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	02/11/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48391 Based on observations, interview and record review, the facility did not ensure 3 (R1, R2, and R3) of 3 residents that based on the comprehensive assessment of a resident, residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. * R1 was admitted on [DATE] with vascular wounds to his left dorsal foot and left shin. The facility did not complete a comprehensive skin assessment or Braden scale assessment for R1. * R2's had a skin tear noted on 1/24/25. No treatment, assessment, or monitoring of R2's skin tear was implemented until 1 week later. * R3 sustained a skin tear on 1/9/25 related to a fall. There is no evidence the facility is monitoring R1's skin tear for signs and symptoms of infection. Findings include: The facility's policy titled Skin Identification, Evaluation, and Monitoring dated 01/2018, last reviewed 11/2024, documents: Licensed nursing associate will evaluate the skin integrity through a physical skin evaluation and use of the Braden Skin at Risk tool. Upon admission, weekly for three weeks, and quarterly and when a significant change is identified. Upon admission: 1. Licensed Nursing Associate will complete physical skin evaluation, document findings 2. Complete Braden Skin at Risk on admission, then weekly for the next 3 weeks, following admission. The facility policy titled Skin Tears - Abrasions and Minor Breaks dated 12/2016, last reviewed 01/2018, documents: The purpose of this procedure is to guide the prevention and treatment of abrasions, skin tears, and minor breaks in the skin. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record any problems or resident complaints related to the procedure. Record any complications related to the abrasion (example: pain, redness, drainage, swelling, bleeding, decreased movement). 1.) R1 was readmitted to the facility on [DATE] with a diagnoses that includes cerebral infarction, aphasia, hemiplegia, and chronic venous hypertension with ulcer of bilateral lower extremities. R1's Significant Change Minimum Data Set (MDS) completed on 1/24/25 documents R1 is dependent with transfers, showering and toileting. R1's MDS documents 2 venous and ulcers present. R1 was documented as having a Brief Interview for Mental Status (BIMS) score of 15, indicating R1 is cognitively intact. R1's a Braden Scale (an assessment tool evaluating R1's risk of developing pressure injuries) dated 11/28/24, documents R1 being slightly at risk for developing pressure injuries. Surveyor noted the facility did not complete a Braden Scale for R1 after his admission on 1/20/25. R1's care plan dated 1/20/25, documents: R1 has impaired skin integrity related to Chronic Venous Hypertension (HTN) with ulcer to the left lower extremity. Interventions include, provide treatment as ordered and R1 follows with wound provider. R1 has Chronic Venous HTN with ulcer of right lower extremity. Interventions include, provide treatment as ordered and R1 follows with wound provider. Surveyor reviewed R1's medical record which documents a facility skin assessment dated [DATE]. Surveyor noted that R1 was admitted on [DATE] and the first facility skin assessment being completed on 1/23/25, which documents R1 having a left dorsal foot vascular wound measuring 3.9 x 2 x 0.1 cm with 50% granulation and 50% epithelial tissue and a left shin vascular wound measuring 10.5 x 8 x 0.1 cm with 50% granulation and 50% epithelial tissue. R1's skin assessment dated [DATE] documents that R1 has a a left dorsal foot vascular wound measuring 2 x 1 x 0.1 cm with 100% granulation, a left shin vascular wound measuring 10.5 x 8 x 0.1 cm with 50% granulation and 50% epithelial tissue, and a right shin vascular wound measuring 4 x 2 x 0.1 with 50% granulation and 50% epithelial tissue. R1's Treatment Administration Record (TAR) documents: *) Change dressing to left lower extremity (LLE) three times per week, every other day. Cleanse with Normal Saline (NS), pat dry, apply ammonium lactate to surrounding skin (do not put lotion on wound bed), apply silver alginate to wound bed followed by abdominal pad dressing (ABD) and 4-layer wraps (wrap from toe to below knee), dated 1/9/25. Surveyor notes R1 received treatments on 1/21/25 and 1/23/25 after admission and did not have a delay in wound care treatment after his admission on 1/20/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*) Change dressing to LLE three times per week, every other day. Cleanse with NS, pat dry, apply ammonium lactate to surrounding skin (do not put lotion on wound bed), apply silver alginate to wound bed followed by ABD and 4-layer wraps (wrap from toe to below knee), dated 1/23/25. *) Change dressing to LLE and top of left foot three times per week, every other day. Cleanse with NS, pat dry, apply ammonium lactate to surrounding skin (do not put lotion on wound bed), apply silver alginate to wound bed followed by ABD and 4-layer wraps (wrap from toe to below knee). Currently no open area wraps with 4-layer wraps, if reopens update skin documentation and apply silver alginate, followed by ABD and 4-layer wraps, dated 1/30/25. *) Change dressing to right lower extremity (RLE) three times per week, every other day. Cleanse with NS, pat dry, apply ammonium lactate to surrounding skin (do not put lotion on wound bed), apply silver alginate to wound bed followed by ABD and 4-layer wraps (wrap from toe to below knee), dated 1/30/25. On 2/10/25, at 12:17 PM, Surveyor interviewed Licensed Practical Nurse (LPN)- F who indicated the facility nurse will get report from the hospital nurse who will mention if the resident has wounds and treatments. The facility nurse will also review the hospital discharge paperwork that is sent with the resident upon admission. LPN-F stated the facility nurse will complete a whole-body skin assessment that would include measurements and descriptors of any wounds present on admission. LPN- F states this skin assessment is to be completed immediately upon admission by the admitting nurse and wound care orders are to be discussed with the provider. LPN- F also stated a Braden Scale is to be completed on admission especially if the resident has been out of the facility for greater than 24 hours. On 2/11/25, at 9:09 AM, Surveyor interviewed LPN- E who indicated that Braden Scales are to be completed with any new admit or readmission from the hospital. LPN- E then stated that the nurse should complete a Braden Scale if the resident is coming back from a hospitalization because you never know what happened while the resident was at the hospital. On 2/11/25, at 10:22 AM, Surveyor notified Director of Nursing (DON)- B of concerns with R1 being readmitted to the facility post hospitalization on [DATE] with no repeat Braden Scale and the facility not completing a skin assessment on R1 until 1/23/25. DON- B acknowledged the concerns with R1 and Surveyor requested additional information if available. None was provided. 38146 2.) R2 admitted to the facility on [DATE]. Diagnoses include lumbar compression fracture, Depression, Dementia and moderate malnutrition. Surveyor reviewed R2's medical record. The facility admission observation/evaluation form dated 1/21/25 documented no skin impairments. Facility progress notes dated 1/23/25 documented R2 had increased combativeness, increased agitation during PM shift, husband witnessed and apologetic for behaviors. Facility progress note dated 1/24/24 documented a left forearm skin tear 3 x 3 x 0.1. 100% flap. Steri strips placed, foam border dressing - change 3 times a week or PRN (as needed). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor noted the Treatment Administration Record (TAR) did not include treatment orders for the skin tear and there was no other documentation in the nursing progress notes regarding the skin tear. Facility progress note dated 1/31/24 documented a new order left forearm skin tear: Xerofoam, bordered foam dressing change 3 times a week and PRN. Keflex 500 milligrams four times daily x 5 days for wound infection. Surveyor noted there was no evidence the facility was assessing R2's skin tear after it was identified on 1/24/25 and no treatment was implemented on the TAR. The skin tear became infected, an antibiotic was ordered, and new treatment was implemented on 1/31/25. On 2/10/25 at 11:15 AM, Surveyor observed R2 lying in bed watching TV. R2's spouse/Power of Attorney was present. R2's spouse reported his granddaughter noticed the skin tear and notified the nurse. He reported it became infected and she was on antibiotic but it's pretty much healed now. Surveyor observed the skin tear was healed with a linear scab and there were no signs or symptoms of infection noted. R2's spouse reported R2 can be resistive, agitated and hits out at staff at times. On 2/10/25 at 1:45 PM, Surveyor spoke with Director of Nursing (DON)-B and advised her of concern R2's granddaughter notified staff of a skin tear on 1/24/25. There is no evidence staff monitored or assessed the skin tear for signs of infection, no treatment was implemented on the TAR and 1 week later, on 1/31/25, R2 was placed on an antibiotic for infection. DON-B reported she understood the concern and no additional information was provided. On 2/11/25 at 1:30 PM, Surveyor spoke with Licensed Practical Nurse (LPN) Manager-C. She reported on 1/24/25 she was called to the room by R2' granddaughter. The resident had a skin tear on her left forearm which was covered with a clear Tegaderm dressing. LPN Manager-C reported she removed the dressing, cleansed the wound and applied steri strips to approximate the edges. Surveyor confirmed there was no documentation of the skin tear prior to R2's granddaughter advising the facility, although a clear dressing was covering the wound. Surveyor advised LPN Manager-C there was no treatment implemented on the TAR, no evidence the facility was monitoring or assessing the wound for signs of infection and 1 week later, on 1/31/25, R2 was placed on an antibiotic for infection. LPN Manager-C stated, I'm sure they (referring to nurses) were looking at it. Surveyor asked how would nurses know to monitor and assess the wound if there was no documentation and it wasn't on the TAR. LPN Manager-C reported the expectation is that the TAR would indicate monitoring of the wound and dressing changes. On 2/11/25 during the daily exit meeting, Surveyor advised Nursing Home Administrator (NHA)-A and DON-B of the above concern. No additional information was provided. 50700 3.) R3 was admitted to the facility on [DATE]. Diagnoses include: history of fall, open reduction and internal fixation surgical procedure for fracture intertrochanteric fracture to the femur, protein - calorie malnutrition, Parkinson's disease and neurocognitive disorder with Lewy bodies. R3's skin care plan, dated 1/28/2025 documents under the Focus area section: impaired skin integrity related to right elbow skin tear, present on admission. Appropriate interventions implemented to include (in part): (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(G)R3 will be free from signs and symptoms of infection and will demonstrate optimal healing. (A) provide treatment as ordered. Surveyor reviewed wound care assessments notes from nurse practitioner, dated 2/6/2025, that stated R3's right forearm skin tear was resolved. However, Surveyor noted that the care plan for R3's skin tear remained open. Surveyor reviewed the interdisciplinary notes, dated: 2/9/2025, a witness fall occurred resulting in a skin tear to the left hand, and Steri-Strips applied. MD notified and orders to continue to monitor documented on progress note. No update was noted to R3's care plan to reflect the new open area. On 2/10/2025 Surveyor reviewed medication and treatment record for R3. Surveyor noted no new orders for the treatment of R3's left hand skin tear resulting from a fall on 2/9/2025. R3's skin evaluation form dated 2/9/2025 documents under the location section: Left hand; type: skin tears, size: length-6 centimeters. Surveyor reviewed the follow up board (24-hour board), a form found at the nurse's station, which updates the nursing staff on new areas of concern or changes of condition. This form had an area where each of the three shifts are expected to give an update, on an issue or concern that is being monitored. The documented days reviewed by surveyor showed: On 2/9/2025, R3 was on the follow up board for a witnessed fall. It was documented for R3 on the follow up board, no head injury, no pain, no issues related to fall. On 2/10/2025, R3 was on the follow up board, report sheet for a fall on 2/9/2025, no documentation was found on any of the three shifts that pertain to R1's skin tear. On 2/11/2025, R3 was on the board for a fall on 2/9/2025 and no mention of a skin tear was documented. Surveyor could not locate any documentation that R3's skin tear was being monitored. Progress notes from 2/9/2025 stated a physician order was to continue to monitor the area. On 2/11/2025, at 8:15 AM, Surveyor and Licensed Practical Nurse (LPN)-H reviewed R3's progress notes from 2/9/2025. LPN-H stated orders to monitor were observed in the progress note. LPN-H stated if LPN-H would have received those orders, then the expectations would be to place an order to monitor the skin tear into the Treatment Administration Record (TAR). LPN-H stated new skin tear would also be added to the follow-up board for oncoming shifts to be aware of new skin tear and new orders. On 2/11/2025, at 10:15 AM, Surveyor observed resident in bed. Surveyor observed LPN-H to be looking at Steri-Strips on R3's left arm, as the area had dried blood that was on R3's blanket. Surveyor observed 4 Steri-Strips to lateral left hand and dried blood along the tear site. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/11/2025, at 10:44 AM, Surveyor interviewed Director of Nursing (DON)-B, who stated the expectations of the nursing staff, which is to put orders received into the TAR and to place new concerns and orders on the follow-up board for monitoring. On 2/11/2025, at the daily exit meeting, concerns were brought to DON-B and Nursing Home Administer (NHA)-A, related to monitoring of skin tear not being documented. NHA-A and DON-B stated communication to management is being addressed. No additional information was provided as to why R3 was receiving care and monitoring for the skin tear sustained as a result of a fall on 2/9/25.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50700 Based on observations, interviews and record review, the facility did not ensure residents received care, consistent with professional standards of practice, and the necessary treatment and services to promote healing, prevent infection and prevent new pressure injuries from developing for that 1 (R3) of 3 residents reviewed for pressure injuries. * R3 did not receive pressure injury treatments for a pressure injury that was discovered during admission. There was no evidence that R3's physician was notified of R3's newly discovered pressure injury and there was a delay in implementing pressure relieving interventions and pressure injury treatments for R3. During this delay, R3's pressure injury increased in size and the condition deteriorated while they were not receiving treatment and interventions. Findings include: The facility procedure titled Pressure Injury Assessment/Treatment dated as last approved July 2024 documents (in part): .The purpose of this procedure is to provide guidelines for a consistent method of identification of and for the initial care of identified pressure injuries, alterations in skin integrity, and the prevention of acquiring additional pressure injuries . Interventions/ Care Strategies: Pressure injury treatment requires a comprehensive approach, including and not limited to: C. Preventative measures to reduce the risk of further tissue loss. E. Interventions that increase the potential for healing. 1.) R3 was admitted to the facility on [DATE] with a diagnoses that includes history of fall, open reduction and internal fixation surgical procedure for fracture intertrochanteric fracture to the femur, protein - calorie malnutrition, Parkinson's disease and neurocognitive disorder with Lewy bodies. R3's initial MDS (minimum data set) with an assessment reference date of 2/1/2025, documented a BIMS (brief interview mental status) score of 7 which indicates severely impaired cognition for R3. R3 is assessed as being substantial to maximal assist for rolling left and right and is dependent for chair/bed to transfers & toilet transfer. R3 is assessed as always being incontinent of urine and bowel. R3's pressure injury/skin prevention care plan dated 1/28/2025 documents under the interventions section: Observe skin for redness and break down during routine care, treatments- as indicated- see physician order sheet, pressure reducing mattress on bed. Use pressure relieving devices, cushion on wheelchair and off heals, as indicated. (continued on next page)

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	525528	A. Building B. Wing	02/11/2025

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R3's discharge report from the hospital dated 1/28/2025 does not document any wound treatment or an open area to R3's heel. R3's initial skin assessment dated [DATE] and completed by RN-I documents: Pressure injury to left upper heel. Tissue type granulation. Light exudate. Measurements 0.2 x 0.3 x 0.1(centimeters); Under the stage it section it documents, further assessment required. Surveyor reviewed R3's electronic medical record and was unable to locate any evidence that R3 received treatment to R3's left upper heel pressure injury from 1/28/25 to 1/30/25. Surveyor also was unable to locate any interventions that were put in place to reduce pressure for R3's newly discovered pressure injury as documented on 1/28/25. Surveyor was unable to locate any evidence that R3's physician was notified and consulted of R3's pressure injury to the left upper heel as documented on 1/28/25. R3's initial visit document dated 1/29/25 and completed by a Nurse Practitioner (NP) documents: Skin-no masses, no rashes, no lesion on exposed skin, dressing to right hip, clean dry and intact. Surveyor could not find any documentation, related to a physician or NP being updated on the pressure injury observed on admission. The NP note dated 1/29/25 did not include any details on the pressure injury to R3's left upper heel as documented on 1/28/25. R3's MAR (Medication Administration Record) and TAR (Treatment Administration Record) does not document any wound treatment for R3 from 1/28/25 to 1/30/25. R3's skin assessment dated [DATE] documents: Full thickness wound/ pressure injury to left upper heel. Tissue type 100% slough. Moderate exudate. Measurements 0.8 x 0.5 x 0.1 under stage it documents, Unstageable slough and or eschar. R3's pressure injury care plan documents new interventions put in place as of 1/30/25 which included: Prevalon boots on while in bed, every shift; air mattress, Prevalon boots, repositioning, and provide treatment as ordered. R3's physician order dated 1/31/25 documents: Change dressing to left heel - once every day, cleanse with normal saline, pat dry, followed by Medi-honey, followed by dressing, change daily and as needed. Surveyor noted that from 1/28/25 to 1/30/25, no documented pressure relieving interventions were put in place. Surveyor noted that from 1/28/25 to 1/30/25, R3 did not receive any treatments to his left upper heel pressure injury. R3's left upper heel pressure injury showed a decline in wound health, as there was an increase in the wound size and a decline in the wound bed of the pressure injury. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 2/10/2025, at 11:56 AM, Surveyor interviewed Registered Nurse (RN)-G regarding pressure injuries. RN-G stated that if there was a new open area discovered, RN-G would measure the area, and call the MD (medical doctor) to update them. RN-G stated the expectations after finding a pressure injury would be to place orders received in the medical record. RN-G informed Surveyor that an update to the next shift would also be expected, as staff would place the concern on the follow up board, so upcoming shifts know to monitor and document on the new concern or condition. On 2/10/2025, at 1:41 PM, Surveyor interviewed Licensed Practical Nurse (LPN) Manager-C who stated that if a new area is discovered on admission, the floor nurse would contact the MD. The floor nurse would be expected to get new orders for treatment. LPN Manager-C stated the facility expects any new orders received to be started and to be documented in the resident's medical record. LPN-C stated the only way LPN Manager-C would know if there is a new pressure injury area is by going back and reviewing progress notes and assessments. LPN Manager-C informed Surveyor that there is nothing in the electronic health record that triggers or notifies LPN Manager-C of new pressure injuries. LPN Manager-C informed Surveyor that LPN Manager-C was the person that was responsible for reviewing residents on the third floor, but that LPN Manager-C does not review residents every day. Surveyor requested R3's wound documentation and was provided with R3's facility skin evaluations. Surveyor was advised that LPN Manager-C is the wound care nurse and was informed that LPN Manager-C is not wound certified and rounds with a wound nurse practitioner (NP) on a weekly basis. Surveyor was informed that the wound NP is the one who completed R3's wound assessments and measurements with LPN Manager-C. On 2/10/2025, at 1:53 PM, Surveyor informed LPN Manager-C of the above findings. Surveyor informed LPN-Manager-C that R3 had no treatment in place or MD update documented that Surveyor could locate in R3's medical record. LPN Manager-C stated no dressing was in place on 1/30/2025 when LPN Manager-C completed wound assessment. LPN Manager-C stated to have looked at R3's physician orders and stated that Prevalon boots were ordered. Surveyor explained to LPN Manager-C that this order wasn't started until after 1/30/2025. Surveyor explained there was a lack of documented updates to to R3's physician and no documented treatment completed from admission until 1/30/25. Surveyor verbalized the concern that during the days of no treatment or interventions there was documented decline to R3's pressure injury. On 2/10/2025, at 2:07 PM, Surveyor interviewed LPN Manager-C whom stated LPN Manager-C was not able to find any documentation that R3's physician was updated or that new treatment orders by RN-I (the nurse that completed initial wound assessment) that documented that R3 received treatment or had interventions in place for R3's left upper heel pressure injury were put in place after R3's pressure injury was discovered upon admission. On 2/10/2025, at 2:37 PM, Surveyor interviewed Director of Nursing (DON)-B. Surveyor asked DON-B if three was any additional information regarding concerns that R3's physician was not updated and the noted delay in treatment to R3's left upper heel pressure injury. DON-B stated expectations of nursing staff is to update MD on new areas and to document any new orders received. DON-B stated that DON-B would need to look through R3's medical record and get back to surveyor. On 2/11/2025, at 10:15 AM, Surveyor observed wound care for R3. Surveyor was able to confirm the documentation of R3's left upper heel pressure injury. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 2/11/2025, during the daily exit meeting, Surveyor informed Nursing Home Administrator (NHA)-A and DON-B, of the above findings. NHA-A and DON-B stated that the wound communication to management was being addressed. No additional information was provided as to why R3 did not get care, consistent with professional standards of practice, and the necessary treatment and services to promote healing, prevent infection and prevent new pressure injuries from developing for residents reviewed for pressure injuries.