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	04/09/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility did not establish and maintain an infection prevention and control program based upon current standards of practice, designed to provide a safe environment and to help prevent the development and transmission of communicable diseases and infections. This deficient practice has the potential to affect all 51 residents. The facility was not monitoring infections, tracking and trending infections and monthly infection rates were not completed in the facility for 2025. In November 2025, the facility did not have any documentation of monitoring infections, surveillance, tracking and trending of infections were not completed, and infection rates were not completed. The facility had a Covid 19 outbreak in September 2025, and the infectious outbreak was not thoroughly investigated. The facility does not have a sink in the laundry room and staff are using a sink located across the hallway. This prevents the laundry workflow from being free of cross contamination. R8 and R51 had an enteric precautions sign and supply cart outside of their room, staff was observed providing care to R8 and R51 without putting on proper personal protective equipment (PPE). Findings include: The facility's policy titled Infection Prevention and Control Program, dated 05/2018, last revised 06/2025, documents the following: The infection prevention and control program (IPCP) is a facility wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement program. The elements of the IPCP consist of coordination/oversight, policies/procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, interventions implemented to promote the prevention of infection, education and associate health and safety. The IPCP covers all residents, associates, contractors, consultants, volunteers, visitors, others who provide care and services to residents on behalf of the facility, and students in the facility's nurse aid training programs or from affiliated academic institutions. The IPCP Is designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The infection preventionist will conduct ongoing surveillance for health care associated infections and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions. The infection preventionist, at routine intervals, reviews Initiated surveillance tools to identify; Health care acquired infections Potential outbreaks Reportable infections Reportable diseases will be reported by IP per state and federal guidelines. Surveillance tools are used for recognizing the occurrence of infections, recording their number and frequencies, detecting outbreaks and epidemics, monitoring associate infections, and detecting unusual pathogens with infection control implications. Data gathered during surveillance is used to identify infections and trends. Data is analyzed by absolute number of cases reported, as well as by infection rate. Compare the rates to previous months in the current year and to the same month in previous years, to identify seasonal trends. Consider how increases or decreases might relate to recent process changes, events, or activities in the community. The infection preventionist and Director of Nursing services will be responsible for: Receiving surveillance information and tabulating data; Maintaining a line listing of identified cases on the appropriate line listing report; Notifying the Medical Director and the attending physicians; On 4/9/26, at 9:08 AM, Surveyor interviewed Laundry-P who stated she performs laundry services for resident's personal items only. Laundry-P stated all other linens are ordered daily and delivered to the facility. While touring the laundry facilities, Surveyor noted no sink in the laundry room. Surveyor asked Laundry-P how she prevents cross contamination and proper hand hygiene without a sink in the laundry room. Laundry-P stated she uses gloves when transporting and loading laundry in the washers and will run across the hallway to the bathroom to wash her hands. Surveyor observed the laundry room door closed and noted staff would need to use the door handle prior to performing hand hygiene. On 4/7/26, at 10:50 AM, Surveyor interviewed Quality Management (QM)-D who stated she is the Infection Preventionist for the facility. QM-D stated she was recently hired and has been in the Infection Preventionist role since January 2026. QM-D stated there were no infection surveillance logs prior to January 2026. QM-D stated she had asked Nursing Home Administrator (NHA)-A for (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	surveillance logs and infection prevention documentation and NHA-A notified QM-D there were no logs or surveillance prior to QM-D starting her position in January 2026. QM-D stated infection tracking was not being performed. QM-D stated in January 2026, she started tracking infections every day and are working with staff about ensuring infections are reported to QM-D. QM-D stated it's an expectation for the facility to have a comprehensive and accurate infection prevention program and stated she is not sure why the facility was not previously implementing the infection prevention program. QM-D then stated staff turnovers was an issue which may have contributed to the infection surveillance not being performed. QM-D provided Surveyor infection prevention logs and surveillance from January 2026 to current. Surveyor notified QM-D of concerns with the facility not implementing and maintaining the infection prevention logs and surveillance prior to January 2026 and QM-D acknowledged these concerns. On 4/8/26, at 11:11 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who stated QM-D started in the Infection Preventionist role in January 2026. NHA-A stated the previous Director of Nursing (DON) was completing the Infection Preventionist task. Surveyor notified NHA-A of concerns with the facility was not monitoring infections, tracking and trending infections and monthly infection rates were not completed in the facility prior to January 2026. NHA-A acknowledged these concerns. On 4/8/26, at 1:24 PM, QM-D provided Surveyor an Infection Prevention binder dated 2025. QM-D notified Surveyor she had previously asked for documentation from 2025 and was not provided the information or notified the 2025 binder existed prior to today on 4/8/26. Surveyor reviewed the 2025 binder and noted the following: -The facility was not monitoring infections, tracking and trending infections and monthly infection rates were not completed in the facility for 2025. In November 2025, the facility did not have any documentation of monitoring infections, surveillance, tracking and trending of infections were not completed, and infection rates were not completed. -The facility had a Covid 19 outbreak in September 2025, and the infectious outbreak was not thoroughly investigated. On 4/8/26, at 3:26 PM, Surveyor notified NHA-A of the following concerns: -The facility was not monitoring infections, tracking and trending infections and monthly infection rates were not completed in the facility for 2025. In November 2025, the facility did not have any documentation of monitoring infections, surveillance, tracking and trending of infections were not completed, and infection rates were not completed. -The facility had a Covid 19 outbreak in September 2025, and the infectious outbreak was not thoroughly investigated. -The facility did not provide QM-D previous infection prevention documentation for the facility and QM-D to review to gather data and analyze data to identify infections and trends. NHA-A acknowledged these concerns and no additional information was provided. 2.) The facility policy titled Standard and Transmission-Based Precautions last revised 6/2025 documents: It is our policy to take appropriate precautions to prevent transmission of pathogens, based on the pathogens' modes of transmission. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Personal Protective Equipment (PPE) refers to specialized clothing or equipment worn by individuals to minimize exposure to hazards and prevent injuries or illnesses. Enhanced Barrier Precautions. A. Each community will fully implement EBP in accordance with CMS regulatory requirements. EBP in addition to standard and contact precautions shall be implemented during high-contact resident care activities when caring for residents that have an increased risk for acquiring and/or transmitting a multidrug resistant organism (MDRO) such as a resident with wounds, indwelling medical devices and residents with colonization with an MDRO. B. Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. C. EBP are indicated (when contact precautions do not otherwise apply) for residents with any of the following: 1. Wound that requires a dressing (not a skin tear/cut that would just require a band aid). 2. Indwelling catheter (foley, suprapubic) 3. Other indwelling medical device (ie., fistula for dialysis, etc.) 4. Enteral tube. 5. Enteral tube 6. Trach 7. Vent Examples of high-contact resident care activities requiring gown and glove use for EBP include device care or use, central line, urinary catheter, feeding tube, tracheostomy/ventilator. On 4/7/26 at 9:35 AM, Surveyor observed Registered Nurse (RN)-M prepare R8's medications that were ordered to be given via Gastrostomy tube (G-tube). RN-M sanitized her hands, applied gloves and entered R8's room. RN-M flushed R8's G-tube with water and administered the medications through the G-tube. Surveyor noted RN-M did not wear a gown during administration of R8's medications. Upon leaving R8's room, Surveyor asked why there was a sign for Enhanced Barrier Precautions (EBP) outside R8's room. RN-M stated, That's for her roommate, she has a wound. Surveyor clarified that R8 is not on EBP, RN-M stated No. Surveyor noted the EBP sign outside of R8's room documented: Everyone must wear gloves and a gown for the following high-contact resident care activities: Device catheter or use: Central line, Urinary catheter, Feeding Tube, tracheostomy. Wound care any skin opening requiring a dressing. On 4/9/26 at 11:48 AM, Nursing Home Administrator (NHA)-A was advised of the above observation and concern that appropriate PPE (gown) was not worn during administration of medications through (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	gastrostomy tube. No additional information was provided. 3.) The facility's policy and procedure titled, Standard and Transmission-Based Precautions, last revised 6/2025, documents: Policy: It is our policy to take appropriate precautions to prevent transmission of pathogens, based on the pathogens' modes of transmission. Transmission-Based Precautions (TBP). D. When implementing transmission-based precautions, the facility will consider the following: 1. The identification of resident risk factors that increase the likelihood of transmission (such as uncontained secretions or excretions, non-compliance, cognition deficits, incontinence, etc.). 5. Signage that includes instructions for use of specific PPE will be placed in a conspicuous location outside the resident's room, wing, or facility-wide. Additionally, either the CDC (Centers for Disease Control) category of transmission-based precautions (e.g., contact, droplet, or airborne) or instructions to see the nurse before entering will be included in the signage. 6. The facility will have PPE (Personal Protective Equipment) readily available near the entrance of the resident's room and will don appropriate PPE before or upon entry into the environment of a resident on transmission-based precautions . Surveyor noted per the CDC for Enteric Precautions the Personal Protective Equipment (PPE) staff and visitors must wear gowns and gloves when entering the room to prevent contact with contaminated surfaces. On 04/06/2026, at 9:55 AM, Surveyor observed two staff members, a nurse and a Certified Nursing Assistant (CNA) go into R51's room to help her sit up in bed. No Personal Protective Equipment (PPE) was put on by either staff member. There was an enteric precautions sign on R51's door frame advising to wear gloves and gown up. Surveyor heard the CNA say to R51 we will get you dressed then up in the chair; the staff then left the room to go find help. On 04/06/2026, at 9:59 AM, Surveyor observed two staff members use hand sanitizer then go into R51's room and shut the door, they did not stop to put on gowns from the cart in hallway. On 04/06/2026, at 10:03 AM, Surveyor observed Minimum Data Set (MDS)-Q exit room to look for a mechanical lift. Surveyor interviewed MDS-Q and was told no we did not put on gowns. The aid is actually getting R51 dressed, I did not touch R51. Surveyor noted the CNA was still in the room. On 04/06/2026, at 10:05 AM, Surveyor interviewed CNA-R regarding why no gown or gloves were worn inside R51's room. Surveyor pointed to sign on door frame and asked if the CNA was trained to know what the sign means. CNA-R replied yes, I just didn't see it or see precautions on R51's chart. I was just dressing R51. On 04/06/2026, at 10:10 AM, Surveyor observed MDS-Q and CNA-R wear gowns into the room to transfer R51 from bed to wheel chair. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 04/08/2026, at 3:11 PM, during end of day meeting with Nursing Home Administrator (NHA)-A Surveyor told of concern there were observations of staff going into R51's room that was posted for enteric precautions with no PPE being donned. No additional information was provided regarding PPE not being worn in a room posted for enteric precautions.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on interview and record review, the facility did not ensure they implemented an effective antibiotic stewardship program with the potential to affect all 51 residents in the facility. Review of the facility infection surveillance logs for residents on antibiotics, indicate antibiotic use without documentation of appropriate use, surveillance, and tracking information. Findings include: The facility's policy titled Antibiotic Stewardship, dated 01/2018, last revised 06/2025, documents: The Ascension Living antibiotic stewardship program's goals are to promote resident safety with the appropriate use of antibiotics, improve resident outcomes and reduce antibiotic resistance and adverse events.Antibiotics shall be prescribed and administered to residents under the guidance of the community's antibiotic stewardship program.The antibiotic stewardship program shall be incorporated in the overall infection prevention and control program and reviewed on an annual basis and as needed.The antibiotic stewardship program promotes appropriate use of antibiotics for quality of care, successful resident outcomes and reduction of potential adverse consequences related to antibiotic use.A collaborative effort between the resident, interdisciplinary team, prescribing practitioners, Medical Director, pharmacist, and leadership team is essential for success of the antibiotic stewardship program.The facility practices the core elements of antibiotic stewardship, outlined by the Centers for Disease Control and Prevention to optimize the treatment of infections while reducing the adverse events associated with antibiotic use including; leadership commitment, accountability, drug expertise, action, tracking, reporting and education. On 4/8/26, at 10:43 AM, Surveyor interviewed Quality Management (QM)-D who stated she is the Infection Preventionist for the facility. QM-D stated she was recently hired and has been the Infection Preventionist role since January 2026. QM-D stated there were no infection surveillance logs prior to January 2026. QM-D stated she had asked Nursing Home Administrator (NHA)-A for surveillance logs and antibiotic stewardship documentation and NHA-A notified QM-D there were no logs or surveillance prior to QM-D starting her position in January 2026. QM-D stated antibiotic tracking was not being performed. QM-D stated in January 2026, she started tracking antibiotics every day and work with staff about ensuring McGeer's criteria is being followed. QM-D stated when she first started, the facility's on call providers started antibiotics without asking questions and QM-D is now working with the providers on Urinary Tract Infection (UTI) protocols that were not previously being followed. QM-D stated it's an expectation to follow the antibiotic stewardship program and stated she is not sure why the facility was not previously following the program. On 4/8/26, at 11:11 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who stated QM-D started in the Infection Preventionist role in January 2026. NHA-A stated the previous Director of Nursing (DON) was completing the Infection Preventionist task. Surveyor notified NHA-A of concerns with the facility not completing surveillance logs for residents on antibiotics, indication of antibiotic use and tracking information. NHA-A acknowledged these concerns. On 4/8/26, at 1:24 PM, QM-D provided Surveyor an Infection Prevention binder dated 2025. QM-D notified Surveyor she had previously asked for documentation from 2025 and was not provided the information or notified the 2025 binder existed prior to today on 4/8/26. Surveyor reviewed the 2025 binder and noted there was no indication for antibiotic use throughout 2025, with the exception of August 2025. On 4/8/26, at 3:26 PM, Surveyor notified NHA-A of concerns with the facility not completing surveillance logs for residents on antibiotics, indication of antibiotic use and tracking information, except for August 2025. NHA-A acknowledged these concerns. No additional information was provided.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that a written consent explaining the risks and benefits of psychotropic medications was obtained for 2 (R10 and R11) of 5 Residents who's medication records were reviewed. *R11 was prescribed Lorazepam, a benzodiazepine that works in the brain to relieve symptoms of anxiety. The facility did not have a signed consent explaining the risks and benefits of Lorazepam. *R10 was prescribed Zyprexa, an antipsychotic medication that helps regulate mood, behaviors and thoughts. The facility did not have a signed consent explaining the risks and benefits of Zyprexa. Findings Include: The facility's policy and procedure titled, Medication Monitoring, effective date 6/21/2017, documents: Policy: A resident's medication regimen shall promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being, as identified by the resident and/or representative(s) in collaboration with the attending physician and facility staff. Procedure: 3. The involvement of residents family members (e.g. care conference or discussion group) in the development and adoption of guidelines relative to the use of psychotropic drugs in the facility is recommended. 1.) R11 was admitted to the facility on [DATE], with pertinent diagnoses that include adjustment disorder with depressed mood (a strong emotional or behavioral reaction to stress or trauma), cognitive communication deficit (difficulty with communication that stems from impaired thinking skills, such as memory, attention, and problem-solving, rather than from physical speech problems), vascular dementia with mood disturbance (refers to changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain), anxiety disorder (persistent, excessive fear or worry in situations that are not threatening), depression (a mental health condition characterized by persistent sadness, loss of interest or pleasure in activities, and other symptoms that significantly affect daily life), insomnia (common sleep disorder that can make it hard to fall asleep or stay asleep), and chronic pain syndrome (a condition characterized by persistent pain that lasts for more than three months). R11's Quarterly Minimum Data Set (MDS) with an assessment reference date of 2/26/26, documents a Brief Interview for Mental Status (BIMS) score of 03, indicating that R11 has severe cognitive impairment. The MDS documents that R11 was assessed to have no behaviors exhibited during the look back period. R11 can make self understood and understands others. R11 was coded as taking an antianxiety and a hypnotic medication. R11's physician order dated 11/18/25 documents: Lorazepam 0.5 mg tablet [generic] 0.5 mg by mouth every 12 hours for anxiousness, restlessness. Surveyor was provided the document Informed Consent dated 11/7/25 for the Psychotropic Medication Order of Lorazepam 1.5mg tab q 1 hour PRN. The Resident Name or Responsible Party's (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Signature line was left blank. Surveyor noted R11 does not have an active PRN order for Lorazepam, as of 11/18/25 the medication was scheduled every 12 hours and no consent was obtained. On 4/8/26, at 3:00pm, during the end of day meeting with Nursing Home Administrator (NHA)-A Surveyor let know of concern that there is no evidence of the informed consent being presented to R11's Representative. No additional information was provided as to why the facility did not ensure that R11 had written consent explaining the risks and benefits of psychotropic medications that were prescribed. 2.) R10 was admitted to the facility on [DATE], with pertinent diagnoses that include Schizophrenia, Alzheimer's disease, hypertensive heart disease with heart failure, acute kidney failure, unspecified, chronic diastolic (congestive) heart failure, Chronic Obstructive pulmonary disease, vascular dementia, severe with agitation. R10's Quarterly Minimum Data Set (MDS) with an assessment reference date of 3/13/26, documents a Brief Interview for Mental Status (BIMS) score of 02 indicating that R10 has severe cognitive impairment. The MDS documents that R10 was assessed to have behaviors exhibited (hitting, kicking, pushing, scratching, grabbing) behavior of this type occurred 1-3 days during the look back period. R10 was coded as taking an antidepressant and an antipsychotic medication. R10's Abnormal Involuntary Movement Scale (AIMS) score of 0, which indicates the complete absence of abnormal movements in a specific area. R10's physician order dated 7/13/25 documents Olanzapine 7.5 mg tablet {generic} 7.5mg by mouth hours of sleep for schizophrenia/bipolar. Surveyor was provided the document Informed Consent dated 06/10/25 for the Psychotropic Medication management Zyprexa (Olanzapine) 2.5mg tab po daily at 0800 5mg PO daily at HS. The Resident Name or Responsible Party's Signature page was missing. On 4/8/26, at 2:43pm, Surveyor asked Nursing Home Administrator (NHA)-A if there was another page to go with the consent form that was provided. NHA-A stated that NHA-A did not have the second half of the missing consent signed page. On 4/8/26 at 3:00pm, during the end of day meeting, Surveyor informed Nursing Home Administrator (NHA)-A of the above concern that there is no evidence of the informed consent being presented to R10's Representative for the use of R10's Olanzapine. No additional information was provided as to why the facility did not ensure that R10 had written consent explaining the risks and benefits of psychotropic medications that were prescribed.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that 3 (R5, R8 and R9) of 4 residents reviewed for transfers or discharges received the proper written notice of transfer, written bed hold policy with reserve bed payment identified and that proper notification was sent to the State Long-Term Care Ombudsman. * R5 was transferred to the hospital on 9/14/25 and 10/20/25, for evaluation due to a change in condition with no evidence of written bed hold notice and transfer notice provided to R5. The State Ombudsman was not sent a copy of the notices. * R8 was transferred and admitted to the hospital on [DATE], while residing in the facility and evidence was not provided that R8 or their representative were notified in writing of the reason for the transfer/discharge to the hospital and the facility policy for bed hold, including reserve bed payment. * R9 was transferred and admitted to the hospital on [DATE], while residing in the facility and evidence was not provided that R9 or their representative were notified in writing of the reason for the transfer/discharge to the hospital. The Ombudsman was not notified of R9's transfer to the hospital. Findings include: The facility's policy titled Bed Holds and Returns, dated 12/2016, last revised 12/2017, documents: At the time of transfer for hospitalization or therapeutic leaves, the nursing facility must provide to the residents or resident representatives written notice which specifies the duration for the bed hold. Prior to a transfer, written information will be given to the residents and the resident representatives that explains in detail: The duration of the bed hold; The reserve bed payment policy as indicated by the state plan; and The details of the transfer (per the Notice of Transfer). The facility's policy titled Transfer or Discharge Notice, dated 12/2016, last revised 06/2020, documents the following: A resident and/or his/her representative will be given a 30-day advance notice of an impending transfer or discharge from our community. A copy of the notice will be sent to the office of the state long term care ombudsman. 1.) R5 was admitted to the facility on [DATE], with a diagnoses including chronic kidney disease (damaged kidneys that are unable to filter blood, waste and excess fluid), Heart Failure (heart muscle (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	is too week to pump) and Type 2 Diabetes (the body resists insulin or fails to produce enough insulin resulting in elevated blood sugar levels). R5's Electronic Medical Record (EMR) documents R5 was transferred to the hospital on 9/14/25 and 10/20/25, for evaluation due to a change in condition. There is no documentation that R5 that was provided a written copy of transfer notice or bed hold rate for R5's hospitalization on 9/14/25 and 10/20/25. Surveyor notes the State Ombudsman was not sent a copy of the notices. On 4/9/26, at 12:06 PM, Surveyor interviewed Social Worker (SW)-O who stated she just started working at the facility recently and started doing bed holds at the facility and has completed one bed hold to dated. SW-O stated someone else was completing bed holds prior to her working at the facility. SW-O stated she has not received training to complete the transfer notices for residents. SW-O stated the facility is not doing notifications of discharges to the State Ombudsman yet. On 4/9/26, at 12:29 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-F who stated no paperwork is completed that is shared with the family prior to sending a resident out with a change in condition or discharge. LPN-F stated the nurses will call the managers and Director of Nursing (DON) with any residents experiencing a change in condition or discharge. On 4/8/26, at 3:33 PM, Surveyor notified Nursing Home Administrator (NHA)-A of concerns that the facility did not provide R5 bed hold notices or transfers on 9/14/25 and 10/20/25. Surveyor notified NHA-A of concerns with the State Ombudsman not being notified of transfers on 9/14/25 and 10/20/25 for R5. NHA-A acknowledged these concerns. No additional information was provided. 2.) R8 was admitted to the facility on [DATE], with pertinent diagnoses that include dysphagia (difficulty swallowing), aphasia (complete inability or refusal to swallow), vascular dementia (a type of cognitive decline caused by damage to the blood vessels in the brain), type 2 diabetes mellitus (happens when the body cannot use insulin correctly and sugar builds up in the blood), and gastrostomy status (a surgically created opening in the abdomen that connects to the stomach, often for the purpose of feeding or administering medication). R8's Quarterly Minimum Data Set (MDS) with an assessment reference date of 2/13/2026 does not document a Brief Interview for Mental Status assessment. R8 is documented to rarely or never be understood and rarely or never understands others. During the look back period of the MDS no behaviors were exhibited by R8. R8 is documented on the MDS for tube feeding. R8's average fluid intake per day by IV or tube feeding is documented as 501cc/day or more. R8's Electronic Medical Record (EMR) documents R8 was transferred to the hospital on [DATE] for evaluation due to a change in condition. There is no documentation that R8 or their representative were notified in writing of the reason for the transfer/discharge to the hospital and the facility policy for bed hold, including reserve bed payment. On 4/7/2026 and 4/8/2026, Surveyor requested bed hold and transfer documents for R8 from 11/12/2025 when R8 was admitted to the hospital. On 4/9/2026, at 12:06 PM, Surveyor interviewed Social Worker (SW)-O who started working at the facility at the end of February. SW-O just started doing bed hold notices. SW-O has completed one bed hold notice to date. SW-O stated someone else was completing bed hold notices before. SW-O stated has not received training to complete the transfer notices for residents yet. SW-O stated they are not (continued on next page)

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	525528	A. Building B. Wing	04/09/2026

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	doing notifications of discharges to the State Ombudsman yet. On 4/9/2026, at 12:29 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-F who stated no paperwork is completed that is shared with the family when sending a resident out with a change in condition or discharge. LPN-F stated the nurses will call the family to update when the resident is experiencing a change in condition. On 4/8/2026, at 3:00 PM, during the end of day meeting, Surveyor notified Nursing Home Administrator (NHA)-A of concern that the facility did not provide R8 or their representative the required bed hold or transfer notices on 11/12/2025. No additional information regarding bed hold or transfer notices was provided. 3.) R9 was admitted to the facility on [DATE] with pertinent diagnoses that include chronic obstructive pulmonary disease (lungs become inflamed, damaged and narrowed), bipolar disorder (mental health condition causes extreme mood swings that include emotional highs, called mania, and lows, known as depression), anxiety disorder (persistent, excessive fear or worry in situations that are not threatening), chronic pain syndrome (a condition characterized by persistent pain that lasts for more than three months), and nicotine dependence (a chronic, relapsing condition characterized by a compulsive need to use nicotine, resulting from physical and psychological addiction). R9's Comprehensive Minimum Data Set (MDS) with an assessment reference date of 2/25/2026 documents R9 had a Brief Interview for Mental Status score of 15 indicating that R9 is cognitively intact. R9 is documented to be understood and understands others. During the look back period of the MDS no behaviors were exhibited by R9. R9 is documented on the MDS as using oxygen. R9 is coded for the question of current tobacco use as no. R9's Electronic Medical Record (EMR) documents R9 was transferred to the hospital on [DATE] for evaluation due to a change in condition. There is no documentation that R9 or their representative were notified in writing of the reason for the transfer/discharge to the hospital. On 4/7/2026, Surveyor requested bed hold and transfer documents for R9 from 12/29/2025 when R9 was admitted to the hospital. Surveyor was given the Franciscan Place Bedhold Policy document dated 12/28/25 given Verbal to whom is not documented. Surveyor requested documentation of the December transfer/discharge residents being provided to the state ombudsman and received none. On 4/9/2026, at 12:06 PM, Surveyor interviewed Social Worker (SW)-O who started working at the facility at the end of February. SW-O just started doing bed hold notices. SW-O has completed one bed hold notice to date. SW-O stated someone else was completing bed hold notices before. SW-O stated has not received training to complete the transfer notices for residents yet. SW-O stated they are not doing notifications of discharges to the State Ombudsman yet. On 4/9/2026, at 12:29 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-F who stated no paperwork is completed that is shared with the family when sending a resident out with a change in condition or discharge. LPN-F stated the nurses will call the family to update when the resident is experiencing a change in condition. On 4/8/2026, at 3:00 PM, during the end of day meeting, Surveyor notified Nursing Home Administrator (NHA)-A of concern that the facility did not provide R9 or their representative the (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	required transfer notice on 12/29/2025. Surveyor notified NHA-A of concern that the State Ombudsman was not notified of R9's transfer on 12/29/2025 to the hospital. No additional information regarding bed hold or transfer notices was provided.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that a resident who is unable to carry out activities of daily living receive the necessary services to maintain good nutrition and assistance with meals for 1 of 15 (R1) residents observed during meals.R1's meal tray was not set up and R1 was not positioned upright to eat and R1 was not provided assistance with meals per R1's plan of care.Findings include:R1 admitted to the facility on [DATE] and has diagnoses that include progressive Multiple Sclerosis, quadriplegia, neuromuscular dysfunction of bladder, sepsis, hypertension, acute respiratory failure, history of pulmonary embolism, Gastroesophageal Reflux Disease, kidney calculus, obsessive compulsive disorder, kidney failure, pressure injuries stage 3, trigeminal neuralgia, adjustment disorder with mixed anxiety and depressed mood, Irritable Bowel Syndrome and anemia. The facility policy titled Assistance with meals revised 1/2025 documents: It is the policy of (facility) that residents shall receive assistance with meals in a manner that meets the individual needs of each resident. A. Dining room residents:1. All residents are encouraged to eat in the dining room for socialization.4. Residents who require assistance with eating should be provided with self-help devices and/or provided help as needed.B. Room bound residents:1. Nursing associates should be responsible for delivering food trays to the residents' room.4. Resident's place setting should be prepared by nursing associates to enable the resident to consume food served.C. Room bound residents who must be fed:1. Nursing associates should be responsible for delivering food trays to the residents' room.2. Nursing services should be responsible for feeding the resident while the food is hot.3. Unless prohibited by medical condition, resident requiring active assistance to eat should be fed in a congregate setting.R1's Quarterly Minimal Data Set (MDS) dated [DATE] documents: Eating - the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident: Substantial/maximal assistance - helper does more than half of the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. R1's Activity of Daily Living (ADL) Functional/Rehab Potential Care Plan dated 3/9/26 documents: Needs assistance with daily ADL care due to impaired mobility. Eating: I need extensive assistance with 1-person staff support.R1's Certified Nursing Assistant (CNA) worksheet for Tuesday 4/7/26 all shifts documents: Eating - I need extensive assistance with 1 person staff support. Encourage eating in Broda chair and eating slowly. Provide assist at meals. Ensure (R1) has a good setup at meals and is positioned properly. On 4/6/26 at 9:59 AM, Surveyor observed R1 lying in bed with the head of bed elevated maybe 30 degrees but not positioned upright to eat. R1's breakfast tray was on the tray table in front of him and he was able to reach only some of the food and was eating independently with his left hand.On 4/8/26 at 9:05 AM, Surveyor observed R1 in bed with his breakfast tray on the tray table in front of him. R1 was not positioned upright to eat. Surveyor observed R1 struggling to reach items on the tray. Surveyor asked if he needed help. R1 stated, I can eat myself, but can you open the sugar for me. Surveyor observed R1's tray had not been set up for him to eat. The sugar packet was not opened/not placed in the hot cereal, the milk had a plastic cover on top, and the silverware was not within reach. R1 stated, I can't eat like this.Surveyor left the room to look for staff assistance. Surveyor advised CNA-I that R1 is asking for assistance opening sugar and can't reach the silverware. CNA-I stated, They didn't set him up? He needs to be set up to eat. CNA-I entered R1's room and said, I'm sorry, let me help you, you can't eat like this. CNA-I raised the head of the bed, opened the sugar, mixed it in the hot cereal and placed the tray in front of him with the utensils within reach. CNA-I stated, There's an agency aid working today, maybe she didn't know he needed to be set up. CNA-I told Surveyor she is contract staff working at the facility from March through May and she usually gets R1 up to eat, because he eats better in the chair, but he wanted to stay in bed this morning. Surveyor asked if the facility has care cards to (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review so that staff or agency staff know how to care for a resident. CNA-I showed Surveyor the binder on the unit containing the CNA worksheets. On 4/9/26 at 10:28 AM, Nursing Home Administrator (NHA)-A was advised of the above observations and concern R1 was not positioned upright to eat, his tray was not set up and the care plan indicates he needs extensive 1 person assistance with eating. No additional information was provided.

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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** Based on interview and record review, the facility did not ensure 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 for the followed for 1 (R10) of 5 residents reviewed.R10's physician order for daily weights every day and to notify provider if greater than 3 pound change in one day or greater than 5 pounds in a week was not implemented per R10's physicians order. occur. Findings include:The facility policy and procedure for the weight monitoring effective 07/2025, documents in part: Policy: It is the policy of [facility name] that appropriate nutritional care shall be provided to residents who have significant weight change. A significant weight change is identified as a weight loss or gain of 5% in 30 days, 7.5% in 90 days or 10% in 180 days.Procedure:A nursing or nutrition associate should notify the health care provider of any significant weight change that is unexplainable or in which the RD has requested a nutritional intervention.R10 was admitted to the facility on [DATE] with pertinent diagnoses that include Alzheimer's, chronic obstructive pulmonary disease, Hypertensive heart disease with heart failure, chronic diastolic (congestive) heart failure, schizophrenia, unspecified vascular dementia severe with agitation.R10's Quarterly Minimum Data Set (MDS) with an assessment reference date of 3/13/26, documents a Brief Interview for Mental Status (BIMS) score of 02, indicating that R10 has severe cognitive impairment.R10's physician order documents: Daily weights d/t CHF diagnosis. Every day notify provider if greater than 3 pound change in 1 day or greater than 5 pound change in a week, nurse to call [facility providers name] will be in contact with [physician provider name].Surveyor reviewed R10's Treatment Administration Record (TAR) for February, March and April 2026. Surveyor noted that R10's TAR documented missing weights for the following dates:February 2026: 4,10,12,17,19,25March 2026: 3,4,14,16,19,20,23,24,26,28April 2026: 4, 6,7.R10's progress note dated 2/20/26 documents: Obtain daily weights until further review by NP (nurse practitioner) for edema and fluid overload.On 4/9/26 at 10:30 AM, Surveyor asked CNA (Certified Nursing Assistant)-K regarding R10's missing weights from 4/5/26 to 4/7/26. CNA-K stated that she was not at the facility working on 4/6/26 and that on 4/7/26, CNA-K was working on both sides of the unit so R10's weight was not taken.Surveyor asked CNA-K if CNA-K notified the nurse that R10's weight was not taken. CNA-K informed Surveyor that CNA-K notified the nurse on R10's weight that R10's weight was not taken.On 4/9/26 at 1:18 PM, Surveyor informed Nursing Home Administrator (NHA)-A of the above findings. NHA-A informed Surveyor that the lack of weight was identified and that education was provided to staff, but that NHA-A could not provide supporting documentation to Surveyor as to when the education took place or who was in attendance.No additional information was provided.

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F 0686 Level of Harm - Minimal harm or potential for 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** Based on observation, interview, and record review, the facility did not ensure residents with pressure injuries or at risk for pressure injury development received necessary treatment and services consistent with professional standards of practice to prevent the development of pressure injuries and to promote healing for 1 (R12) of 4 residents reviewed for pressure injuries.* R12 was admitted to the facility with a sling to the left arm. There is no evidence of monitoring the skin under the sling and R12 developed an unstageable pressure injury that declined to a stage 4 pressure injury to R12's left elbow with exposed hardware. Interventions were not implemented timely to prevent R12's pressure injury from developing/ declining.Findings include:The facility policy titled Prevention of Pressure Injuries Protocol last approved 1/2026 documents: Purpose: The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. General Guidelines: .C. Pressure can also come from splints, casts, bandages, and wrinkles in bed linen. If pressure injury are [sic] not treated when discovered, they quickly get larger, become very painful for the resident, and often become infected.J. Routinely assess and document the condition of the resident's skin per community wound and skin care program for any signs and symptoms of irritation or breakdown. Immediately report any signs of a developing pressure injury to the supervisor. Assessment: .D. Because a resident at risk can develop a pressure injury within 1 to 4 hours of the onset of pressure, the at-risk resident needs to be identified and have interventions implemented promptly to attempt to prevent pressure ulcers. The admission evaluation helps define those initial care approaches and interventions. Interventions and Preventative Measures: Residents with Risk Factors: .4. Place resident on a minimum of every 2 hour check/ reposition routine, complete more frequently if needed.7. Monitor the placement of splints, immobilizers, and casts to ensure they are not placing friction on the resident's skin.13. Protect bony prominences as needed.Additional Factors that Indicate Residents at Risk:A. Impaired/ decreased mobility and decreased functional ability .F. Cognitive impairment .The facility policy titled Pressure Injury Assessment/ Treatment last approved 1/2026 documents: Purpose: 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. General Guidelines: The pressure injury treatment program should focus on the following strategies: 1. Evaluation of the residents and the current status of pressure injuries2. Observe currently used support surfaces and/or pressure relieving devices, initiate as needed. 3. Resolution of current Pressure injuries and prevention of additional pressure injuries. Interventions/ Care Strategies: A. Eliminate or reduce source of pressure using positioning techniques .C. Preventative measures to reduce the risk of further tissue loss .G. Managing system issues (edema, venous insufficiency, etc.) .R12 was admitted to the facility on [DATE] with the following diagnoses left humerus fracture, UTI, Parkinson's disease, Dementia, severe protein-calorie malnutrition, cachexia (wasting syndrome/ involuntary weight loss), cognitive communication deficit, and weakness.R12's admission Minimal Data Set (MDS) dated [DATE] indicated R12 has severely impaired cognition with a Brief Interview for Mental Status (BIMS) score of 0 and the facility assessed R12 being dependent on 1 staff member for repositioning, dressing, and hygiene care, R12 is dependent on 2 staff for transferring with gait belt and pivot with wheeled walker, and toileting/ toileting hygiene.R12 was admitted with a deep tissue injury to the coccyx that healed on 3/31/2026 and a fracture to the left humerus and an order for a sling to the left arm. R12 was assessed on 3/12/2026 to be high risk for pressure injury development with a Braden score of 10. R12's weight was documented as 77 pounds.R12's at risk for pressure ulcers and other skin related injuries care [plan was initiated on 3/12/2026 with the following interventions:- Braden scare to be completed- Do not use excess pads- Observe skin for redness and breakdown during routine care- use pressure (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	relieving devices, cushion on wheelchair and off of heels as indicated- Follow community skin care protocol- Treatments, as indicated, see physician order sheet- Low air loss mattress at correct setting and functioning properly (initiated 3/17/2026)- Prevlon boots on when in bed (Initiated 3/19/2026)R12's fracture other than hip/ vertebra: (R12) has left humerus fracture care plan was initiated on 3/15/2026 with the following interventions:- Make sure (R12) is eating to ensure (R12's) fracture heals. If (R12) is not eating well, contact doctor about nutritional status. Provide snacks of (R12's) choice, including protein.- Administer pain medication as ordered by doctor. Notify doctor if pain medication is ineffective.- Make sure to administer pain medications at least 30 minutes prior to therapy appointments so pain is well controlled and able to progress with therapy.- Make sure (R12) has enough time to rest after therapy sessions.- Assist (R12) with following doctor orders regarding weight bearing status- (R12) is NON-weight bearing to left upper extremity (LUE).- Make sure (R12's) call light is in easy reach and answer it promptly.Surveyor noted there are no interventions regarding R12 left arm sling or monitoring of skin under the sling for R12's left arm. Surveyor noted interventions do not include repositioning of R12 or protection of R12's left arm or if R12's sling can come off at any time. Surveyor reviewed R12's physician orders and noted the following:1. Weekly skin check sheets on Thursday and Sunday (Start: 3/20/2026)2. Sling to arm every shift for fracture (Start 4/1/2026)Surveyor noted there is not an order to monitor R12's skin under the sling for R12's left arm fracture daily/ every shift to monitor R12's skin or if R12 is to wear sling at all times or if it can come off. Surveyor reviewed R12's progress notes and noted nursing documenting R12's sling on left arm in place, however, Surveyor notes nursing did not document if skin was intact under the sling or if the R12's skin was checked under R12's sling on the left arm. On 3/31/2026 R12's wound medical doctor (MD)-C assessment documented:- NEW CONCERN: Left Elbow Unstageable pressure injury- 3.0 X 1.0 X 0.1 (Length X width X depth)- 100% eschar (thick, dry, black layer of dead tissue (necrosis) that forms over wounds)- Treatment: wash area with normal saline, skin prep to area followed by foam border dressing. Change daily and as needed.- An X-ray was ordered for R12's left elbow to rule out osteomyelitis (infection to the elbow bone)R12's impaired skin integrity related to unstageable necrosis pressure injury to left elbow was initiated on 3/31/2026 with the following interventions:- Will follow wound MD- Will follow all treatment orders- Update nurse practitioner (NP)/ MD will [sic] concerns. worsening of areas, or signs/ symptoms of infection- Keep skin clean and dry- low air loss mattress at correct setting and functioning properly- Prevlon boots while in bed- Turn and reposition with rounds and as needed (PRN)- Offload elbowsOn 4/1/2026- R12's left elbow x-ray results document:- Osteoarthritis of left elbow- No acute fracture or dislocation- No osteomyelitisOn 4/7/2026 wound M-C assessment documented:- Unstageable pressure injury to left elbow exacerbated and is not a Stage 4 pressure injury with protrusion of prosthetic.- 4.0 X 2.0 X 0.1- 100% necrotic tissue, moderate serous (thin, clear, watery drainage- part of the healing process) drainage.- Area was debrided (medical removal of dead, damaged, or infected tissue/ biofilm from a wound to promote healing)-Treatment: Clean with normal saline, dry area, apply calcium alginate, followed by border foam dressing three times a week and as needed.- Continue current measures to prevent further skin breakdown: New: apply left elbow protector, Monitor skin under left arm sling for redness or breakdown.R12's impaired skin integrity related to unstageable necrosis pressure injury to left elbow was revised on 4/7/2026 with the following interventions:- Ensure left elbow protector is on- Monitor L arm under sling every (Q) shift for skin breakdownSurveyor noted monitoring of R12's left arm under sling was not initiated or documented as being completed until 4/7/2026.On 4/8/2023, at 12:03 PM, Surveyor observed R12 being assisted with lunch in the dining room. R12 had a blue fabric sling on the left arm. Surveyor was unable to observe if R12 was wearing an elbow protector on the left elbow.On 4/8/2026, at 12:03 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-J who stated CNA-J often cares for R12. CNA-J was not sure if R12's left arm sling could come off and was told to make sure R12 had the left arm sling on. Surveyor asked CNA-J if the sling comes off during baths/ showers. CNA-J replied giving R12 a bed bath and did not remove the sling and that (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nursing would do the skin assessments. CNA-J stated if something was observed that was concerning CNA-J would tell the nurse, however CNA-J did not recall seeing anything concerning but sis not remove R12's left arm sling during the bed bath and was not sure if the nurse assessed R12's skin under the sling or not. Surveyor asked CNA-J if R12's left elbow protector was applied when getting R12 ready for the day. CNA-J was not aware of R12 having anything other than a treatment and sling applied to R12's left arm/ elbow area.On 4/8/2025, at 1:45 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-L who stated LPN-L assess R12's left arm prior to putting R12's sling on but could not speak for other nursing employees. Surveyor asked LPN-L how staff are aware that monitoring needs to be completed for R12's left arm. LPN-L stated usually it would be in the care plan and sign out on the medication/ treatment administration record (MAR/TAR) but for R12 it is not, LPN-L stated from experience and knowledge that skin gets checked under slings. LPN-L stated R12 had an area on the coccyx that was getting treatments and was not aware of any concerns to R12's left elbow until a treatment was ordered. LPN-L could not recall any concerns on R12's elbow during assessments. Surveyor asked LPN-L if R12 has an elbow protector on the left arm. LPN-L was not aware of an elbow protector for R12 but would look into it. Surveyor asked LPN-L who initiates or revises care plans. LPN-L stated being a LPN, LPN-L does not revise or initiate care plans, but nursing management usually takes care of the care plans.On 4/8/2026, at 1:50 PM, Surveyor interviewed Registered Nurse Unit Manager (RNUM)-G who stated RNUM-G completes wound rounds with wound MD-C on Tuesdays. RNUM-C stated will do wound assessments for residents that are admitted to the facility or if a new concern is noted if in the facility at the time, otherwise nursing will do assessments and RNUM-G will follow up. RNUM-G stated nursing staff can initiate, or revise care plans and the interdisciplinary team (IDT) gets together every morning, Monday through Friday so discuss new/ ongoing concerns for residents, at that time care plans are reviewed and initiated/ revised accordingly. Surveyor asked if residents come in with slings or braces what is expected for monitoring. RNUM-G stated monitoring of the skin under the appliance should be monitored for breakdown. Surveyor shared concern R12 did not have interventions implemented to monitor skin under R12's sling to the left arm. RNUM-G confirmed interventions were not implemented to monitor or prevent R12's left arm from breakdown under the sling. RNUM-G stated monitoring of skin under R12's sling on the left arm should have been added to the care plan and MAR/TAR for staff to document completion. RNUM-G stated the pressure injury to R12's left elbow was found by accident during wound rounds on 3/31/2026 with wound MD-C, when RNUM-G rolled R12 onto her side so wound MD-C could assess R12's coccyx pressure injury, (which had resolved on 3/31/2026), wound MD-C and RNUM-G noted R12's left elbow came out of the sling a little bit and both noted a black area to R12's left elbow. RNUM-G stated RNUM-G was not made aware or notified of any concerns to R12's left elbow area until RNUM-G observed it during wound cares on 3/31/2026. Surveyor asked how R12 could have developed the area on R12's left elbow. RNUM-G stated was most likely caused by pressure to that area, on 4/7/2026 when RNUM-G and wound MD-C assessed R12's elbow, both were surprised to see hardware on the left elbow on 4/7/2026, when the x-ray results to the left elbow were received, there was no mention of hardware to that area. RNUM-G stated interventions were put into place for a left elbow protector and to monitor the skin under the sling to R12's left arm, but those interventions should have been implemented and followed up that they were being completed prior to 4/7/2026. On 4/8/2026, at 3:03 PM, Surveyor interviewed wound MD-C who stated R12's left elbow pressure injury was first noted on 3/31/2026 during R12's wound assessment to the coccyx, which is now healed. Wound MD-C stated R12's left elbow was noted to have dry eschar to the tip of the elbow so wound MD-C ordered skin prep daily with foam border dressing for protection and also ordered an x-ray to rule out osteomyelitis. Wound MD-C stated the x-ray came back negative on 4/1/2026 and when R12's left elbow was assessed on 4/7/2026 the eschar was loosed a little so wound MD-C debrided the elbow area and that is when metal hardware was noted on the elbow. Wound MD-C was surprised because there was no mention of hardware to the left elbow on R12's (continued on next page)

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	525528	A. Building B. Wing	04/09/2026

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	x-ray results from 4/1/2026. Surveyor asked how the pressure injury could develop on R12's left elbow. Wound-MD stated pressure to the area could develop within 2 hours if there was no pressure relief. Wound-MD stated R12 is very thin, frail, and not able to move without assistance so something could develop rather quickly. Wound MD-C stated the pressure injury to R12's left elbow could also be secondary to the hardware resulting in medical induces pressure especially from the swelling that occurred from R12's left humerus fracture, hardware and swelling induced pressure versus pressure to that area, uncertain at this time. On 4/8/2026, at 3:10PM, Surveyor asked Nursing Home Administrator (NHA)-A what the expectations/ process was for monitoring skin of a resident that has orders for a splint or brace. NHA-A stated to follow physician orders, if no orders were received then nursing staff would be expected to call the physician for orders such as monitoring of area, if it can be removed, therapy orders, etc Surveyor asked NHA-A who would be overseeing if care plan initiation and revision were being completed with appropriate interventions. NHA-A stated on admission or new concern development, care plans would be initiated or revised and Monday through Friday the IDT meets to discuss to and ongoing concerns and review care plans at that time. Surveyors share concerns with NHA-A, R12 was admitted to the facility 3/12/2026 with sling to the left arm and there were no care plan interventions for the skin on R12's left arm to be monitored under the sling daily/ each shift and R12 developed an unstageable pressure injury to the left elbow on 3/31/2026 that declined to a stage 4 with exposed metal hardware on 4/7/2026. Surveyor shared concerns regarding no revisions were made to the care plan until 4/7/2026 to monitor the skin under R12's sling on the left arm. No additional information was provided.

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F 0689 Level of Harm - Minimal harm or potential for 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 interview and record review, the facility did not ensure residents received adequate supervision to prevent accidents for 1 (R9) of 1 residents reviewed for smoking.*R9 smokes and the facility lacked ongoing smoking supervision and assessments or a cessation program.The facility's policy and procedure titled, Smoking Policy-Residents, last revised 10/2025 documents in part: Policy Statement- This policy is established to maintain safe resident smoking practices in accordance with the fire safety regulations. Residents who wish to smoke on the community premises should comply with the requirements in the policy. Smoking is defined as a practice in which a substance, most commonly tobacco, is burned and the smoke is tasted or inhaled. This policy applies to the use of all smoking materials, consumed by cigarette, pipe, vaporizers, electronic cigarettes and other vapor devices.F. The resident should be evaluated on admission to determine smoking preference. If the resident prefers to smoke, the evaluation will include:1. Current level of tobacco consumption;2. Method of tobacco consumption (traditional cigarettes; electronic cigarettes; pipe, etc.);3. Desire to quit smoking, if a current smoker; and4. The resident's capabilities and deficits to determine whether or not supervision is required while smoking (per a completed Safe Smoking Evaluation)G. The associates should consult with the Attending Physician and/or Nursing Leadership to determine if safety restrictions need to be placed on a resident's smoking privileges based on the Safe Smoking Evaluation.I. Smoking-related privileges, restrictions, and concerns are noted on the care plan.K. Smoking is not permitted while oxygen is in use.L. Resident agrees to the level of associate supervision indicated on the Safe Smoking Evaluation.R9 was admitted to the facility on [DATE] with pertinent diagnoses that include chronic obstructive pulmonary disease (lungs become inflamed, damaged and narrowed), bipolar disorder (mental health condition causes extreme mood swings that include emotional highs, called mania, and lows, known as depression), anxiety disorder (persistent, excessive fear or worry in situations that are not threatening), chronic pain syndrome (a condition characterized by persistent pain that lasts for more than three months), and nicotine dependence (a chronic, relapsing condition characterized by a compulsive need to use nicotine, resulting from physical and psychological addiction).R9's Comprehensive Minimum Data Set (MDS) with an assessment reference date of 2/25/26 documents R9 had a Brief Interview for Mental Status score of 15, indicating that R9 is cognitively intact. R9 is documented to be understood and understands others. During the look back period of the MDS, no behaviors were exhibited by R9. R9 is documented on the MDS as using oxygen. R9 is coded for the question of current tobacco use as no.R9's care plan Safety R9 is at risk for injury related to smoking started on 12/31/2025, has the following intervention: R9 seen outside smoking a cigarette and was educated on smoking cessation and the risks of continuing to smoke.R9's progress note written on 1/2/2026, at 11:06am, documents: at 0700 this am resident was found in bed smoking a cigarette, O2 (oxygen) on. Cigarette was extinguished, and removed from room with lighter, resident educated on the danger to her and others in facility of smoking with O2, DON (Director of Nursing) notified.Surveyor noted the care plan only addresses when R9 was seen smoking outside, there were no interventions to protect R9 from the safety concerns of smoking in bed and being on oxygen.R9's Smoking Assessment form was triggered on 3/1/26, this was not completed, nor on any other dates. Surveyor noted R9 admitted with the diagnosis of nicotine dependence and there is no documentation of a cessation program or safety assessments being completed.On 04/09/2026, at 7:54 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-I and was told that R9 was not a smoker. R9 can't get out of bed to smoke.On 04/09/2026, at 8:14 AM, Surveyor interviewed Registered Nurse (RN)-G who stated R9 doesn't go outside to smoke. Surveyor asked why after R9 smoked in R9's room, in bed with oxygen on, wasn't the incident added to the care plan. RN-G replied that the manager managing 1st floor is no longer (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	here and that RN-G doesn't know why it was not added to the care plan. Surveyor asked what RN-G's expectation would be regarding R9s smoking. RN-G informed Surveyor that RN-G was told they took R9's cigarettes and educated R9 when it happened. RN-G would have followed up with frequent rounding and care planned the incident.On 04/09/2026, at 10:45 AM, Surveyor interviewed R9 and was told when I lit up, I wasn't even thinking about it. I pulled the pack out of my purse and I took 2 drags. I realized what I was doing and I put out the cigarette. I didn't mean to that do that. Surveyor asked if the facility had offered help for smoking cessation and was told R9 asked for it and nobody followed up. R9 learned to use meditation instead.On 04/09/2026, at 11:11 AM, Surveyor let Nursing Home Administrator (NHA)-A know of concern that R9 was smoking in bed with oxygen on and the lack of follow up from the facility. Surveyor let NHA-A know that R9 would have liked help with cessation and this was not followed up on.No additional information regarding supervision or assessments of R9 and care plan interventions to keep R9 and other residents in the facility safe was provided.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure 1 (R8) of 1 residents who is fed by enteral means received the appropriate treatment and services to prevent complication from enteral feeding.R8 received an enteral feed and a flush was not done prior to starting the feeding per R8's physician order. Findings:The facility policy and procedure titled Enteral Nutrition last approved 1/2026, documents: Policy Statement: Adequate nutritional support through enteral feeding should be provided to residents as ordered.C. The Dietitian, with input from the Physician and Nurse, should:1. Estimate calorie, protein, nutrient and fluid needs.4. Calculate fluids to be provided.The facility policy and procedure titled Enteral Tube Feeding Via Continuous Pump last approved 1/2026, documents, in part: PurposeThe purpose of this procedure is to provide nourishment to the resident who is unable to obtain nourishment orally.Steps in the Procedure.J. When correct tube placement has been verified, flush tubing with at least 30mL tap water (or prescribed amount) .R8 was admitted to the facility on [DATE], with pertinent diagnoses that include dysphagia (difficulty swallowing), aphasia (complete inability or refusal to swallow), vascular dementia (a type of cognitive decline caused by damage to the blood vessels in the brain), type 2 diabetes mellitus (happens when the body cannot use insulin correctly and sugar builds up in the blood), and gastrostomy status (a surgically created opening in the abdomen that connects to the stomach, often for the purpose of feeding or administering medication).R8's Quarterly Minimum Data Set (MDS) with an assessment reference date of 2/13/2026 does not document a Brief Interview for Mental Status assessment. R8 is documented to rarely or never be understood and rarely or never understands others. During the look back period of the MDS, no behaviors were exhibited by R8. R8 is documented on the MDS for tube feeding. R8's average fluid intake per day by IV or tube feeding is documented as 501cc/day or more.R8's physician order dated 2/25/25 documents: Flush enteral tube with 150 mls water before and after each feeding - four times a day.On 04/09/2026, at 10:55 AM, Surveyor observed Registered Nurse (RN)-H prepare and administer R8's enteral tube feed. After the preparation steps were completed, RN-H attached the tube feeding line to the peg-tube. Surveyor asked if R8 gets a flush before the feeding is started and RN-H replied R8 gets flushes after medications and after feedings.On 04/09/2026, at 11:06 AM, Surveyor interviewed RN-G about when R8 should be receiving flushes. Per RN-G, R8 is supposed to get 150ml of water before and after the feeding. RN-G read the order to Surveyor. Surveyor let RN-G know that RN-H did not give R8 a flush before starting the feeding and when asked stated it is done after feeding and medications are given. Surveyor stated this is a concern. RN-G was going to follow up with RN-H immediately.On 04/09/2026, at 11:11 AM, Surveyor informed Nursing Home Administrator (NHA)-A that the tube feed set up was observed and RN-H did not flush before the feed was started and told Surveyor the flush is done after feed and after meds.No additional information was provided why the physician ordered flush was not done prior to starting the feeding for R8.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide pharmaceutical services for 1 (R55) of 15 residents reviewed.R55 was not provided multiple medications per physician orders and not signed out as given on the Medication Administration Record (MAR) dated January 2026 through April 2026.Findings include:The facility's policy titled Medication Administration, dated 6/21/17, documents: Medications will be administered by legally authorized and trained persons in accordance to applicable state, local and federal laws and consistent with accepted standards of practice.R55 was admitted to the facility on [DATE] with diagnoses that include Multiple Sclerosis (MS) (chronic autoimmune disease that attacks the nerve fibers affecting the brain, spinal cord, and optic nerves), Major Depressive Disorder (MDD) (a serious mental health condition characterized by persistent, intense feelings of sadness, worthlessness, and a loss of interest in activities), encephalopathy (damage or dysfunction that alters the brain's structure or function), constipation and chronic pain.R55's Minimum Data Set (MDS) dated [DATE], documents that R55 requires substantial/maximal assistance with toileting, showering, dressing, and rolling left to right. R55 is dependent with transfers and is documented as taking an antianxiety, antidepressant, hypnotic, anticoagulant and anticonvulsant. R55 was assessed as having a Brief Interview for Mental Status (BIMS) score of 15, indicating that R55 is cognitively intact.R55's care plan documents:R55 has a mood state problem related to diagnosis of depression, multiple sclerosis and unspecified mood effective disorder.Interventions include: Administer medication as ordered and observed for adverse side effects. If adverse side effects are noted, update MD with changes (start date 12/26/25); Observe effectiveness of mood enhancement medication (start date 12/26/25).R55's care plan documents:R55 has multiple sclerosis and has the potential for complications. Interventions include: Administer medications for symptom management or to treat disease progression. Observe for side effects and inform physician of concerns (start date 12/26/25).Surveyor reviewed R55's Medication Administration Record (MAR) which documents the following missed medications:January 2026:1/4/26 night shift - Baclofen 20 mg (milligrams) three times daily for muscle spasm1/6/26 night shift - Levothyroxine 100 mcg (micrograms) daily for hypothyroidism1/8/26 PM shift - Sucralfate 1 gram four times daily for acid reflux1/8/26 night shift - Sucralfate 1 gram four times daily for acid reflux1/14/26 AM shift - Clarithromycin 500 milligrams twice daily for H pylori1/26/26 PM shift - Nortriptyline 25 milligrams every 12 hours for polyneuropathy1/26/26 PM shift - Clonazepam 0.5 milligrams twice daily for anxiety and MS.1/26/26 PM shift - Gabapentin 600 milligrams, give two tablets for polyneuropathy.1/26/26 PM shift - Lactobacillus acidophilus 1 capsule every 12 hours.1/26/26 night shift - Sucralfate 1 gram four times daily for acid reflux1/26/26 night shift - Bisacodyl 10 mg for 3 days for constipation1/26/26 night shift - Baclofen 20 mg three times daily for muscle spasm1/27/26 PM shift - Clonazepam 0.5 milligrams twice daily for anxiety and MS.1/27/26 night shift - Bisacodyl 10 mg for 3 days for constipation1/28/26 night shift - Bisacodyl 10 mg for 3 days for constipation1/29/26 AM shift - Acetaminophen 325 mg four times daily for pain1/29/26 AM shift - Paxlovid 150 milligrams Twice daily for five days for COVID1/29/26 PM shift - Combivent inhaler one puff four times daily for congestion1/29/26 PM shift - Mucinex 600 mg every 12 hours for congestion1/29/26 night shift - Levothyroxine 100 mcg daily for hypothyroidism1/30/26 AM shift - Combivent inhaler one puff four times daily for congestion1/30/26 noon shift - Combivent inhaler one puff four times daily for congestion1/31/26 AM shift - Combivent inhaler one puff four times daily for congestion1/31/26 noon shift - Combivent inhaler one puff four times daily for congestionFebruary 2026:2/1/26 noon shift - Combivent inhaler one puff four times daily for congestion2/2/26 noon shift - Combivent inhaler one puff four times daily for congestion2/2/26 AM shift - Fingolimod 0.5 milligrams once daily for MS2/2/26 AM shift - Lactulose 15 milligrams once daily for constipation2/2/26 PM (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shift - Senna 15 mg twice daily for constipation2/2/26 PM shift - Molnupiravir 200 mg every 12 hours for COVID2/3/26 AM shift - Lactulose 15 milligrams once daily for constipation2/3/26 AM shift - Senna tab 15 mg twice a day for constipation2/3/26 AM shift - Molnupiravir 200 milligrams twice daily for COVID2/6/26 night shift - Acetaminophen 650 milligrams four times daily for pain2/8/26 AM shift - Fingolimod 0.5 milligrams once daily for MS2/10/26 AM shift - Lactobacillus acidophilus 1 capsule every 12 hours.2/10/26 AM shift - Vitamin D3 take 50 micrograms once daily for supplement2/10/26 AM shift - Baclofen 20 mg three times daily for muscle spasm2/10/26 AM shift - Bupropion 150 milligrams once daily for MDD2/10/26 AM shift - Ferrous Sulfate 325 milligrams once daily for anemia2/10/26 AM shift - Vitamin B12, take 1,000 micrograms once daily for supplement2/10/26 AM shift - Protonix 40 milligrams twice daily for acid reflux2/10/26 AM shift - Xarelto 20 mg once daily for Deep Vein Thrombosis (DVT) prophylaxis2/10/26 AM shift - Myrbetriq 25 milligrams daily for overactive bladder2/10/26 AM shift - Nortriptyline 25 milligrams every 12 hours for polyneuropathy2/10/26 AM shift - Cranberry 20 milligrams once daily for UT prevention2/12/26 PM shift - Nortriptyline 25 milligrams every 12 hours for polyneuropathy2/12/26 PM shift - Clonazepam 0.5 milligrams twice daily for anxiety and MS.2/12/26 PM shift - Gabapentin 600 milligrams, give two tablets for polyneuropathy2/12/26 PM shift - Lactobacillus acidophilus 1 capsule every 12 hours.2/12/26 PM shift - Senna tablet twice daily for constipation2/23/26 day shift - Modafinil 200 milligrams twice daily for chronic fatigue2/23/26 PM shift - Nortriptyline 25 milligrams every 12 hours for polyneuropathy2/23/26 PM shift - Clonazepam 0.5 milligrams twice daily for anxiety and MS.2/23/26 PM shift - Lactobacillus acidophilus 1 capsule every 12 hours.2/23/26 PM shift - Gabapentin 600 milligrams, give two tablets for polyneuropathy2/23/26 night shift - Sucralfate 1 gram four times daily for acid reflux2/23/26 night shift - Baclofen 20 mg three times daily for muscle spasm2/27/26 noon shift - Gabapentin 600 milligrams three times a day for polyneuropathy2/27/26 noon shift - Methylphenidate 10 milligrams once daily for fatigue2/27/26 day shift - Sucralfate 1 gram four times daily for acid refluxMarch 2026:3/6/26 noon shift - Methylphenidate 10 mg once daily for chronic fatigue3/7/26 noon shift - Methylphenidate 10 mg once daily for chronic fatigue3/8/26 noon shift - Methylphenidate 10 mg once daily for chronic fatigue3/9/26 noon shift - Methylphenidate 10 mg once daily for chronic fatigue3/9/26 noon shift - Sucralfate 1 gram four times daily for acid reflux3/12/26 noon shift - Gabapentin 600 milligrams, give two tablets for polyneuropathy3/12/26 noon shift - Methylphenidate 10 mg once daily for chronic fatigue3/13/26 noon shift - Methylphenidate 10 mg once daily for chronic fatigue3/29/26 noon shift - Methylphenidate 10 mg once daily for chronic fatigue3/30/26 noon shift - Methylphenidate 10 mg once daily for chronic fatigue3/31/26 PM shift - Modafinil 200 milligrams twice daily for chronic fatigueApril 2026:4/2/26 AM shift - Sucralfate 1 gram four times daily for acid reflux4/2/26 PM shift - Sucralfate 1 gram four times daily for acid reflux4/2/26 night shift - Sucralfate 1 gram four times daily for acid reflux4/3/26 AM shift - Sucralfate 1 gram four times daily for acid reflux4/3/26 PM shift - Sucralfate 1 gram four times daily for acid reflux4/3/26 night shift - Sucralfate 1 gram four times daily for acid reflux4/4/26 AM shift - Sucralfate 1 gram four times daily for acid reflux4/4/26 PM shift - Sucralfate 1 gram four times daily for acid reflux4/4/26 night shift - Sucralfate 1 gram four times daily for acid refluxOn 4/6/26, at 11:41 AM, Surveyor interviewed R55 who stated she has multiple missed medications. R55 expressed concerns with missing medications and having chronic diseases that require medications. R55 stated R55 has MS which causes chronic fatigue and will experience increased fatigue if staff do not administer medications as prescribed. R55 also stated R55 was recently hospitalized due to blood clots in the lungs and expressed concern if medications are not administered as prescribed with the history of having blood clots in the lungs.On 4/9/26, at 10:14 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-F who stated medications are delivered nightly and placed in the medication cart. LPN-F stated staff can use contingency medications or contact the pharmacy for next day delivery if medications are not available.On 4/8/26, at 3:25 PM, Surveyor notified Nursing Home Administrator (NHA)-A of concerns with R55 having (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	multiple missed medications listed above. NHA-A acknowledged these concerns.No additional information was provided as to why the facility did not provide or administer the above medications to R55 per physician's orders.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that drugs and biologicals used in the facility were be labeled in accordance with currently accepted professional principles and included the expiration date when applicable for 2 of 2 medication carts reviewed.Medication carts contained insulin that was not dated when opened and/or was expired.Findings include:The facility policy titled Insulin Administration effective [DATE] documents:Insulin is a high-risk drug and warrants additional precautions for the safe and effective administration. Insulin administration is performed by licensed nurses. Facility nursing procedures supersede this procedure if present.6. Follow the manufacturer's instruction for storage and expiration. Ensure that the opened date is documented on the vial or pen.7. Check the expiration date prior to administration to ensure it is within the usage date. Expired insulin should be immediately discarded. Vials and pens without an open date recorded should be discarded.On [DATE] at 9:30 AM, Surveyor observed the 1st floor medication cart. In the top drawer, Surveyor located the following:2 Lantus insulin vials belonging to R16 which were open and used. The label on each vial documented: Expires 28 days after opening. One vial was dated 1/16 and the other was dated 1/17, indicating both vials were past the expiration date.On [DATE] at 10:34 AM, Surveyor observed the 2nd floor medication cart. In the top drawer, Surveyor located the following:A Humalog Kwik pen in a bag belonging to R5 which was open and used but not dated when opened. The label documented: Expires 28 days after opening.A Novolog insulin vial belonging to R25 which was open and used but not dated when opened. The label documented: Throw away any medication that remains 28 days after first use.Nursing staff were advised of the above insulin that was not dated and were expired.On [DATE] at 11:48 AM, Nursing Home Administrator (NHA)-A was advised of concern regarding residents' insulin that was not dated when opened and were expired. No additional information was provided.

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	04/09/2026

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure a resident's hospice notes were readily available for communication and collaboration of care in accordance with professional standards of practice for 1 (R11) of 1 residents reviewed for hospice services.Hospice visit notes were not updated in R11's medical record or in R11's hospice binder.Findings include:The facility's policy and procedure titled, Hospice Program, last approved 12/2025, documents, in part: Policy Interpretation and Implementation.D. When a resident participates in the hospice program, a coordinated plan of care between the community, hospice agency and resident/resident representative will be developed and shall include directives for managing pain and other uncomfortable symptoms. The care plan shall be revised and updated as necessary to reflect the resident's current status.The contract titled Nursing Facility Services Agreement (Basic, Respite and General Inpatient Care for Hospice Patients) signed on 1/25/2021, documents, in part: 1.8 Coordination of Care.Each party is responsible for documenting such communications in its respective clinical records to ensure that the needs of Hospice Patients are met 24 hours per day.R11 was admitted to the facility on [DATE], with pertinent diagnoses that include adjustment disorder with depressed mood (a strong emotional or behavioral reaction to stress or trauma), cognitive communication deficit (difficulty with communication that stems from impaired thinking skills, such as memory, attention, and problem-solving, rather than from physical speech problems), vascular dementia with mood disturbance (refers to changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain), anxiety disorder (persistent, excessive fear or worry in situations that are not threatening), depression (a mental health condition characterized by persistent sadness, loss of interest or pleasure in activities, and other symptoms that significantly affect daily life), insomnia (common sleep disorder that can make it hard to fall asleep or stay asleep), and chronic pain syndrome (a condition characterized by persistent pain that lasts for more than three months).R11's Quarterly Minimum Data Set (MDS) with an assessment reference date of 2/26/26, documents a Brief Interview for Mental Status (BIMS) score of 03, indicating that R11 has severe cognitive impairment. The MDS documents that R11 was assessed to have no behaviors exhibited during the look back period. R11 can make self understood and understands others. R11 was coded as being on hospice services.Surveyor reviewed R11's Hospice communication binder located in the nursing station. In the binder there was: Residential Communication Form dated 2/4/26 completed by a Licensed Practical Nurse, 3/4/26 completed by a home health aide and an additional dated 3/13/26 that looked like the Nurse Practitioner signed. There were also five forms completed by the chaplain with the most recent being 4/6/26.On 04/09/2026, at 8:25 AM, Surveyor interviewed Registered Nurse (RN)-G about the process of hospice staff and facility staff exchanging resident information. Per RN-G, the hospice staff check in with the floor nurse before they leave. Surveyor asked if the floor nurse should make a progress note to document the visit and was told no, hospice staff should be writing in the binder on the unit. Surveyor explained the lack of documentation in the binder.On 04/09/2026, at 11:11 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A about the concern that Surveyor reviewed the hospice binder and there is a lack of communication when hospice staff visit.No additional information regarding why the facility did not have an effective system of communication between hospice staff and facility staff or why R11's hospice visit notes were not being updated in R11's medical record or in R11's hospice binder was provided.

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	04/09/2026

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

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 1 (R10) of 5 residents reviewed were offered/administered the influenza vaccination. R10's Electronic Medical Record (EMR) does not contain any documentation as to whether R10 was offered, received or declined the influenza immunization. Findings include: The facility's policy titled Clinical Protocol: Influenza Vaccine, dated 09/2018, last revised 09/2022 documents: Residents who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza. A resident's refusal of the vaccine shall be documented in the resident's medical record. R10 was admitted to the facility on [DATE] with diagnoses that includes Alzheimer's Disease (progressive irreversible brain disorder that slowly destroys memory and thinking skills), Chronic Obstructive Pulmonary Disease (COPD) (lung disease that makes breathing difficult causing airflow obstruction) and Urinary Tract Infection (UTI) (bladder infection). Surveyor reviewed R10's EMR and was unable to locate whether R10 was offered, received or declined the influenza immunization in 2025 or 2026. Surveyor notes R10 received the influenza immunization on 11/12/2024. On 4/8/26, at 10:43 AM, Surveyor interviewed Quality Management (QM)-D who stated immunizations including influenza are offered to the resident upon admission and during the flu season. QM-D stated documentation is scanned in the EMR if a resident declines the influenza immunization. Surveyor reviewed R10's influenza immunization record and notes R10 last received the influenza immunization on 11/12/2024. QM-D stated the facility noted concerns with the previous infection control program and residents not receiving or being offered the influenza immunization. QM-D stated the facility started a Performance Improvement Plan (PIP) at the end of February 2026/beginning of March 2026. QM-D stated there were staffing turnovers and challenges that contributed to R10 not receiving or being offered the influenza immunization. On 4/8/26, at 11:11 AM, Surveyor informed Nursing Home Administrator (NHA)-A of concerns with R10 not receiving or being offered the influenza immunization. NHA-A acknowledged this concern. On 4/8/26, at 1:24 PM, QM-D notified Surveyor that QM-D looked into R10's EMR and was unable to locate documentation that R10 was offered or declined the influenza immunization. Surveyor notified QM-D of concerns with R10 not receiving or being offered the influenza immunization. QM-D acknowledged this concern. No additional information was provided.

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure medical records contained documentation related to COVID-19 (Coronavirus disease 2019) immunizations for 1 (R10) of 5 residents reviewed for immunizations. R10's Electronic Medical Record (EMR) does not contain any documentation as to whether R10 was offered, received or declined the COVID-19 immunization. Findings include: The facility's policy titled COVID-19, dated 06/2020, last revised 06/2025 documents: Residents will be offered the COVID-19 vaccination to remain up to date with the most current Center for Disease Control (CDC) vaccination schedule. If a resident/resident legal representative wishes to receive the COVID-19 vaccination, the facility will obtain the consent and provide the vaccination to the resident as soon as it is available in alignment with the vaccination schedule. R10 was admitted to the facility on [DATE] with diagnoses that includes Alzheimer's Disease (progressive irreversible brain disorder that slowly destroys memory and thinking skills), Chronic Obstructive Pulmonary Disease (COPD) (lung disease that makes breathing difficult causing airflow obstruction) and Urinary Tract Infection (UTI) (bladder infection). Surveyor reviewed R10's EMR and was unable to locate whether R10 was offered, received or declined the COVID-19 immunization in 2023, 2024, 2025 or 2026. Surveyor noted R10 received the COVID-19 immunization on 10/29/2021. On 4/8/26, at 10:43 AM, Surveyor interviewed Quality Management (QM)-D who stated immunizations including COVID-19 are offered to the resident upon admission and during the flu season. QM-D stated documentation is scanned in the EMR if a resident declines the COVID-19 immunization. Surveyor reviewed R10's COVID-19 immunization record and noted R10 last received the COVID-19 immunization on 10/29/2021. QM-D stated the facility noted concerns with the previous infection control program and residents not receiving or being offered the COVID-19 immunization. QM-D stated the facility started a Performance Improvement Plan (PIP) at the end of February 2026/beginning of March 2026. QM-D stated there were staffing turnovers and challenges that contributed to R10 not receiving or being offered the COVID-19 immunization. On 4/8/26, at 11:11 AM, Surveyor informed Nursing Home Administrator (NHA)-A of concerns with R10 not receiving or being offered the COVID-19 immunization. NHA-A acknowledged this concern. On 4/8/26, at 1:24 PM, QM-D notified Surveyor, that QM-D looked into R10's EMR and was unable to locate documentation that R10 was offered or declined the COVID-19 immunization. Surveyor notified QM-D of concerns with R10 not receiving or being offered the COVID-19 immunization. QM-D acknowledge this concern. No additional information was provided.