A stated he felt RN E had addressed the issue; however, he had two concerns. He stated he was concerned that he was not notified immediately, and that CNA D was not sent home but only removed from R1's care. NHA A stated he and the DON had provided education to RN E related to abuse, reporting allegations of abuse to the Administrator immediately, and the facility's policy and procedure related to adhering to federal guidelines for reporting allegations of abuse. NHA A stated he had informed RN E that he was available, no matter the time of the day. During an interview on 11/08/24 at 5:50 PM, DON B confirmed she expected staff to notify her of any issues or concerns with residents. She stated her expectation was to be notified of allegations of abuse immediately. DON B confirmed she provided education to RN E related to abuse and reporting allegations of abuse to her or NHA A immediately. During an interview on 11/08/24 at 5:59 PM, R1 stated he was unable to provide the exact date of the incident. He stated he and CNA D had some words, and he called her a name. He stated she called him a name as well but could not remember what it was. He stated he was not afraid of any staff and was alright. The Surveyor attempted to reach CNA D on 11/07/24 and 11/08/24. Messages were left, but no return phone call was received. CNA D left R1 alone in the dark and without R1's communication, thus depriving R1, a resident who is dependent on staff for all activities of daily living, of the ability to communicate his needs to staff. CNA D was allowed to continue to work on the same unit on two additional shifts, creating opportunity to further retaliate against R1. The failure to ensure residents were free from abuse or the ongoing threat of abuse created a reasonable likelihood for serious harm, thus leading to a finding of immediate jeopardy. The facility removed the immediate jeopardy on 11/8/24 when the following was completed: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	RN E was given a verbal education on abuse policy, reporting compliance, and to always contact the Administrator if there are any allegations of abuse on 10/25/2024 CNA D was removed from resident care on 10/24/2024 prior to the start of shift. All nursing staff will be re-education on abuse, neglect and misappropriation policy education; abuse reporting and compliance policy; resident call light accessibility. Administrator or designee to orient all new staff on the abuse reporting policy and how to contact those individuals 24/7. Director of Nursing or designee to provide education on abuse reporting policy monthly at staff meetings.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21382 Based on interview, record review, and facility policy review, the facility failed to report an allegation of abuse immediately to the Administrator. Failure to report an allegation placed all residents at risk as the accused staff person was allowed to work throughout the building. CNA D refused to provide cares to R1, removed R1's puff activated call light, and shut R1's room door. CNA D reported her actions to RN E. RN E did not report the allegation of abuse to NHA A (Nursing Home Administrator). CNA D was allowed to continue to work with residents for an additional 3 shifts before it was reported to administration. Findings include: Review of the facility's policy titled Abuse, Neglect, Exploitation, dated 10/24/22, revealed, .The facility will have written procedures that include .Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury . R1 was readmitted to the facility on [DATE] with diagnoses that include traumatic spinal cord dysfunction and quadriplegia. R1's Minimum Data Set (MDS) assessment dated [DATE], revealed R1 is cognitively intact, has functional limitations in range of motion on the upper and lower extremities bilaterally, and is dependent on staff for all activities of daily living. R1's Care Plan, dated 02/01/23 included, .Be sure puff call light is in reach. Review of the facility's investigative file found an incident that occurred between R1 and CNA D. A statement from RN E dated 10/25/24 indicated; .Resident put his call light on, and CNA D went to answer it. A couple minutes later, I, RN, came down the hall, and noted resident's door closed, which was strange. I thought maybe he was getting cares. However, when I got to the nurses' station, I noted the CNA sitting there. I asked her why was R1's door closed, and she replied that she shut it, and took away his call light. She stated they had some words, both of them calling each other names. She stated she got angry, took away the call light and slammed the door closed. I told her that she can not [sic] do that, and that I gave him back his call light and opened the door. I told the CNA not to go back into the resident's room, that she would need to switch him with another CNA. After giving the resident back his call light and opening up his door, the resident stated he feels better and now safer. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/08/24 at 4:00 PM, RN E stated an incident occurred between CNA D (Certified Nursing Assistant) and R1 on 10/19/24 (Saturday) at approximately 9:20 PM. RN E stated she observed CNA D at the nurses' station and R1's door was closed. When she asked CNA D why the door was closed, CNA D responded, We had words. RN E stated CNA D had informed her that she had positioned R1's puff activated call light out of his reach and closed his door. RN E stated she told CNA D not to go in his room again. RN E stated she entered R1's room, spoke to him, and placed the call light within his reach. RN E stated she asked R1 if he felt safe or was afraid of anyone and R1 had stated he was fine. RN E stated when she returned to the desk where CNA D was seated, she inquired about what happened and CNA D reported R1 had called her a fat ass bitch. RN E stated she felt she had handled the situation and did not need to report it to anyone else. RN E confirmed she did not report the altercation to her supervisor or NHA A (Nursing Home Administrator) on 10/19/24 when it occurred, and CNA D continued to work 3 additional shifts over 4 days providing care to residents, until 10/24/24. During an interview on 11/07/24 at 9:45 AM, NHA A stated he had not been aware the incident occurred on 10/19/24. He stated it had been reported to him that the incident occurred on 10/23/24. NHA A confirmed the incident was not reported to the State Survey Agency until 10/24/24 and that an investigation had not begun until after 10/24/24.