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	11/13/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that residents remained free of accident hazards and each resident received adequate supervision and assistance devices to prevent accidents for 2 (R1 and R2) of 3 residents reviewed for accidents. *R1 rolled out of bed while receiving cares on 10/15/2025 that resulted in a closed displaced intertrochanteric fracture of the right femur. *R2 did not have reminder signs placed in R2's room or trip hazards removed from R2's room per care plan, and did not have an accurate fall risk assessment completed on 10/9/2025. Findings include: The facility policy titled Falls and Fall Risk, Managing last approved 5/2025 documents: Based of previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try and prevent the resident from falling and to try to minimize complications from falling. Fall Risk Factors:1. Environmental factors that contribute to the risk of falls include: .d. Obstacles in the foot path. Resident-Centered Approaches to Managing Falls and Fall Risk:1. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk or with a history of falls.7. In conjunction with the attending physician, staff will identify and implement relevant interventions . to try to minimize serious consequences of falling.Monitoring Subsequent Falls and Fall Risk:1.The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. 1.) R1 was admitted to the facility on [DATE] and has diagnoses that include cerebral palsy, hemiplegia affecting the left nondominant side, neuralgia, major depressive disorder, and mild cognitive impairment. R1's annual minimum data set (MDS) dated [DATE] indicated R1 has intact cognition with e Brief Interview for Mental Status (BIMS) score of 15 and the facility assessed R1 having an impairment to the left upper extremity and impairments to right and left lower extremities and required total assist of 1 staff member for toileting hygiene, and maximal assistance with 1 staff member for personal hygiene and dressing. The MDS also documented that R1 was transferred using a Hoyer lift with assist of two staff. R1 is incontinent of bowel and bladder and wears a protective brief and is able to make R1's needs known. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's activities of daily living (ADL) self-care performance deficit related to confusion, hemiplegia, impaired balance, limited mobility, limited rang of motion, left hand contracture, incontinence, . and cerebral palsy care plan last revised on 9/10/2025 documents the following interventions:- Toilet use: [R1] is totally dependent on assist of one for incontinence care. [R1} does not use the toilet, uses a bed pan.- Personal hygiene: [R1] requires total assistance of 1 staff member for all personal hygiene care. On 10/15/2025, at 11:30am, R1's progress notes written by director of nursing (DON)-B documented: While receiving daily ADL cares, certified nursing assistant (CNA)-C attempted to turn (R1). (R1) right contracted leg moved faster than expected and (R1) rolled out of bed and hit R1's right hip and shoulder on the floor. 911 call initiated and R1 sent out to hospital. On 10/15/2025, at 16:13 (4:13pm), in the progress notes, DON-B documented call made to hospital for status update on R1. Hospital informed DON-B R1 has a right femur fracture. On 10/21/2025, at 22:08 (10:08pm), in the progress notes, nursing documented R1 readmitted to facility . Diagnosis: displaced intertrochanteric fracture of the right femur which occurred on 10/15/2025 from fall at facility. On 11/13/2025 Surveyor reviewed the facility self-report that was completed for R1's fall on 10/15/2025 that resulted in a displaced intertrochanteric fracture of the right femur. CNA-C documented while doing cares on R1, R1 rolled to the left side and fell onto the floor. CNA-C denied R1 hitting head on the floor. On 11/13/2025, at 11:20am, Surveyor observed R1 lying in bed watching TV. R1 stated R1 had a fall out of bed couple weeks ago and broke R1's right leg. Surveyor asked R1 what happened. R1 stated staff was changing and getting dressed and was rolled out of the bed. Surveyor asked R1 if R1 helps hold self up when staff is helping change R1. R1 stated that R1 did not help because R1's left hand is contracted and not strong enough to help. Surveyor observed R1's bed in the middle of the wall with the right and left side of the bed open. R1 stated that 1 staff used to help R1, but now 2 staff come in and help R1 during cares. On 11/13/2025, at 11:40am, Surveyor interviewed CNA-D who stated if a resident is assist of one with repositioning or ADL care, staff are taught to always roll a resident towards you and never away. CNA-D stated if a resident needed to be turned away such as with incontinence cares, then staff is to ask another staff member for help, so the resident does not roll and fall onto the floor. On 11/13/2025, at 12:59pm, Surveyor interviewed CNA-C who stated CNA-C was doing cares on R1 on 10/15/2025. CNA-C turned R1 away from CNA-C so CNA-C could perform incontinent cares on R1. CNA-C turned R1 onto R1's left side and R1's right leg continued to go over and R1 rolled out of bed and fell onto the floor. Surveyor asked what skills training staff get when repositioning or performing cares on a resident that is assist of one. CNA-C stated that staff should make sure the resident is in the middle of the bed and to roll the resident towards you, not away from you. Surveyor asked if CNA-C asked other staff to assist with R1's cares. CNA-C did not ask other staff members for assistance because R2 was an assist of 1 staff at that time. CNA-C stated CNA-C was not sure how to perform incontinence care on R1 if R1 was not rolled away from CNA-C. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 11/13/2025, at 2:45 pm, Surveyor interviewed Nursing Home Administrator (NHA)-A and DON-B who stated all staff receive training upon hire, quarterly, and as needed on proper and safe techniques. Surveyor asked what staff is trained to do while doing cares for a resident that is assist of 1 staff member. DON-B stated staff are taught to never roll a resident away from them unless there is another person on the other side or some kind of barrier such as a wall. DON-B stated staff are told to get assistance of another staff member to assist with repositioning or cares if the resident needs to be turned away from the staff member even if they are an assist of 1. Surveyor shared the above findings with NHA-A and DON-B regarding CNA-C not following facility guidance rolling R1 away from CNA-C during cares and as a result R1 rolled out of the bed resulting in a right femur fracture. No additional information was provided. 2.) R2 was admitted to the facility on [DATE] with diagnoses including epilepsy (brain condition that causes recurring seizures), malignant neoplasm of unspecified female breast (breast cancer), chronic pain syndrome, and mild intermittent asthma. R2's Falls Care Area Assessment (CAA) dated 4/7/25 documents . resident has no known recent falls . will monitor resident for safety . using antidepressant and narcotics . is incontinent of bowel and bladder . R2's Quarterly Minimum Data Set (MDS) dated [DATE] documents R2 has a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documents R2 requires supervision for rolling and bed mobility, and R2 is dependent for sit to stand, bed to chair, and toilet transfers. R2's falls care plan with initiation date 10/23/25 and revision date 10/29/25 documents the following interventions: .-Put the following intervention in place: educated resident on importance of waiting for assistance. Placed reminder signs in room.-Remove trip hazards from my room. R2's Fall Risk Evaluation dated 10/9/25 documents a score of 3.0. Surveyor noted under section AS_3. Medications question 1 documents medications: respond based on the following types of medications: anesthetics, antihistamines, antihypertensives, antiseizure, benzodiazepines, cathartics, diuretics, hypoglycemics, narcotics, psychotropics, sedatives/hypnotics and question 2 for medication documents no response. R2's Medication Administration Record (MAR) documents the following medications were administered to R2 between 10/1/25 and 10/9/25: -Oxycodone, www.drugs.com documents this medication's drug class as a narcotic.-Ativan, www.drugs.com documents this medication's drug class as a benzodiazepine. -Lacosamide, www.drugs.com documents this medication's drug class as an anticonvulsant/antiseizure.-Lasix, www.drugs.com documents this medication's drug class as a diuretic. -Levetiracetam, www.drugs.com documents this medication's drug class as an anticonvulsant/antiseizure. -Diphenhydramine, www.drugs.com documents this medication's drug class as an antihistamine. -Hydroxyzine, www.drugs.com documents this medication's drug class as an antihistamine.Surveyor noted question 2 for medication should have been marked as c. Takes 3-4 of these medications (or medication classes) currently and/or within last 7 days. R2's Fall Risk Evaluation dated 10/23/25 documents a score of 14.0, indicating R2 is at risk for falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A nurse's progress note in R2's electronic health record (EHR) dated 10/23/25 documents on 10-23-25 . writer heard loud banging noise coming from resident's room. Writer responded and observed resident sitting upright on buttocks on the floor in front of . w/c (wheelchair) and next to commode. attempting to self transfer/self toilet and fell to the floor. On 11/13/25, at 11:03 AM, Surveyor interviewed R2 in R2's room. R2 stated R2 had a fall about 2 weeks ago when trying to get onto the commode from the wheelchair. Surveyor observed R2 sitting on the edge of the bed with R2's feet resting on a folded-up sheet on the floor. R2 stated R2's family brought in a door mat and placed the folded-up sheet on top of it to prevent R2 from falling. Surveyor did not observe any signage posted in R2's room reminding R2 to wait for assistance. R2 stated no signs were ever put up in R2's room. On 11/13/25, at 11:33 AM, Surveyor interviewed certified nursing assistant (CNA)-D regarding trip hazards. CNA-D stated online training the facility provides touches on trip hazards. Surveyor asked if the folded-up sheet in R2's room would be considered a trip hazard, and CNA-D replied CNA-D would consider that a trip hazard, but R2 specifically requested it to be there because R2's legs are currently leaking and R2 does not want the floor to get wet. Surveyor asked what the process is if a resident makes a request that is not considered safe, and CNA-D replied CNA-D was not sure, but the nurse on duty would know the process. On 11/13/25, at 11:50 AM, Surveyor interviewed Unit Manager-F regarding the process if a resident makes a request that is not considered safe. Unit Manager-F stated staff would try to have a conversation with the resident and educate them on safe practices. Unit Manager-F stated a risk versus benefits could be completed, and the resident's care plan could be updated to include the request. Surveyor asked Unit Manager-F if a folded-up sheet on the floor would be considered a trip hazard, and Unit Manager-F replied yes, that is a trip hazard. Unit Manager-F was not aware the folded-up sheet was in R2's room and stated Unit Manager-F would educate R2 and remove the sheet. Surveyor reviewed R2's EHR and did not locate any risk versus benefits or care plan revisions regarding the folded-up sheet in R2's room. On 11/13/25, at 2:45 PM, Surveyor interviewed Director of Nursing (DON)-B and Nursing Home Administrator (NHA)-A regarding fall risk evaluations. DON-B stated a fall risk evaluation would be completed when triggered by the MDS coordinator, after a fall, or if there is a change in condition. DON-B stated the fall risk evaluation is typically completed by the nurse on the floor or the MDS coordinator. Surveyor shared concern with DON-B and NHA-A that Surveyor observed R2's feet resting on a folded-up blanket and that Surveyor did not observe any signage in R2's room reminding R2 to wait for assistance per R2's care plan. DON-B agreed that the folded-up blanket would be a trip hazard, and staff has talked with R2's family in the past regarding trip hazards, but DON-B would follow up. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 11/13/25, at 3:08 PM, Surveyor interviewed MDS coordinator-G via phone call. MDS coordinator-G stated fall risk evaluations are completed by MDS coordinator-G only on a quarterly basis when it gets triggered in the EHR that a quarterly MDS assessment is due. MDS coordinator-G confirmed that MDS coordinator-G completed the fall risk evaluation for R2 dated 10/9/25. Surveyor asked why there was no response for question 2 under the medications section on this assessment. MDS coordinator-G responded MDS coordinator-G must have accidentally clicked to the next page, and the fall risk evaluation was not completed correctly. MDS coordinator-G stated question 2 under the medications section should have been marked as c. Takes 3-4 of these medications (or medication classes) currently and/or within last 7 days which would have resulted in a higher fall risk score. On 11/13/25, at 3:34 PM, Surveyor shared concern with NHA-A and DON-B that the fall risk evaluation for R2 dated 10/9/25 was not completed accurately. No additional information was provided as to why R2's fall interventions were not in place to prevent future falls or why an accurate fall risk evaluation was not completed for R2.