STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525552	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wheaton Franciscan Hc - Terrace at St Francis	3200 S 20th St Milwaukee, WI 53215

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review and interviews, the facility failed to ensure that two residents (Resident (R) R2 and R3) out of a total sample of 13, were protected from abuse when, R2 and R3 were observed holding hands and kissing by staff members. Findings include: Review of the facility's policy titled, Abuse Prevention, dated 08/2024 stated, Our residents have the right to be free from abuse .This includes, but is not limited to .sexual or physical abuse .'Sexual abuse' is 'non-consensual sexual contact of any type with a resident.' . Generally, sexual contact is non-consensual if the resident either: a. Appears to want the contact to occur, but lacks the cognitive ability to consent; or . Reported sexual activity involving residents scoring below cognitively intact, ?12 on a BIMS, shall be investigated per Abuse Investigation Policy . Review of the facility's Capacity to Consent for Sexual Intimacy assessment provided by the Business Operations Manager revealed assessments were not completed for R2 and R3. The facility did not have a policy on Capacity to Consent for Sexual Intimacy. Review of the facility's Alleged Nursing Home Resident Mistreatment, Neglect and Abuse Report dated 05/02/25 revealed R2 and R3 .were noted allegedly kissing, holding hands and R2 had his hand on R3's knee in the dining room hallway during breakfast. Both residents are demented (sic) and have APOAs (activated power of attorneys) . Review of the facility's Final Self-Report Summary dated 05/07/25 and provided by the facility stated R2 and R3 were noted to have allegedly been kissing and holding hands. Video footage showed R2 had his hand on R3's knee in the dining room hallway during breakfast. R2 was noted to be sitting in his wheelchair minding his own business when R3 got closer to him, grabbed his hand and then proceeded to kiss him. R2 placed his hand on R3's knee while kissing. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of video footage, dated 05/02/25 at 8:13 AM, revealed R2 and R3 were sitting face to face at a table in the main dining area on the third floor. R2 was sitting on a chair with his rollator (a wheeled walker usually with a seat) next to him, R3 was sitting in her wheelchair. There was a column blocking the faces of R2 and R3, however, it could be seen that R2 reached for R3's hand and pulled her toward him. Both residents were rubbing each other's hand and R2 was rubbing R3's leg. Food Service Worker (FSW)1 was observed pointing at R2 and R3 at this time and FSW2 was observed looking at them. At 8:14 AM an unknown staff member walks over to the kitchen area, speaks with FSW1 and FSW2. At 8:46 AM the Scheduler assists R3 down the hall toward her room; R2 remained seated at the table in the dining room. No further contacted was observed after 8:46 AM. Review of R2's Detail Summary located in the EMR under the Resident tab revealed he was admitted to the facility on [DATE] with a primary diagnosis of hemiplegia following cerebral infarction affecting left nondominant side, and comorbidities including vascular dementia. Review of R2' quarterly Minimum Data Set (MDS) located in the Electronic Medical Record (EMR) under the MDS tab with an Assessment Reference Date (ARD) of 02/21/25 revealed a Brief Interview for Mental Status (BIMS) score of three indicating the resident was severely cognitively impaired. R2's MDS also indicated he had no behaviors directed toward other residents. Review of R2's Care Plan revised on 10/01/24 indicated that R2 had .impaired behavior related to touching other residents. This had a start date of 09/08/24 and resolved date of 10/01/24. R2's Care Plan was not updated to include inappropriate sexual contact. See F657. Review of R2's Physician Order provided by the facility, did not include behavior monitoring. Review of R3's Detail Summary located in the EMR under the Resident tab revealed she was admitted to the facility on [DATE] with a primary diagnosis of dementia with other behavioral disturbances. Review of R3' quarterly MDS located in the EMR under the MDS tab with an ARD of 04/19/25 revealed a BIMS score of 99 indicating the resident was unable to complete the assessment due to cognitive deficit. R2's MDS also indicated she had daily wandering behaviors. Review of R3's Care Plan provided by the facility did not include sexual inappropriateness. The care plan did include impaired behavior secondary to dementia- exhibited by wandering and rummaging into other resident's rooms. Refer to F657. Review of R3's Physician Order provided by the facility, did not include behavior monitoring. During an interview on 06/10/25 at 6:04 PM with Certified Nursing Assistant (CNA) 1 confirmed that FSW1 saw R2 and R3 kissing and no one was going to be able to stop it. CNA1 stated that she reported it to the Director of Nurses (DON)1. CNA1 did not see R2 and R3 kissing but she had seen R3 go into R2's room in the past and rub his chest. The residents were separated by a staff member at the time they were seen kissing. During an interview on 06/10/25 at 6:17 PM Licensed Practical Nurse (LPN)1 stated that a CNA reported to her that R2 and R3 were kissing, the residents were separated. R2 had a history of being flirtatious and in the past he had been sexually inappropriate with a male resident. LPN1 stated that R3 had a history of roaming into other residents rooms. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/11/25 at 8:44 AM with FSW2 stated that on 05/02/25 R2 and R3 were sitting at the table across from each other and were seen holding hands and kissing. R2 then put his hand up R2's skirt. R3 initiated the kiss. R2 had a history of being sexually inappropriate with other residents in the past which had resulted in him having multiple room changes. FSW2 had not seen R3 be sexually inappropriate in the past but had seen her roaming into other resident's rooms. During an interview on 06/11/25 at 9:23 AM with Dietary Aide (DA)1 stated that on the day that R2 and R3 were seen kissing, she was preparing food. She heard FSW1 say that R2 and R3 were kissing. DA1 saw R2 and R3 kissing and holding hands at that time. R2 had a history of making inappropriate sexual comments, especially with men. R3 had a history of roaming in and out of other residents rooms, but she had not seen her have any inappropriate sexual behaviors. During an interview on 06/11/25 at 9:33 AM FSW1 stated that the day that R2 and R3 were seen being physically affectionate, he saw R2 initiate holding R3's hand, then R2 kissed R3. FSW2 told FSW1 that she saw R2 put his hand up R3's dress. FSW1 stated he then reported this to the DON. R3 had a history of going in and out of other resident's rooms but he had not seen her touch anyone inappropriately. R2 had a history of touching other males and females and had told him He liked my dick. R2 would say things like that to staff and residents. During an interview on 06/11/25 at 11:45 AM Business Operations (BO) stated that she was not at the facility on 05/02/25 when the incident between R2 and R3 occurred. BO arranged for video footage to be viewed from 05/02/25. BO stated that the facility did not have a policy related to Capacity to Consent to Sexual Intimacy. BO confirmed that R2 had a history of being sexually inappropriate in the past with a male resident and that the interventions had included separating the residents and moving R2 to another room. A call was placed to the Administrator on 06/11/25 at 1:58 PM with no return call. Corporate staff attempted to get in touch with the Administrator as well with no response. During an interview on 06/11/25 at 2:12 PM with Scheduler (SCH) stated that on 05/02/25 she had come out of her office and saw R2 and R3 holding hands. SCH stated that she immediately separated R2 and R3. R2 had a history of inappropriately sexually touching another male while residing on the second floor. R3 had a history of roaming the halls, going in and out of other resident's rooms. During an interview on 06/11/25 at 3:59 PM with DON1 stated that she had been in her office on 05/02/25 when LPN1 came into her office and said that R2 and R3 were holding hands and kissing. DON1 stated that R2 and R3 had the right to do that unless one was forcing the other. CNA1 demanded that she go to the dining room, she saw them holding hands and R2 had his hand up R3's skirt. The Clinical Operations Manager came in after that and reported the incident to the Administrator. DON1 stated that she had been told by multiple staff members that R2 had a history of making sexually inappropriate gestures with both men and women. In the past he had been observed masturbating and when the CNA approached him he hit her. During an interview on 06/11/25 at 4:45 PM with Business Operations (BO) stated that she was aware of the incident between R2 and R3 and that R2 had a history of inappropriate sexual behaviors. BO confirmed that on 09/08/24 R2 had touched a male resident's private area and 04/06/25 R2 was observed masturbating in a public area. The incident on 09/08/24 and the incident on 05/02/25 were both FRIs and were investigated. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/11/25 at 6:09 PM with DON2 (current interim DON) stated that she was not working at the facility at the time of the incident between R2 and R3.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, policy review and interviews, the facility failed to ensure that two residents (Resident (R)2 and R3) out of a total sample of 13 had accurate care plans. This failure increased the risk of the resident's safety and monitoring. Specifically, R2 had a history of sexually inappropriately touching other residents and was observed kissing/holding hands with R3 on 05/02/25. Findings include: Review of the facility policy titled, Care Plans- Comprehensive Person-Centered revised 10/2021 stated A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs, that are identified through evaluation and assessment, is developed and implemented for each resident .The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment .The comprehensive, person-centered care plan will: 1. Include measurable objectives and time frames .J. Areas of concern that are identified during the resident assessment will be evaluated before interventions are added to the care plan. K. Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process . Review of R2's Detail Summary located in the electronic medical record (EMR) under the Resident tab revealed he was admitted to the facility on [DATE] with a primary diagnosis of hemiplegia following cerebral infarction affecting left nondominant side, and comorbidities including vascular dementia. Review of R2's quarterly Minimum Data Set (MDS) located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 02/21/25 revealed a Brief Interview for Mental Status (BIMS) score of three indicating the resident was severely cognitively impaired. R2's MDS also indicated he had no behaviors directed toward other residents. Review of R2's Care Plan revised on 10/01/24 indicated that R2 had .impaired behavior related to touching other residents. This had a start date of 09/08/24 and resolved date of 10/01/24. R2's Care Plan was not updated to include inappropriate sexual contact. Review of R3's Detail Summary located in the EMR under the Resident tab revealed she was admitted to the facility on [DATE] with a primary diagnosis of dementia with other behavioral disturbances. Review of R3' quarterly MDS located in the EMR under the MDS tab with an ARD of 04/19/25 revealed a BIMS score of 99 indicating the resident was unable to complete the assessment due to cognitive deficit. R2's MDS also indicated she had daily wandering behaviors. Review of R3's Care Plan provided by the facility did not include sexual inappropriateness. The care plan did include impaired behavior secondary to dementia- exhibited by wandering and rummaging into other resident's rooms. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/11/25 at 11:45 AM with Business Operations (BO) stated that any nurse could/should update the Care Plan, however the MDS nurse was usually the nurse that updated the Care Plan. BO stated that R2's initial Care Plan dated 09/08/24-10/01/24 included impaired behavior related to touching other residents. She was not sure why this was resolved on 10/01/24 but should not have been. During an interview on 06/11/25 at 6:09 PM with DON2 (current interim DON) confirmed that R2's Care Plan should have included inappropriate sexual behaviors. R2 discharged prior to her employment at the facility. DON2 stated that she was not aware of R3 having any inappropriate sexual behaviors with other residents. An interview with the MDS nurse was not available on 06/11/25 at 6:30 PM.