STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525528	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franciscan Woods	19525 W North Ave Brookfield, WI 53045

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46133 Based on interviews, record review, and facility policy review, the facility failed to document the provision of activities of daily living (ADLs), the percentage of meals eaten, and the administration of scheduled treatments for 4 (R1, R2, R4, and R5) of 18 sampled residents. Findings included: 1. A review of a facility policy titled, Shower/Tub Bath, revised in February 2024, revealed, The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. The policy indicated, The following information should be recorded on the resident's ADL record and /or in the resident's medical record: A. The date and time the shower/tub bath was performed. B. All assessment data (e.g., any reddened areas, sores, etc. [et cetera, other similar things], on the resident's skin) obtained during the shower/tub bath. C. How the resident tolerated the shower/tub bath. D. If the resident refused the shower/tub bath, the reason(s) why and the intervention taken. E. The signature and title of the person recording the data. A review of R4's Detailed Summary revealed the facility admitted the resident on 09/22/2023 with diagnoses that included hemiplegia (paralysis on one side of the body), aphasia (language comprehension and communication disorder), and muscle weakness. A review of an admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/26/2023, revealed R4 had a Brief Interview for Mental Status (BIMS) score of 0, indicating the resident had severe cognitive impairment. According to the MDS, the resident was totally dependent on staff for showers and baths. A review of R4's Care Plan revealed a Category addressing ADL Functional/Rehab [rehabilitation] Potential, dated 09/22/2023, that indicated the resident required assistance with daily ADL care, including extensive assistance with bathing. A review of R4's October 2023 Monthly Charting/Flow Sheet revealed ten days in which one of two shifts and three days in which two of two shifts had no documentation to indicate if a shower or bath was provided. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/05/2024 at 8:15 AM, the Director of Nursing (DON) said bed baths should be provided as needed in between shower days. He said staff should document whether a shower or bath was completed in the ADL logs for each resident. During an interview on 04/05/2024 at 8:26 AM, Certified Nursing Assistant (CNA) F said showers were provided to residents once a week and bed baths were done as needed. She said she documented in the computer when showers were provided. She said the facility utilized a yes or no documentation system, and there was no option to document a refusal. During an interview on 04/05/2024 at 10:13 AM, Licensed Practical Nurse (LPN) G said the CNAs typically provided showers and bed baths to residents. She said showers should be offered one to two times a week, depending on the resident's needs. She said bed baths should ideally be provided every day. She said CNAs documented baths and showers in the computer, and she expected CNAs to notify her if a resident refused care. She said she was familiar with R4 and did not recall them refusing care. During an interview on 04/05/2024 at 10:50 AM, LPN H said residents were usually scheduled for one, sometimes two, showers a week, with bed baths provided as needed in between. She said there should be documentation that reflected showers and bed baths were provided. LPN H said gaps in the documentation of ADL care probably meant that it was not charted, not necessarily that the care was not provided. She said a CNA could tell the nurse if a resident refused care, and the nurse could document the refusal. During an interview on 04/05/2024 at 1:16 PM, all progress notes that reflected any refusals of ADL care by R4 were requested from the DON. The DON checked and said there were no documented refusals found for R4. During an interview on 04/05/2024 at 8:50 AM, the DON stated he had been with the facility for one year. He stated staff should document when and what care was provided to residents. He stated it was known the facility had a documentation issue in their nursing records, especially the CNA documentation of daily care. He stated without proper documentation of the care provided, it was difficult to prove it happened. During an interview on 04/05/2024 at 2:23 PM, the Executive Director (ED) stated he thought there was a place in the computer for staff to document the ADL care they provided, including baths and showers. 2. A review of R5's Detailed Summary revealed the facility admitted the resident on 04/05/2023. According to the Detailed Summary, the resident had a medical history that included diagnoses of quadriplegia and legal blindness. A review of a quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/11/2023, revealed a Staff Assessment for Mental Status (SAMS) determined R5 had short- and long-term memory problems and severely impaired cognitive skills for daily decision making. The MDS indicated the resident was totally dependent on staff for personal hygiene and bathing. A review of R5's Care Plan revealed the resident was legally blind, nonverbal, and required assistance with ADLs. The care plan Category addressing assistance with ADL care indicated the resident required one-person support for hygiene and oral care. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R5's Monthly Charting/Flow Sheets for the timeframe from December 2023 through March 2024 revealed multiple days without documentation to indicate if oral care was provided. For December 2023, there were 19 days in which two of two shifts and eight days in which one of two shifts had no documentation as to whether oral care was provided. For January 2024, there were 12 days in which two of two shifts and 11 days in which one of two shifts had no documentation as to whether oral care was provided. For February 2024, there were 14 days in which two of two shifts and 13 days in which one of two shifts had no documentation as to whether oral care was provided. For March 2024, there were 13 days in which two of two shifts and 13 days in which one of two shifts had no documentation as to whether oral care was provided. During an interview on 04/03/2024 at 5:16 PM, Certified Nursing Assistant (CNA) A said they had worked with R5 a few times in the past. She said R5 was fully dependent on staff for ADL care, and oral care should be provided every shift. During an interview on 04/03/2024 at 5:36 PM, CNA D said staff provided oral care at bedtime using either a toothbrush or mouth swabs. During an interview on 04/05/2024 at 8:26 AM, CNA F said oral care should be provided every day before breakfast, and again at night before the resident went to bed. She said oral care was documented under hygiene in the computer. During an interview on 04/05/2024 at 8:50 AM, the DON said grooming and oral care were expected to be provided to residents daily. He stated staff should document when and what care was provided to residents. He stated it was known the facility had a documentation issue in their nursing records, especially the CNA documentation of daily care. He stated without proper documentation of the care provided, it was difficult to prove it happened. During an interview on 04/05/2024 at 10:50 AM, LPN H said gaps in the documentation of ADL care probably meant that it was not charted, not necessarily that the care was not provided. She said a CNA could tell the nurse if a resident refused care, and the nurse could document the refusal. During an interview on 04/05/2024 at 1:16 PM, all progress notes that documented any refusals of ADL care by R5 were requested from the DON. The DON checked and provided two Interdisciplinary Notes, neither of which reflected the refusal of oral care. During an interview on 04/05/2024 at 2:23 PM, the Executive Director (ED) said he thought there was a place in the computer for staff to document the ADL care they provided, including oral care. 42192 3. A review of the facility policy titled, Pressure Injury Assessment/Treatment, revised in January 2018, revealed Documentation The following information should be recorded in the resident's medical record, treatment sheet or designated wound form: A. The date and time the dressing was changed. A review of R2's Profile Face Sheet revealed the facility admitted the resident on 09/22/2023, with diagnoses that included chronic peripheral venous insufficiency, hypertension, trigeminal nerve disorder, thrombocytopenia, muscle weakness, lymphedema, urinary tract infection, non-pressure chronic ulcer of right calf, obesity, overactive bladder, and polyneuropathy. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R2's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/26/2023, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The MDS revealed the resident was at risk of developing pressure ulcers/injuries, had three venous and arterial ulcers present, and moisture associated skin damage. A review of R2's undated care plan, revealed the resident was at risk for pressure ulcers and other skin related injuries due to diagnoses of lymphedema, venous stasis dermatitis, and obesity. A review of R2's physician's orders revealed an order dated 09/22/2023, that directed staff to clean the resident's bilateral lower extremities with soap and water, pat dry, apply gentamycin to the resident's right lower extremity, Aquaphor to the resident's bilateral lower extremities, and cover with a 2x2 gauze and a dressing every day. On 10/17/2023, this order was discontinued. Per the physician orders, a new order dated 10/17/2023, directed staff to clean the resident's bilateral lower extremities with soap and water, pat dry, and apply Aquaphor every day. A review of R2's treatment record for September 2023, revealed no evidence to indicate staff performed the resident's wound care on 09/29/2023 and 09/30/2023. A review of R2's treatment and medication record for December 2023, revealed no evidence to indicate staff performed the resident's wound care on 12/21/2023. A review of R2's treatment and medication record for January 2024. revealed no evidence to indicate staff performed the resident's wound care on 01/02/2024. During an interview on 04/05/2024 at 8:50 AM, the Director of Nursing acknowledged the facility had a documentation issue. The DON stated without documentation it was difficult to prove what happened. During a telephone interview on 04/05/2024 at 2:22 PM, the Executive Director stated wound care should be provided as ordered by the physician. During an interview on 04/05/2024 at 3:29 PM, Licensed Practical Nurse (LPN) R stated she had worked at the facility as an agency nurse since March 2023. Per LPN R, she worked with R2 during the resident's stay in the facility. According to LPN R, the resident's leg care would be done on the day shift. During an interview on 04/05/2024 at 3:38 PM, Certified Nursing Assistant (CNA) K stated she worked at the facility through the internal float pool for the past two years and with R2 during the resident's stay in the facility. Per CNA K, she remembered R2 well. According to CNA K, at times she witnessed the nurses provide wound care on the resident's legs. 4. A review of the facility policy titled, Nutritional Intake Monitoring and Documentation, revised in June 2020, revealed It is the standard of [facility name] to monitor Resident nutritional intake routinely. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R1's Detailed Summary revealed the facility admitted the resident on 06/08/2023, with diagnoses to include pulmonary embolism, muscle weakness, noncompliance with treatment and medications, and legal blindness. A review of R1's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/13/2023, revealed R1 had a Staff Assessment for Mental Status (SAMS) which indicated the residents had moderately impaired cognitive skills for daily decision making. The MDS revealed the resident was dependent on staff for eating and the resident refused the ability to transfer to and from a bed to a chair. The MDS revealed the resident was on a mechanically altered diet. A review of R1's care plan, started on 06/08/2023, revealed the resident was at risk for impaired nutrition related to lying flat while eating and poor intake at meals. A review of R1's physician orders, revealed an order dated 07/11/2023, for a mechanical soft diet. A review of R1's breakfast, lunch, and dinner meal intake logs for June 2023, revealed no evidence staff documented how much the resident ate for breakfast on 06/10/2023 and 06/17/2023; lunch on 06/10/2023, 06/172023, and 06/30/2023; and dinner on 06/09/2023, 06/11/2023, 06/12/2023, 06/16/2023 - 06/18/2023, 06/20/2023, 06/24/2023, 06/26/2023, 06/29/2023, and 06/30/2023. A review of R1's breakfast, lunch, and dinner meal intake logs for July 2023, revealed no evidence staff documented how much the resident ate for breakfast and lunch on 07/02/2023, 07/05/2023, 07/14/2023, 07/16/2023, 07/22/2023, and 07/25/2023 and dinner on 07/02/2023 - 07/04/2023, 07/07/2023 - 07/10/2023, 07/14/2023, 07/16/2023, 07/17/2023, 07/21/2023 - 07/24/2023, 07/26/2023, 07/28/2023, and 07/31/2023. A review of R1's breakfast, lunch, and dinner meal intake logs for August 2023, revealed no evidence staff documented how much the resident ate for breakfast on 08/01/2023, 08/05/2023, 08/06/2023, 08/16/2023, and 08/30/2023; lunch on 08/03/2023 - 08/06/2023, 08/16/2023, 08/30/2023, and 08/31/2023; and dinner on 08/01/2023, 08/02/2023, 08/04/2023, 08/06/2023, 08/08/2023, 08/13/2023, 08/13/2023, 08/22/2023, 08/25/2023, 08/28/2023, and 08/30/2023. A review of R1's breakfast, lunch, and dinner meal intake logs for September 2023, revealed no evidence staff documented how much the resident ate for breakfast and lunch on 09/08/2023, 09/11/2023, 09/21/2023, 09/24/2023, 09/27/2023, and 09/28/2023 and dinner on 09/01/2023, 09/02/2023, 09/04/2023, 09/05/2023, 09/08/2023, 09/10/2023, 09/14/2023 - 09/16/2023, 09/18/2023, 09/20/2023, 09/23/2023 - 09/25/2023, 09/27/2023, and 09/28/2023. A review of R1's breakfast, lunch, and dinner meal intake logs for October 2023, revealed no evidence staff documented how much the resident ate for breakfast and lunch on 10/10/2023, 10/12/2023, 10/22/2023, 10/24/2023, 10/25/2023, and 10/29/2023 and dinner on 10/01/2023, 10/02/2023, 10/05/2023, 10/06/2023, 10/08/2023 - 10/13/2023, 10/15/2023 - 10/17/2023, 10/19/2023 - 10/21/2023, and 10/30/2023. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R1's breakfast, lunch, and dinner meal intake logs for November 2023, revealed no evidence staff documented how much the resident ate for breakfast and lunch on 11/03/2023, 11/10/2023, 11/12/2023 - 11/14/2023, 11/17/2023, 11/21/2023, 11/23/2023, 11/24/2023, 11/28/2023, and 11/30/2023 and dinner on 11/02/2023 - 11/04/2023, 11/06/2023 - 11/09/2023, 11/11/2023 - 11/16/2023, 11/19/2023 - 11/22/2023, and 11/26/2023 - 11/30/2023. A review of R1's breakfast, lunch, and dinner meal intake logs for 12/01/2023 to 12/21/2023, revealed no evidence staff documented how much the resident ate for breakfast on 12/04/2023, 12/06/2023, 12/08/2023 - 12/10/2023, 12/13/2023 - 12/18/2023, 12/20/2023, and 12/21/2023. During an interview on 04/04/2024 at 5:30 PM, Licensed Practical Nurse (LPN) O stated R1 was dependent on staff for meals and often refused meals. LPN O stated the resident was a picky eater and their visitors often brought them food to eat. During an interview on 04/05/2024 at 10:25 AM, the Registered Dietitian (RD) stated she had been contracted with the facility for [AGE] years. The RD stated the resident was not a phenomenal eater, and supplements were attempted but the resident refused for most of their stay. The RD stated the resident was very specific in what they would and would not do. According to the RD, when R1 admitted to the facility, they had a diagnosis of protein malnutrition. Per the RD, R1 drank well and loved cranberry juice which was provided at each meal and as requested. The RD stated the resident's weight remained consistent throughout their stay in the facility. During an interview on 04/05/2024 at 8:50 AM, the Director of Nursing (DON) acknowledged the facility had a documentation issue. The DON stated without documentation it was difficult to prove what happened.