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	05/30/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of the facility policy, and the resident assessment instrument (RAI) manual, the facility failed to ensure the Minimum Data Set (MDS) was coded accurately for one (Resident (R3) in a total sample of 13. The facility failed to accurately code the correct weight on the quarterly assessment and the correct documentation of the number of wounds on the discharge return anticipated assessment. This failure placed residents at risk of unmet care needs and a diminished quality of life. Findings include: Review of the facility policy, titled MDS 3.0 Completion, dated 03/04/23 revealed, .Correction of Error on the Assessment .A Modification Request is used when an MDS record (assessment, entry tracking record or death in facility tracking record) .(already transmitted and accepted by CMS [Center for Medicaid and Medicare Service], but the information in the record contains clinical or demographic errors. It must be corrected within 14 days after identifying the errors . Review of the October 2024 RAI manual, page 1-5 revealed, .An accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations .It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident's actual status was during the observation period) by the IDT [interdisciplinary team] completing the assessment . Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed R3 was admitted to the facility on [DATE] with diagnoses that included peripheral vascular disease (PVD), a stroke, and diabetes. Review of the quarterly MDS located in the MDS tab of the EMR with an assessment reference date (ARD) of 03/12/25 revealed R3 had a Brief Interview of Mental Status (BIMS) score of 14 out of 15 which indicated R3 was cognitively intact and weighed 155 pounds. Review of the Weights/Vitals tab in the EMR revealed on 03/05/25 (seven days prior to the quarterly assessment) R3 had a documented weight of 141 pounds and not 155 pounds which was his admission weight. (continued on next page)

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
	525526	A. Building B. Wing	05/30/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the discharge return assessment MDS located in the MDS tab of the EMR with an ARD of 05/04/25 revealed R3 had a staff assessed BIMS score of being cognitively intact and had one Stage 3 pressure ulcer (full thickness skin loss), four Stage 4 pressure ulcers (full thickness skin and tissue loss that exposes underlying muscle, tendons, or bone) and five unstageable wounds (a deep wound where the actual depth and extent of damage cannot be determined) all of which were present upon admission to the facility. Review of the 05/01/25 Wound Care Provider Visit Note located in the Miscellaneous tab of the EMR revealed, R3 had four unstageable wounds and not five unstageable wounds as documented in the assessment. During an interview on 05/29/25 at 11:19 AM, the MDS Coordinator (MDSC)1 stated, The quarterly assessment was coded inaccurately for the weight of 155 pounds. MDSC1 further confirmed that she had coded incorrectly the number of unstageable wounds for R3, and it should have been coded four wounds and not five wounds.

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	05/30/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility policy , the facility failed to ensure showers were provided for two residents dependent on staff for care (Residents (R1, R3) out of a total sample of 13 residents. This failure placed the residents at risk of skin breakdown and a diminished quality of life. Findings include: Review of facility procedure titled, Bath, Tub/Shower, dated February 2018 revealed, .Documentation .The date and time the shower/tub bath was performed .The name and title of the individual(s) who assisted the resident with the shower/tub bath .All assessment data (e.g., any reddened areas, sores, etc., on the resident's skin) obtained during the shower/tub bath .If the resident refused the shower/tub bath, the reason(s) why and the interventions taken .How the resident tolerated the shower/tub bath .The signature and title of the person recording the data .Reporting .Notify the supervisor if the resident refuses the shower/tub bath .Notify the physician of any skin areas that may need to be treated .Report other information in accordance with facility policy and professional standards of practice . 1. Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed R1 was admitted to the facility on [DATE] with a diagnosis of spina bifida (a type of birth defect where the spinal column doesn't close completely during fetal development) and paraplegia (paralysis of two limbs). Review of a 04/16/20 and revised on 10/04/22 ADL [activities of daily living] Self Care Performance Deficit Care Plan located in the Care Plan tab of the EMR revealed, R1 has limited mobility, urostomy [a tube inserted into the kidney to drain urine], refusal of cares/showers at times, paraplegia, spina bifida, hydrocephalus [fluid which accumulates in the brain]. Approaches included: a. Bathing: I require substantial to max assist by one staff to provide a bath/shower as scheduled and PRN [as needed], dated 03/31/25. b. Bathing: Provide me with a sponge bath when a full bath or shower cannot be tolerated. Dated 06/05/23. Review of a quarterly Minimum Data Set (MDS) located in the MDS tab of the EMR with an assessment reference date (ARD) of 03/29/25 revealed, R1 had a Brief Interview of Mental Status (BIMS) score of 15 out of 15 which indicated R1 was cognitively intact, had verbal, other types of behaviors, and rejection of care for one to three days out of the seven-day observation period. In addition, R1 required substantial assistance for bathing. Review of the Order Summary located in the Orders tab of the EMR revealed, Ensure showers completed, document refusals in nurse's note, in the morning every Wed, Sat. Dated 04/03/25. Review of a 03/29/25 Nurse's Note located in the Progress Notes tab of the EMR revealed, Res. Notified writer at this time that he had refused shower earlier today due to he did not want his dressings changed. This was the only nursing documentation in the progress notes regarding a refusal. (continued on next page)

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	05/30/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 04/29/25 to 05/27/25 CNA (certified nurse aide) Bathing/Shower documentation located in the Tasks tab of the EMR revealed R1's shower days were Wednesday and Saturdays on the afternoon shift. The documentation further revealed: a. R1 received a shower on Tuesday 04/29/25. b. No documentation for Wednesday 04/30/25. c. Was not offered/refused a shower on Saturday 05/03/25. d. Not offered/refused a shower on Wednesday 05/07/25. e. Was not offered a shower on Saturday 05/10/25. f. R1 received a documented shower on Wednesday 05/14/25. g. Was not offered/refused a shower on Saturday 05/17/25. h. Refused to shower on Wednesday 05/21/25, accepted a shower on Friday 05/23/25 and refused on Saturday 05/24/25. i. The remainder of the days were documented as Not applicable. During an interview on 05/28/25 at 10:21AM, R1 was asked when his shower days were. R1 stated, I have a schedule on Wednesday and Saturday. R1 was asked when the last time was, he had a shower. R1 stated, I had a shower three weeks ago and I have refused on two occasions. During an interview on 05/28/25 at 10:26 AM, Certified Medication Aide (CMA)1 stated, The aides have shower sheets that they fill out in in addition to documenting in the EMR. CMA1 provided a stack of shower sheets from May 2025 going back to January 2025. Only one shower sheet for R1 was located in the stack which was a refusal on 01/27/25 and was not signed by the nurse, as required on the shower sheet. During an interview on 05/28/25 at 11:02 AM with the Unit Manager (UM) and Director of Nursing (DON), who were asked about the lack of documented showers and nursing documentation in the Progress Notes for R1, per the Order Summary. The DON stated, They (CNAs) are to report to the nurse if the resident refuses. They are to ask the residents at least three times and then the nurse will ask the residents why they refused. The nurse is then to document the refusal and the reason in the progress notes. The UM stated, R1 is consistently refusing. The UM was asked why that particular intervention regarding using male caregivers was not on the Care Plan. The UM stated, I don't know. The DON stated, We do have a periodic shower aide, but the CNAs are to give showers when the shower aide is not available. The DON was asked what does Not applicable mean on the CNA documentation form. The DON stated, It was not done nor was the resident asked. 2. Review of the admission Record located in the Profile tab of the EMR revealed, R3 was admitted to the facility on [DATE] with diagnoses that included peripheral vascular disease (PVD) and multiple wounds. (continued on next page)

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	05/30/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a 12/13/24 and revised on 02/26/25 ADL Self Care Performance Deficit Care Plan located in the Care Plan tab of the EMR revealed, Impaired balance, Musculoskeletal impairment. Approach: I require total assistance with bathing by one staff. Review of the quarterly MDS located in the MDS tab of the EMR with an ARD of 03/12/25 revealed, R3 had a BIMS score of 14 out of 15 which indicated R3 was cognitively intact, had no behaviors and was dependent on staff assistance for showering/bathing. Review of the Order Summary located in the Orders tab of the EMR revealed, Ensure showers completed, document refusals in nurse's note in the afternoon every Tue, Sat. Start Date: 04/05/25. Review of the nursing documentation on the Treatment Administration Record (TAR) for April 2025 revealed, R3 had a documented shower seven times and one refusal. Review of the Shower Sheets provided by the UM revealed R3 was offered a shower/bed bath on 04/01/25, 04/08/25, 04/11/25 and 04/18/25 and all were documented as refusals. In addition, no nurse had signed off on the Shower Sheet. A review of the Nursing Progress Notes did not show any documentation for the reason of the refusals. The UM stated that these four documented shower sheets was the only documentation she could find for R3. During an interview on 05/29/25 at 12:15 PM, CNA3 was asked if R3 was getting his showers, per the shower schedule. CNA3 stated, R1 would get bed baths, he did not want to get up in the shower. He would tell me he wasn't feeling well, but for me he took his showers. CNA3 was asked where did you document to show that R3 showers or bed baths were given or refused. CNA3 stated, We have shower sheets, and we also put the information in the computer. CNA3 was asked what the facility process was when a resident refused. CNA3 stated, If the resident refuses a shower, we have to try again at least three times, we then tell the nurse. The nurse would go in and ask the resident why they don't want a shower. We document this on the shower sheets and the nurse also signs. During an interview on 05/29/25 at 1:10 PM, Registered Nurse (RN)1 stated, If a resident refused a shower, the aides are to report to the nurse or supervisor to find out why they did not want to have a shower. RN1 was asked where this was to be documented. RN1 stated, On the shower sheets that the aide fills out and gives to me. I will sign off and will state the reason why they refused. RN1 was asked if he was to document refusals in the Progress Notes or on the TAR RN1 stated, No, I don't believe I document there.

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	05/30/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility policy, the facility failed to ensure there was oversight/supervision from the Registered Dietician (RD) of the Dietary Technician (DT) for one resident (Resident (R)6) of three residents reviewed in a total sample of 13 residents. This failure placed the resident at risk of further weight loss and a diminished quality of life. Findings include: Review of the facility policy titled, Nutritional Assessment, dated 11/28/22 revealed, The facility provides care and services to each resident to ensure the resident maintains acceptable parameters of nutritional status in the context of his or her overall condition. Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed R6 was admitted to the facility on [DATE] with a diagnosis of a stroke with left side paralysis, difficulty swallowing and dementia. Review of the admission Minimum Data Set (MDS) located in the MDS tab of the EMR with an assessment reference date (ARD) of 05/23/25 revealed R6 had a Brief Interview of Mental Status (BIMS) score of five out of 15 which indicated R6 was severely impaired in cognition. Review of the 05/22/25 and revised on 05/27/25 Nutritional Care Plan located in the Care Plan tab of the EMR revealed, Resident have (sic) increased risk for unintended weight loss .as evidenced by poor appetite, rec. [recommendation] appetite stimulant, needs mechanically modified diet, needs assistance with meals, refused ONS [oral nutritional supplement], BMI [body mass index]=28 (overwt). 05/27/25 PO [by mouth] intake < (less than) 50%, ONS added. Interventions included, but not limited to: a. Provide assistance with meals; needs encouragement; needs supervision d/t [due to] pocketing food. SLP [speech language practitioner] will follow up and clarify recommendations. Dated 05/22/25. b. Provide regular diet, pureed texture, thin liquids. Dated 05/28/25. Review of the 05/22/25 Nutritional Assessment, located in the Assessments tab of the EMR revealed, . Supplement refused by POA [power of attorney]/Resident, added fortified foods .UBW [usual body weight] 150 pounds - overweight .Meal intake: 50-75% .Feeding ability total dependence .Increased risk for unintended weight loss r/t poor appetite .Goal: res will maintain stable weight 140 pounds plus/minus five pounds . Review of the Weights/Vitals tab in the EMR revealed the following weights: a. 05/21/25: 142.5 pounds (lbs.) b. 05/28/25: 135.8 lbs. (6.7 lb. weight lost in one week) (continued on next page)

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	05/30/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 05/28/25 at 11:45 AM, R6 was observed seated at the table in the main dining room. There were no staff sitting with her at the table and her food was untouched. At 11:58 AM, an unidentified dietary aide (DA) told the resident, I am going to go get the nurse and have her sit with you. R6 stated, Why. The DA stated, To help you. At 12:07 PM, an unidentified staff member was seated with the resident and assisted her to eat. The resident was noted to eat less than 25% of her meal. During an observation on 05/29/25 at 8:40 AM, Certified Nurse Aide (CNA)8 was seated next to R6 in the resident's room assisting her to eat breakfast. CNA8 was asked if R6 was to have feeding assistance for meals. CNA8 stated, That is what I have been told. R6 was asked if she was hungry. R6 shook her head no. At 9:07 AM when R6 was finished with the meal, less than 25% of the meal was consumed. During an interview on 05/29/25 at 10:36 AM, the DT stated, When R6 was admitted , her daughter was very specific about R6's likes and dislikes. I told her that we could do fortified foods [higher calorie food]. The daughter refused the ensure plus and the ensure juice drinks. The supervision order came from the hospital and the daughter stated she needed assistance with meals. I put her on weekly weights, and I changed the order today to total dependence on eating. Her average intake is 0-50%. During an interview on 05/30/25 at 11:20 AM the RD was asked if she was made aware of high-risk residents, such as new admissions with weight loss, nutritional assessments which were completed by the DT. The RD stated, I do the high-risk resident nutritional assessments, and I will review them with her. The RD was asked why the DT completed the admission Nutritional Assessment and not her and if she aware of the weight loss. The RD stated, I was not made aware.

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	05/30/2025

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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the Scope of Practice for Nutrition and Dietetics Technician, Registered (NDTR), the facility failed to ensure the Dietary Technician (DT) had oversight/supervision by the Registered Dietician (RD) to meet the assessment and ongoing needs of the residents for two residents (Residents (R)3 and R6) out of a total sample of 13 residents. This failure placed all residents at risk of unidentified nutritional needs. Findings include: Review of the 2024 Scope and Standards of Practice for the Nutrition and Dietetics Technician, Registered by the Commission on Dietetic Registration; pages 15-16 revealed, .NDTRs work under the clinical supervision of an RDN .NDTRs may work independently in providing general nutrition education to healthy populations .Conducting nutrient analysis, collecting data and conducting research, and managing food and nutrition services in a variety of settings .As a member of the NDTR/RDN team, the NDTR supports the RDN by providing key oversight and communication concerning the delivery of quality person-centered food and nutrition services . The NDTR and other technical, and support staff work under the clinical supervision of the RDN when engaged in direct patient/client nutrition activities in any care setting .The RDN is responsible for nutrition care assigned and completed by the NDTRs and other staff . The RDN is responsible for completing the nutritional assessment; determining the nutrition diagnosis or diagnoses; developing the care plan; implementing the nutritional intervention; evaluating the patient/client response; and, also supervising the activities of professional, technical and support personnel assisting with the patient/clients' care .The NDTRs actively participates in nutrition care by contributing information and observations, guiding patients and clients in menu and snack selections, monitoring meals/snacks/nutritional supplements for compliance to diet order and providing nutrition education on prescribed diets. The NDTR reports to the RDN on the patient's/client response, including documenting outcomes or providing evidence signifying the need to adjust the interventions/plan of care . 1. Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed R3 was admitted to the facility on [DATE] with multiple pressure ulcers and was diabetic. Review of the 12/23/24 admission Nutritional Assessment located in the Assessments tab of the EMR revealed the DT had documented R3's diet order, diagnoses, weight trends, measurements, intake, medications, feeding ability, laboratory values, skin conditions, estimated nutritional needs, risk assessment, weight goal, monitoring interventions, summary. There was no documented evidence in the Nutritional Assessment that the RD had completed the Nutritional Assessment or had R3 been referred for consultation by the DT. In addition, the 01/23/25 and 02/21/25 Nutritional Assessments also showed the summary did not include documentation that showed the RD had been in consultation regarding the assessments. (continued on next page)

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	05/30/2025

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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of R3's 03/11/25 Weight Change Note located in the Progress Notes tab of the EMR revealed that R3 had a weight warning due to significant weight loss of 9.8% over the last 90 days. The Weight Change Note further indicated, . Appetite slightly improved (per resident); PO [by mouth] intake remains variable 25-75%. res able to feed self; able to make needs known, food preferences added to tray ticket. Resident has pressure to the left ischium 2.0 centimeters (cm) x 2.2 cm x 1.2cm, unst. [unstageable] due to necrosis [dead tissue]; right heel 5.0 cm x 6.5cm x 0.1cm unstageable due to necrosis; left heel 2.8 cm x 1.2 cm; right second toe 1.0 cm x 1.2cm; right calf pressure ulcer 9.3 cm x 2.1 cm x 0.1cm, unstageable due to necrosis; unstageable pressure ulcer to the 1-2nd toe 1.8 cm x 3.2 cm. Resident receives ONS [oral nutritional supplements] for weight maintenance, to promote skin healing; Ensure plus 8oz BID [twice daily], Active liquid protein 30 ml [milliliters]; ONS: 880 kcal [kilo calories], 71 g [grams] protein. CBW [current body weight]141# [pounds] ENN [estimated nutritional needs]: 1602-1922.79 kcal/day, 96.1 g/day protein. Proceed to POC [plan of care]. The DT had signed the progress note as the dietician and there was no documentation to show the RD had provided any oversight in R3's high-risk needs. During an interview on 05/29/25 at 10:19 AM, the DT stated, R3 was admitted back and forth from the hospital. Previously he was on a therapeutic diet and then it was changed to a regular diet. At the hospital they put R3 on a fluid restriction and he was readmitted with the fluid restriction, but R3 did not comply with it. The Nurse Practitioner (NP) was aware of this. The goal was to get him to eat, so he would heal. I offered Ensure Plus and active protein liquid three times a day, but he did not take it all the time. He was eating less than 25% due to the food he didn't like. When he returned from his last hospital stay, he started to accept Ensure Plus. Family would bring him snacks from home and then he would not eat the meals. I brought him the regular menu, and the ala carte menu and I would try and get him to replace those foods he didn't like, but then he would not do this. 2. Review of the admission Record located in the Profile tab of the EMR revealed, R6 was admitted to the facility on [DATE] with diagnoses that included having had a recent stroke and had difficulty swallowing. Review of the Weights/Vitals tab in the EMR revealed R6 had an admission weight of 142.5 pounds (lbs.) on 05/21/25. Seven days later, on 05/28/25 R6 had a weight of 135.8 lbs. indicating a 6.7 lb. weight loss. Review of R6's 05/22/25 admission Nutritional Assessment located in the Assessments tab of the EMR revealed the DT had documented R6's diet order, diagnoses, weight trends, measurements, intake, medications, feeding ability, laboratory values, skin conditions, estimated nutritional needs, risk assessment, weight goal, monitoring interventions, summary. There was no documentation in the Nutritional Assessment that the RD had completed the Nutritional Assessment or had R6 been referred for consultation by the DT. During an interview on 05/29/25 at 10:36 AM, the DT stated, I remember her as she admitted in the evening, and her daughter had asked to see me. The daughter was very specific about her likes/dislikes. We decided to do fortified foods [high calorie], but the daughter had refused the Ensure plus and the Ensure juice drink. R6 is now on a pureed diet and her daughter stated she needs assistance with meals. I put her on weekly weights. Today, she is dependent on staff for assistance to eat. She is on an appetite stimulant which was started at the hospital. When residents first admit, there is a transition period, but she consumes from 0-50% of her meals. (continued on next page)

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	05/30/2025

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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 05/30/25 at 9:30 AM, the RD stated, I was hired five years ago, to oversee the DT role, but remotely. The RD was asked if she came to the facility anytime during the month. The RD stated, If a resident wants to meet with me, then I will go in but it's on an as needed basis. The RD further stated, The DT will alert me to any high-risk cases or residents with pressure ulcers, tube feedings, and those who have had weight loss or gain. I review her notes, and if asks me to come in, I will do that within 24 hours. The RD was asked if she attended any patient at risk meetings when the facility identifies issues with residents. The RD stated, the DT attends those meetings for high-risk nutrition residents and then will get back to me with what is discussed. The RD was asked if she attended the QAPI [quality assurance and performance improvement] meetings quarterly. The RD stated, I am not contracted to work a ton of hours at the facility, so I rely on her to attend the meetings. The RD was asked if she signs off on the Nutritional Assessments and Dietary Progress Notes. The RD sated, I guess not. I will do the assessments for the high-risk residents and will review them with the DT. The RD was asked if she was aware that the DT is signing the Dietary Progress Notes as the Dietician. The RD stated, No, I was not aware of this. The RD was asked if she was aware of R6's multiple pressure ulcers and his decline. The RD stated, No, I was not aware. The RD was asked if she was aware of R3 being a new admission and her one-week weight loss and if this could be considered high-risk. The RD stated, I am not aware. The RD was asked if she had received any emails or phone conversations regarding R3, and R6. The RD stated, I don't remember.

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	05/30/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility policy, the facility failed to utilize enhanced barrier precautions (EBP) during wound care for one resident (Resident (R)8) of three sampled residents reviewed for pressure ulcers out of a total sample of 13. This failure placed the residents at risk of developing complications from an infection. Findings include: Review of the facility policy titled, Enhanced Barrier Precautions, dated 02/13/25 revealed, .It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms .Enhanced barrier precautions refer to the use of gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with a MDRO [multidrug-resistant organism] as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices) .Wounds generally include chronic wounds, not shorter-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage or similar dressing. Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers . Review of the admission Record located in the Profile tab of the EMR revealed R8 was admitted to the facility on [DATE] with diagnoses that included diabetes. Review of the quarterly Minimum Data Set (MDS) located in the MDS tab of the EMR with an assessment reference date (ARD) of 03/26/25 revealed, R8 had a Brief Interview of Mental Status (BIMS) score of 15 out of 15 which indicated R8 was cognitively intact and had no pressure ulcers or venous stasis ulcers. During wound care observation on 05/29/25 at 3:03 PM with Physician1, Registered Nurse (RN)4 and Wound Tech (WT)1 did not don(put on) a gown when entering the room for the wound care. There were gowns readily available in the room and there was signage on the door outside indicating EBP was required. RN4 and WT1 completed the wound care per physician's orders with hand hygiene completed and the donning of gloves. Physician1 stated the wounds were venous stasis ulcers. During an interview on 05/29/25 at 3:15 PM, RN 4 was asked why she and WT1 did not wear a gown during wound care per the signage on the door to utilize EBP. RN4 stated, We were told that we only had to wear the gown when there was wound drainage, but not during wound care. During an interview on 05/29/25 at 4:00 PM, the Unit Manager (UM) was asked when EBP should be used. The UM stated that staff are to utilize EBP for any high contact resident care including wound care. The UM was told of the observation during wound care with RN4 and WT1. The UM stated that staff have been in service on EBP and EBP is for all wound care not just draining wounds.