

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525526	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2025
NAME OF PROVIDER OR SUPPLIER Chi Franciscan Villa		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. (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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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure resident was free from misappropriation of property for 14 of 14 residents reviewed for misappropriation.*The Facility identified multiple medication discrepancies involving Registered Nurse (RN)-D. The Facility did not ensure misappropriation of resident's narcotic medications did not occur and did not ensure resident's narcotic medications were accounted for appropriately. Findings include: Surveyor reviewed the Facility Reported Incident submitted to the State Agency on 06/02/2025 regarding medication diversions. Surveyor noted the Facility documented on 05/30/2025, multiple controlled medication errors were brought to the Facility's attention. The Facility documented that Registered Nurse (RN)-D was identified as the nurse responsible for the multiple discrepancies with the controlled medications. Surveyor reviewed the Facility provided document titled, CONTROLLED DRUG PROCESS AUDIT, completed on 06/05/2025 through 06/06/2025. Surveyor noted the following residents had controlled medication signed out in the control log, but was not documented in the resident's Medication Administration Record (MAR) by RN-D: *R5's order for Liquid Morphine Sulfate 20 mg/ml (milliliter), give 0.25 ml by mouth every 2 hours as needed. Discrepancy identified for 33 total doses if R5 would have been given the minimum dose or 16.5 ml if R5 was given the maximum dose, indicating R5 was missing 8.5ml total. It is identified that RN-D was the last person to document giving R5 0.5 ml on 05/28/2025 at 3:00 PM. This was one of the first discrepancies to be identified by Certified Medication Aide (CMA)-G while performing a medication count at change of shift. Surveyor noted that the discrepancy was not identified till 05/30/2025, which would have been about 3 missed opportunities for the discrepancy to be discovered during the controlled medication counts at change of shifts. On 07/14/2025, at 12:53 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A. NHA-A informed Surveyor that R5's liquid Morphine discrepancy was brought to the NHA-A's attention on 05/30/2025, after review and identification of approximately 3 discrepancies identified involving RN-D, RN-D was suspended pending the investigation. NHA-A indicated that Certified Medication Aide (CMA)-G reported the missing Morphine for R5. On 07/15/2025, at 10:47 AM, Surveyor interviewed CMA-G. CMA-G indicated that while doing control counts with another nurse on unit Skylight North, the liquid Morphine for R5 was completely off. CMA-G brought the discrepancy to the Unit Manager. CMA-G informed Surveyor that RN-D has asked CMA-G, in the past, for CMA-G 's medication cart keys; for RN-D to administer pain medication to residents prior to wound care. CMA-G did not allow RN-D to have the keys and would pull the medication herself and administer to the resident. CMA-G indicated that RN-D was the Wound care Nurse but would be pulled to do medication pass when there were call-ins or short staffed. *R7's order for Lorazepam 2 milligrams (mg), take 1 tablet as needed 45-60 minutes prior to radiation treatment, and 15 minutes before radiation if needed. Discrepancy identified for 05/29/2025 at 6:45 PM. *R6's order for Oxycodone HCl 5mg, give 0.5 tablet by mouth every 6 hours as needed for pain. Discrepancy identified for 2 doses on 05/28/2025 at 10:00 AM and 05/28/2025 at 9:00 PM. *R8's order for Morphine Sulfate oral tablet 15mg, give 0.5 tablet by mouth every hour as needed for pain or shortness of breath. Discrepancy identified for 4 doses on 04/30/2025 at 11:15 AM, 8:36 PM, 10:30 PM and on 05/28/2025 at 9:00 AM. *R9's order for Oxycodone-Acetaminophen 5-325 mg, 1 tablet by mouth every 4 hours as needed for mild pain and give 2 tablets by mouth every 4 hours for severe pain. Discrepancy identified for 1 dose on 04/23/2025 at 2:40 PM. *R10's order for Morphine Sulfate oral tablet 15 mg, 0.5 tablet by mouth every 1 hour as needed for pain. Discrepancy identified for 1 dose on 05/28/2025 at 10:30 PM. *R11's order for Tramadol HCl oral tablet 50 mg, 1 tablet by mouth every 8 hours as needed for pain. Discrepancy identified for 1 dose on 05/01/2025 at 5:00 PM. *R12's order for Oxycodone-Acetaminophen 5-325 mg, 1 tablet by mouth every 4 hours as needed for pain. Discrepancy identified for 2 doses on 05/18/2025 05/28/2025 at 10:55 AM. *R13's order for Morphine Sulfate oral tablet 15mg, give 7.5 mg every 1 hour as needed for pain. Discrepancy identified for 2 doses on 05/28/2025 at 3:50 PM and 9:45 PM. *R2's order for Hydrocodone-Acetaminophen oral tablet 5-325 mg, 1 tablet by mouth every 4 hours as needed for pain. Discrepancy identified for 2 doses on 05/30/2025 and 05/31/2025. *R5's order for Liquid Morphine Sulfate 20 mg/ml (milliliter), give 0.25 ml by mouth every 2 hours as needed. Discrepancy identified for 33 total doses if R5 would have been given the minimum dose or 16.5 ml if R5 was given the maximum dose, indicating R5 was missing 8.5ml total. It is identified that RN-D was the last person to document giving R5 a dose on 05/28/2025 at 3:00 PM. *R6 INAME1 Morphine Sulfate (Concentrate) Oral</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on interview and record review, the facility did not ensure 1 of 2 Facility Reported Incidents was submitted to the State survey agency timely. *On 05/30/2025, The Facility was made aware of a possible diversion of narcotic medications. The facility did not report this to the State Survey Agency until 06/02/2025. Findings include: Surveyor reviewed the Facility Reported Incident submitted to the State Agency on 06/02/2025 regarding medication diversions. Surveyor noted the Facility documented on 05/30/2025, multiple controlled medication errors were brought to the Facility's attention. The Facility documented that Registered Nurse (RN)-D was identified as the nurse responsible for the multiple discrepancies with the controlled medications. On 07/14/2025, at 3:00 PM, Surveyor interviewed NHA-A regarding the late reporting of medication misappropriation to the State Agency. NHA-A indicated that NHA-A spoke with corporate and was told not to report and indicated that the Facility was still investigating if it was truly a misappropriation at that time. NHA-A indicated that NHA-A reported it on Monday, 06/02/2025, admitted ly over the reporting time frame for misappropriation. On 07/15/2025, Surveyor notified the Facility of the concerns regarding reporting allegations of misappropriation timely. No further information was provided at time of write up.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on interviews and record review, the facility did not ensure an allegation of Narcotic Medication Misappropriation was thoroughly investigated for 1 of 2 Facility Self Reports to the State Agency.* 9 (R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14 and R15) of 14 residents were not interviewed by the Facility for pain outcomes after the Facility identified narcotic medication discrepancies. Findings include: Surveyor reviewed the Facility Reported Incident submitted to the State Agency on 06/02/2025 regarding medication diversions. Surveyor noted the Facility documented on 05/30/2025, multiple controlled medication errors were brought to the Facility's attention. The Facility documented that Registered Nurse (RN)-D was identified as the nurse responsible for the multiple discrepancies with the controlled medications. Surveyor reviewed the Facility provided document titled, CONTROLLED DRUG PROCESS AUDIT, completed on 06/05/2025 through 06/06/2025. Surveyor noted the following residents had controlled medication signed out in the control log but was not documented in the resident's Medication Administration Record (MAR) by RN-D. Surveyor noted that total, there were 17 residents identified. Surveyor reviewed the Facility's documents, with no title, of pain evaluations for the residents identified with controlled medication discrepancies. Surveyor noted, 9 of the 14 residents listed on the Facility Reported Incident, did not have documented follow up pain evaluations as part of the Facility's investigation. On 07/14/2025, at 11:28 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A. NHA-A indicated that the Facility assessed 15% of residents to determine outcome from the medication discrepancies. Surveyor informed NHA-A of the concern that the Facility did not conduct a thorough investigation by interviewing all affected residents. On 07/14/2025, at 1:52 PM, Surveyor interviewed Director of Nursing (DON)-B. DON-B indicated that DON-B and Assistant Director or Nursing (ADON)-C conducted the investigation for the controlled medication discrepancies. DON-B indicated that DON-B conducted pain evaluations both verbal and written for all residents but did not document all the evaluations. DON-B indicated to Surveyor that no residents had any uncontrolled pain identified. On 07/15/2025, Surveyor informed the Facility of the above concern. No further information was provided at time of write up.</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure residents received adequate supervision and assistive devices to prevent accidents for 1 of 3 residents (R) reviewed for elopement (R16). Facility elopement assessment upon R16's admission indicated R16 was an elopement risk. The facility did not pick up on this conclusion and did not put measures in place to prevent elopement. On 06/09/2025, R16 eloped from the facility, fell on the railroad tracks approximately 0.4 miles from the facility, and was brought to R16's family members house/R16's former home by persons who found R16. The facility was not aware of R16's elopement until R16's family member notified the facility that R16 had eloped to R16's family members house and sustained a fall. R16's family member brought R16 to the Emergency Room, where R16 was diagnosed with abrasions to R16's forehead, right knee, and right hand. The failure to provide adequate supervision to prevent R16 from eloping from the facility created a finding of Immediate Jeopardy that began on 06/09/2025. The Nursing Home Administrator (NHA)-A and Director of Nursing (DON-B) were notified of the immediate jeopardy on 07/15/2025 at 1:35 PM. The immediate jeopardy was removed and corrected on 06/12/2025. The deficiency is being cited as past noncompliance. Findings include: The facility's policy titled Elopements and Wandering Residents, dated 03/21/2025, documents i 3. The Facility shall establish and utilize a systemic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. 4. Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering . b. The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person-centered care plan. c. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff. d. Adequate supervision will be provided to help prevent accidents or elopements. R16 was admitted to the facility on [DATE] with diagnoses of Dementia (the loss of cognitive function, including memory, thinking, and reasoning, that interferes with daily life) and falls. R16's admission Minimum Data Set (MDS), dated [DATE], documents a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. The MDS documents that R16 requires supervision or touching assistance to walk 10 feet, requires supervision or touching assistance to walk 50 feet with two turns, and requires supervision or touching assistance to walk 10 feet on uneven surface. R16's Activities of Daily Living care plan noted an intervention of AMBULATION: 50 feet with 2 wheeled walker and CGA. (Contact Guard Assist) R16's admission elopement assessment, dated 05/05/2025, documents, Any 3 or more risk factors indicate the resident is at risk for elopement. Surveyor noted the following three areas were marked for R16: Does the resident ambulate independently, with or without the use of an assistive device? (i.e. walker, cane or wheelchair). 3. Does the resident have a diagnosis of Dementia, OBS, Alzheimer's, Intellectual/Developmental Disability, Delusions, Hallucinations, Anxiety disorder, depression, bipolar, and/or Schizophrenia?. 2. Cognitively impaired with poor decision-making skills (i.e. disorientation, cognitive deficits, disorganized thinking? Surveyor noted the acknowledgment section documents R16 is not an elopement risk but was checked for 3 risk factors. Surveyor reviewed the Facility Reported Incident (FRI), dated 06/09/2025, which documents R16 was sitting outside the facility enjoying the sun and decided R16 wanted to visit R16's daughter's house which is 0.7 miles away from the facility. The facility's self-report documents that R16 was found 0.4 miles away from the facility by a passerby on the sidewalk after falling on the railroad tracks. R16's family member notified the facility that R16 was with the family member and R16 was ok. R16 was taken to the emergency room by R16's family member with no concerns found from the fall. Surveyor noted that on 06/09/2025, the official temperature was 66 degrees Fahrenheit around 2 PM when R16 eloped from the facility. Surveyor noted that the speed limit in front of the building is 30 miles per hour (mph) and changes to 25 mph where R16 was found. On 07/14/2025, at 11:38 AM, Surveyor interviewed NHA-A regarding R16's elopement. NHA-A indicated that marking 3 sections on the elopement assessment would indicate an elopement risk. NHA-A indicated that R16 had never actually eloped and would not be considered an elopement risk. NHA-A explained that R16 just wanted to go to R16's daughter's house but while R16 was walking across the railroad tracks, NHA-A believes R16's walker got stuck in the ruts in the railroad track and fell. NHA-A was unsure of how long R16 was gone from the facility and said would get back to Surveyor with</p>		