

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525552	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/06/2026
NAME OF PROVIDER OR SUPPLIER Wheaton Franciscan Hc - Terrace at St Francis		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure 1 (R1) of 4 residents are treated with respect & dignity and recognizes each resident's individuality. At the end of November, the facility was changing resident's beds that were not changed five or six years ago. R1 was approached about changing her bed and said no. R1's bed was changed on 11/25/25. R1 complained to staff about the bed and being in pain. Surveyor did note an increase in her pain scale and use of prn (as needed) Norco 5/325 mg (pain medication) during the time R1 was provided with the new bed. After a few weeks, the facility agreed to change R1's bed back to an older bed and R1's bed was switched back to an older bed on 12/18/25. For the beds to be switched R1's belongings needed to be removed to the hallway. During this process several of R1's possessions were removed from the hallway and placed in the garbage chute room as staff had been trying to clean R1's room. After the bed was switched and R1's belongings were brought back in the room, R1 realized some of her belongings were missing and came out in the hallway visibly upset. R1's usual custom is not to leave her room. A housekeeper then went to the garbage chute room and returned the items. Findings include: The facility's policy titled, Residents Rights and last revised 7/2018 under policy statement documents It is the policy of [Corporate Name] to promote and protect the rights of residents residing in our ministry. Under policy interpretation and implementation includes documentation of 2. Residents are entitled to exercise their personal and legal rights and privileges to the fullest extent possible. 3. Our ministry will make every effort to assist the resident in exercising his/her rights and to assure that the resident is always treated with respect, kindness and dignity. R1's diagnoses include progressive multiple sclerosis (disease in which the immune system eats away the protective covering of nerves resulting in disruption in communication between the brain and body), hypertension (high blood pressure), and glaucoma (group of eye conditions that damage the optic nerve). R1's quarterly MDS (minimum data set) with an assessment reference date of 10/21/25 has a BIMS (brief interview mental status) score of 15 which indicates cognitively intact. R1's care plan documents, has impaired behavior related to hoarding items in her room, hx (history) of displacement twice due to hurricanes; refuses care at times, refuses medications, won't allow room to be more organized and clutter free; care plan initiated 10/22/24 document approaches of: *Avoid the following identified triggers: removing items from room without resident participation including but not limited to items such as additional linen in bathroom and Styrofoam cups. Initiated 10/22/24. *Provide on going education, encouragement why routine care and medication is important; enlist her cooperation by offering alternative times to return. Initiated 5/20/25. *Refer to psych if appropriate and as she allows. Refuses Psychiatric intervention. Initiated 5/20/25. R1's progress note dated 12/1/25, at 16:39 (4:39 p.m.), and written by Chaplain-G documents Resident was lying on the bed when writer arrived. Resident continues to express her depression and concern for her quality of life. Resident stated that she would much rather live with/near her family and</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 525552	If continuation sheet Page 1 of 12

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>friends. Resident reviews her emotions regarding living her sic (here) and her hopes for living in New York with/near her sisters. Writer assisted resident in finding items in her room. Writer offered to assist resident in throwing out any food or garbage. Resident declined underscoring that she can't imagine these items filling the land fill. Writer was able to find many items and rearrange them in her room to allow better accessibility. Writer provided a ministry of active reflective listening and emotional support.R1's progress note dated 12/7/25, at 13:06 (1:06 p.m.), and written by Licensed Practical Nurse (LPN)-M documents Resident alert. Able to make needs known. Resident c/o (complained of) increased pain to right hip and lumbar area. Requesting x-ray. Resident denies falling or sudden movement that would cause pain in those areas. Updated [Physician Name] on request. New order received for x-ray right hip, lumbar area. 2 views. Order placed to [Name] Mobile Imaging.R1's progress note dated 12/9/25, at 15:57 (3:57 p.m.), and written by Registered Nurse/Unit Manager (RN/UM)-J documents Xray result reviewed and faxed to [Physician Name]. No new orders received at this time.R1's social service note dated 12/18/25, at 14:18 (2:18 p.m.), with event date of 12/17/25 and written by Interim Social Worker (ISW)-H documents SW spoke with the resident during angel rounds. States she is not happy with the new bed received and prefers the older model. Resident says the current bed is causing back pain and she would like the bed switched as soon as possible. SW told resident she would follow up with maintenance regarding the switch and would assist with the transition. SW received an email correspondence from the ombudsman stating that she had been contacted by the resident regarding the bed. SW informed the ombudsman that the transition was already in progress to occur 12/19 and SW will keep the ombudsman updated. ED (Executive Director) updated.R1's social service note dated 12/18/25, at 14:24 (2:24 pm.), and written by ISW-H documents SW met with the resident for bed change. The resident has requested to switch back from the new model to previous one. SW moved multiple of resident belongings off the bed, underneath and side of the bed into the hallway and on nightstand to clear a pathway for removal while resident sat in wheelchair and watched. Resident held both of her purses and glasses along with a couple of other items. Resident initially refused to have soiled bedding changed, SW was able to convince her to do so. Maintenance was called in and removed old bed, brought in older model already made up. Resident had SW remove all pillows and placed a throw blanket inside of the pillow slip. Stating it is easier for her to sleep on and better on her neck/back. SW assisted resident with placing personal items back underneath, on top and to side of the bed. Resident stated she would arrange everything to her liking. Stated thank goodness. SW sent correspondence to ombudsman and updated facility IDT (interdisciplinary team).R1's physician orders include assess pain and document every shift dated 8/3/22 and Norco 5/325 mg (milligrams) [Hydrocodone-acetaminophen] three times a day PRN for breakthrough pain dated 6/9/25.Surveyor reviewed R1's October 2025 MAR (medication administration record) and noted the daily pain assessments q (every) shift documents 0 for each day and each shift. R1 received Norco 5/325 mg prn one time on 10/16/25 at 2151 (9:51 p.m.) with a pain scale documented as 8.Surveyor reviewed R1's November 2025 MAR and noted the daily pain assessments q (every) shift documents 0 for each day and each shift. R1 did not received Norco 5/325 mg prn during November 2025.Surveyor reviewed R1's December 2025 MAR and noted the following daily pain assessments: During the night shift on 12/7/25 the pain scale is 10 and on 12/17/25 the pain scale is 8. Surveyor noted all other days for the night shift are 0. During the day shift on 12/31/25 the pain scale is 4. All other days during December for the day shift are documented as 0. During the evening shift 12/2/25 the pain scale is 2, 12/5/25 the pain scale is 3, 12/10/25 the pain scale is 9, 12/16/25 the pain scale is 7, 12/19/25 the pain scale is 7, 12/20/25 the pain scale is 6, 12/22/25 the pain scale is 8, 12/23/25 the pain scale is 4, 12/24/25 the pain scale is 5,</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>12/26/25 the pain scale is 9, 12/29/25 the pain scale is 8 and on 12/31/25 the pain scale is 6. During December 2025 R1 received Norco 5/325 mg prn on 12/3/25, 12/5/25, 12/8/25, 12/9/25, 12/10/25, 12/11/25, 12/12/25, 12/15/25, 12/16/25, 12/17/25, 12/18/25, 12/22/25, 12/20/25, & 12/31/25. Surveyor noted an increase in R1 being administered Norco 5/325 mg prn during the period when R1 had the new bed & mattress she did not want and had an increase in her pain level. R1 received Norco 5/325 mg 11 times during this time. On 1/5/26, at 9:22 a.m., Surveyor observed R1 in bed on the left side with multiple items/bags on the bed. Surveyor observed there are boxes on the left side as Surveyor entered the room. There is an over bed table stacked with used Styrofoam cups and medication cups. Along the perimeter of the walls there are bags, various items and boxes stacked. Between R1's bed and personal type recliner there are multiple items, and the personal type of recliner is piled with linens and various other items. Surveyor asked R1 how she was doing. R1 stated to Surveyor her major complaint is the bed situation. R1 explained a few weeks ago maybe longer they insisted I have a new bed. I said no. R1 informed Surveyor a Corporate person said she had to get a new bed. The corporate person was with nurse Registered Nurse (RN)-E [first name] and informed Surveyor she's on duty now. R1 stated Chaplain-G came in to help me move items and they gave me a new bed. Surveyor asked R1 if staff said why she needed a new bed. R1 replied they said everyone was getting a new bed. R1 informed Surveyor she told head of maintenance this bed is killing me. Surveyor asked how long she had the new bed. R1 replied two weeks, every day, every shift I complained the bed was killing me, I could feel the bars in my back, couldn't stand up. R1 informed Surveyor she stupidly told the NP (nurse practitioner) from [company]. Surveyor asked R1 what she meant by stupidly. R1 informed Surveyor the NP sent PT (physical therapy) in to fix me not the bed. Surveyor asked R1 why the facility staff decided to change her bed back to the old bed. R1 replied I called the Ombudsman; she knows me so well and right then they were changing Administrators. R1 informed Surveyor when they changed her bed back Chaplain-G wasn't here so first name of Interim Social Worker (ISW)-H moved my things to put the old bed back in, that's when it happened. Surveyor asked what happened. R1 replied she, referring to ISW-H, stole my things. Surveyor asked what was stolen. R1 replied this bag, pointing to a flower bag on the bed and the other bag pointing to the bag with an Eiffel Tower located on the floor. R1 informed Surveyor she has the bag there so she can keep an eye on it and two small tote bags. Surveyor asked R1 how she got her bags back. R1 informed Surveyor she didn't get everything back as there is another bag with \$75.00 of snacks, cookies, bar-b-que chips and other chips she didn't get back. Surveyor asked R1 about the other bags. R1 informed Surveyor housekeeping ran and said she was going to look for them. Surveyor asked who the housekeeper was. R1 informed Surveyor the first name of Housekeeping-F. R1 stated this bag, referring to the bag with the flowers on R1's bed, was in a black garbage bag. R1 explained the other two bags were not in the garbage bag and the housekeeper said the snacks were gone as she couldn't find them. R1 informed Surveyor this was on 12/18. R1 informed Surveyor she asked to speak to the Social Worker two times and the new Administrator, but they never came up to speak to her. On 1/5/26, at 9:48 a.m., Surveyor asked Registered Nurse (RN)-E when R1 received a new bed. RN-E informed Surveyor she doesn't remember exact time, but all the beds got switched, could be a month, it wasn't long. Surveyor asked RN-E if she knew why the beds were being changed. RN-E replied no, I'm just a floor nurse. RN-E informed Surveyor the mattresses were also changed. Surveyor asked RN-E if R1 complained about her new bed. RN-E informed Surveyor R1 told her so any times about the bed and one time she caught the Administrator and maintenance. RN-E informed Surveyor R1 is a hoarder and when they changed the bed, they needed to get R1's stuff away and R1 complained. RN-E informed Surveyor R1 got a new bed & mattress, and she didn't like it. R1 wanted the old ones back.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>RN-E informed Surveyor R1 told everyone, R1 called [Name of company] NP. RN-E informed Surveyor she didn't know the solution and reached out to the chain of command. Surveyor asked who the chain of command was. RN-E informed Surveyor the first name of RN/UM-J. RN-E informed Surveyor R1 is happy with the old mattress and bed. On 1/5/26, at 10:51 a.m., Surveyor interviewed Director of Facilities Management (DFM)-D regarding the new beds. DFM-D explained about five years ago they replaced 26 beds and just got 52 or 54 beds in. Surveyor asked DFM-D which residents received the new beds. DFM-D informed Surveyor it was by rooms and all the first floor. DFM-D informed Surveyor they replaced all the beds that were not replaced five years ago. Surveyor asked who swapped out the beds. DFM-D informed Surveyor of the name of the company and they had extra CNAs getting residents out of their beds. Surveyor asked what if a resident didn't want a new bed. DFM-D replied they had to be changed because they were older beds. Surveyor asked DFM-D if there were any residents who refused to have their beds changed. DFM-D replied there was, I can read your mind, there was a resident who didn't want their bed changed. Surveyor asked who the resident was. DFM-D replied the first name of R1. DFM-D explained they tried one day to change the bed, but she didn't want it so the following day they did change it out. DFM-D informed Surveyor R1 was not happy with him so he had the Chaplain speak with R1. DFM-D explained R1 was not happy with the new bed, mattress or grab poles. Surveyor asked DFM-D if R1 still has the new bed. DFM-D replied no and explained they put a bed in there like they replaced five or six years ago. Surveyor asked when the bed was replaced. DFM-D replied believe couple weeks ago. Surveyor asked why R1's bed was changed. DFM-D informed Surveyor she had asked for it. DFM-D informed Surveyor after they changed everything to the old bed & mattress everything was fine. Surveyor asked DFM-D if he could investigate when R1's bed was originally changed and when R1 received the old bed back. DFM-D later this same day left a yellow piece of paper for Surveyor which indicated R1 got the new bed 11/25/25 and changed bed, mattress, and side rails on 12/18/25. On 1/5/26, at 11:26 a.m., Surveyor interviewed Housekeeping-F regarding R1's belongings. Surveyor informed Housekeeping-F R1 had informed Surveyor when her bed was being changed back to the old bed, she had bags missing and R1 indicated she (Housekeeping-F) brought the bags back. Housekeeping-F informed Surveyor they had been trying to clean R1's room. Housekeeping-F informed Surveyor they were going to switch R1's bed so her and the social worker were going to get rid of some of R1's things. Housekeeping-F explained there is a garbage chute and she put R1's things in there. Housekeeping-F informed Surveyor she knows not to throw R1's things away. Housekeeping-F informed Surveyor R1 said her things were missing, R1 was out in the hallway and throwing a fit saying she wanted everything back from her room. Housekeeping-F stated I went right to the room, referring to the garbage chute room, and brought all her stuff back. Surveyor asked if R1 was missing anything after that. Housekeeping-F replied no I put everything in the room. I made sure they didn't get thrown down. Housekeeping-F explained there was an incident before when R1's bedding was changed and R1 was upset with the CNA, so she knows how R1 is. Surveyor asked Housekeeping-F who decided which bags to remove from R1's room. Housekeeping-F replied she did referring to Interim Social Worker (ISW)-H. Housekeeping-F informed Surveyor they have been trying to clean out R1's room and R1 says no. Housekeeping-F informed Surveyor R1 knows her stuff that's why she didn't throw her things down the chute. Surveyor asked Housekeeping-F if she was there when R1's bed was changed to the new bed. Housekeeping-F replied no and R1 kept complaining about the new bed. On 1/5/26, at 12:12 p.m. Surveyor asked Chaplain-G if she was there when R1 received a new bed. Chaplain-G replied I was and explained she was there because of R1's things and R1 trusts her. Chaplain-G informed Surveyor she moved her things out of the way, cleaned her floor, and changed the linen. Chaplain-G explained they changed out R1's bed and mattress. Chaplain-G informed</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Surveyor R1 did not want her bed changed but they were changing the beds in the facility. Chaplain-G informed Surveyor it is a better bed, could go in a sitting position. Surveyor stated to Chaplain-G R1 didn't want her bed to be change. Chaplain-G replied correct. Chaplain-G informed Surveyor she and Director of Nursing (DON)-B were there. Chaplain-G informed Surveyor R1 was not happy with her new bed. Surveyor asked Chaplain-G if R1 complained to her about the new bed. Chaplain-G informed Surveyor she is R1's guardian angel so she gets all R1's complaints. Chaplain-G informed Surveyor she's at the facility on Monday, Tuesday, and every other Friday. Chaplain-G informed Surveyor R1 told her she was not comfortable, and Chaplain-G asked R1 to give it a full week. Surveyor asked Chaplain-G if she was here when R1's bed was switched back to the old bed. Chaplain-G informed Surveyor she wasn't. On 1/5/26, at 1:46 p.m., Surveyor asked ISW-H if she was involved when resident's beds were switched out. ISW-H replied not so much that was maintenance. Surveyor asked ISW-H if R1 complained about the new bed. ISW-H informed Surveyor apparently R1 had been complaining for a couple weeks about the bed, complaining about back pain, and wanted her old bed back. ISW-H informed Surveyor one morning she stopped in R1's room and R1 was asking to get her old bed back. ISW-H informed Surveyor she talked to maintenance, arranged to get the new model out and the old bed and mattress back. ISW-H informed Surveyor R1 wanted to keep the assist bars which were on the new bed and was able to get these assist bars on the old bed. ISW-H informed Surveyor R1 watched them, they cleared a pathway to switch the bed. ISW-H informed Surveyor everything was placed in bags or left. ISW-H informed Surveyor they placed R1's things along the wall in the hallway. Surveyor asked ISW-H who helped her place R1's items in the hall. ISW-H informed Surveyor one of the housekeepers. Surveyor asked if anything was taken to the garbage chute room to be thrown away. ISW-H replied no. Surveyor asked ISW-H if she had any contact with the Ombudsman-I regarding R1. ISW-H informed Surveyor she had an email from Ombudsman-I that morning about R1 having pain. ISW-H informed Surveyor she did email her that everything was taken care of, and she did hear from R1 and everything was fine. On 1/5/26, at 2:14 p.m., Surveyor asked DON-B if she was involved with residents receiving new beds and asked if she spoke to any residents about having to get a new bed. DON-B replied no. DON-B informed Surveyor from what she understands it came down from corporate, they ordered the beds. Surveyor asked DON-B if she was aware R1 did not want to change her bed. DON-B replied yes. Surveyor asked DON-B how she became aware. DON-B informed Surveyor she went to R1's room with the Chaplain. R1 was concerned about the beds being taken to the land fill. DON-B informed Surveyor she didn't know where the beds were going. DON-B informed Surveyor corporate wanted all the beds to be changed as they had changed 25 beds before, they were buying better beds, better quality. Surveyor asked DON-B if anyone asked corporate if R1 could keep her old bed. DON-B replied I do not know. On 1/5/26, at 3:20 p.m. Surveyor asked Housekeeping-F if ISW-H told her to throw R1's belongings out. Housekeeper-F informed Surveyor she's not going to say she did, but she was there. Housekeeper-F explained R1's things were sitting in the hallway; she just grabbed them and took them to the back. Surveyor asked Housekeeping-F if she was referring to the garbage chute room. Housekeeping-F replied yes. Surveyor asked Housekeeping-F if she or ISW-H asked R1 if they could throw any of her belongings away. Housekeeping-F replied no. Surveyor asked Housekeeping-F if ISW-H knew she had taken R1's belongings to the garbage chute room. Housekeeping-F replied yes, I told ISW-H. Housekeeping-F informed Surveyor after she brought R1 back her belongings back to R1's room she told her boss. On 1/6/26, at 9:07 a.m., Surveyor asked R1 who she spoke to about not liking her bed and having pain. R1 informed she told the night nurse, [Name] he comes in sometimes and said he has nothing to do with the beds, name of Chaplain-G, and another nurse who R1 doesn't know her name but works for an agency. Surveyor asked R1 if she spoke to any CNAs. R1 replied no I</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility did not ensure a resident wound was comprehensively assessed weekly, along with interventions to promote healing. This was observed with 1 (R4) of 1 resident observed with a skin wound. R4 developed a skin wound requiring a treatment. This wound was not comprehensively assessed weekly to determine progression of healing. Findings include: The facility policy and procedure titled Skin Identification, Evaluation and Monitoring dated 11/2022 documents: The purpose of this policy is to outline a method of identification, evaluation and monitoring for alterations in skin integrity. Communities will implement preventative measures, and an individualized care plan will be formulated upon completion of findings. The Procedure; Weekly: the licensed nursing associate will document integumentary findings appearance of the wound including measurements treatment applied or initiated per healthcare provider order in the medical record. Document evaluation in the medical record. Update plan of care with each intervention. R4 was admitted to the facility on [DATE] for a traumatic brain injury and has a guardian. On 12/4/25 the Progress Note (PN) documents: R4 seen by wound care doctor today and was assessed to have a full thickness non-pressure wound to right upper scapula measuring 6 centimeters (cm) by 6 cm by 0.1 cm with light serous drainage. There is 10% necrotic tissue and no signs of infection. Dressing change done as ordered. The Wound Evaluation and Management Summary dated 12/4/25 by the wound care doctor documents: The treatment plan is a gauze island with border dressing daily and as needed. Follow-up: Evaluation by wound care provider weekly. The Wound Evaluation and Management Summary dated 12/11/25 by the wound care doctor documents: The right upper scapula wound measures 6 cm by 3 cm by 0.1 cm with light serous drainage. The area has 20% slough which was debrided at this time. The treatment plan is unchanged. The Recommendations: to reposition per facility protocol and off-load wound. The Follow-up: Evaluation by wound care provider weekly or sooner as needed, with further intervention as indicated based on response to current treatment plan. R4 Plan of Care (POC) was reviewed. There is no documentation identifying the non-pressure wound. Therefore, there are no documented interventions to promote healing. The Wound Evaluation and Management Summary dated 12/18/25 by the wound care doctor documents: The patient's visit has been rescheduled. Patient refused wound evaluation. Surveyor notes R4's medical record does not have a comprehensive assessment of their non-pressure wound since 12/11/25. Surveyor also notes there is not a POC for the non-pressure wound. On 1/5/26, at 2:15 PM, Surveyor interviewed the Director of Nurses (DON) -B. DON-B stated the wound care doctor comes very week on Thursday. They do wound rounds with the Registered Nurse Manager (RNM)-J. The Floor Nurse will do the assessment if they are not available. Surveyor shared there is no documentation of a comprehensive wound assessment since 12/11/25. The DON-B stated they will look into it. On 1/5/26, at 3:00 PM, at the facility exit meeting with Nursing Home Administrator (NHA) -A, DON-B and Regional Nurse Consultant (RNC) -C, Surveyor shared the concern R4 did not have a comprehensive wound assessment since 12/11/25 and no plan of care that identifies this wound with interventions to promote healing. On 1/5/26, at 3:28 PM, Surveyor observed R4's wound and treatment by Licensed Practical Nurse (LPN) -N. Surveyor notes R4 has 2 wound areas as stated in the 12/11/25 wound assessment. On 1/6/26, at 7:35 AM, Surveyor interviewed RN/Unit Manager-J. The RN/Unit Manager-J stated the floor nurse will also conduct the weekly assessment. RN/Unit Manager-J stated they will look into any documented wound assessments since 12/11/25. On 1/6/25, at 10:31 AM, Surveyor interviewed RN/Unit Manager-J. The RN/Unit Manager-J did not provide a comprehensive wound assessment after 12/11/25. The RN/Unit Manager-J stated the Minimum Data Set (MDS) Nurse does the plan of cares. The RN/Unit Manager-J did not know why the wound was not identified in R4 POC. The</p> <p>(continued on next page)</p>		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MDS Nurse was not available to interview. Surveyor notes there is no documentation R4's wound was identified in R4's care plan with interventions to promote healing. Surveyor also notes R4's medical record did not contain documentation of a comprehensive wound assessment from 12/11/25 through 1/6/25, and the wound was not identified on R4's care plan with person-centered interventions to promote healing and identify if interventions and/or treatments needed to be adjusted.		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure a resident receives care, consistent with professional standards of practice, to prevent pressure injuries and does not develop pressure injuries unless the individual's clinical condition demonstrates that they were unavoidable; and a resident with pressure injuries receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new injuries from developing for 1 of 1 (R2) residents reviewed for pressure injuries.R2 was assessed to be at risk for the development of pressure injuries and developed a facility acquired pressure injury that was not comprehensively assessed until 1 week later when seen by the wound physician, which then documented an unstageable pressure injury due to necrosis. The care plan did not identify person-centered interventions for the frequency of turning and repositioning, the frequency of checking and changing due to incontinence, and the care plan was not revised when a new pressure injury was identified and recommended treatment was not transcribed and completed as ordered. Two different wound treatments were ordered and are documented as being completed. The facility did not clarify with the wound physician what treatment should be completed. Findings include:R2 admitted to the facility on [DATE] and has diagnoses that include primary progressive Multiple Sclerosis (MS), chronic kidney disease, osteoporosis, severe protein-calorie malnutrition and cirrhosis of liver. R2 entered onto hospice care 9/25/23.The facility policy titled Pressure Injury Assessment/Treatment documents (in part) . The purpose of this procedure is to provide guidelines for a consistent method of identification and for the initial care of identified pressure injuries, alterations in skin integrity and the prevention of acquiring additional pressure injuries.Pressure injury treatment requires a comprehensive approach, including and not limited to:Eliminate or reduce the source of pressure using positioning techniques, preventative measures to reduce the risk of further tissue loss, interventions that increase the potential for healing.Stage 3 pressure injury: Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss.Unstageable: Full thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar in the wound bed.The following information should be recorded in the resident's medical record, treatment sheet or designated wound form:All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound. R2's bowel and bladder evaluation dated 9/15/25 documents (in part) . Always incontinent of bowel and bladder. Treatment/management program: Provide scheduled incontinence care and comfort. R2's care plan documents: At risk for pressure ulcers and other skin related to but not limited to Braden and other skin related injuries. Has history of resolved pressure area on buttocks - dated 7/5/23. Interventions include:-Goal: Maintain skin integrity without new skin related injuries over the next review period - goal 2/17/26.-Enc (encourage) proper peri hygiene and the use of barrier cream after each incontinence episode and PRN (as needed) - dated 7/5/23-Observe skin for redness and breakdown during routine care - dated 7/5/23.-Low air loss mattress set to pulse weight setting 6. Check function and settings every shift - dated 7/5/23.-Encourage to float heels - dated 7/6/23.-Use pressure relieving gel pad cushion to Broda - dated 5/21/25.-Turn and reposition during rounding - dated 6/19/25.-Use lift sheet to reduce friction and sheer - dated 6/19/25. (R2) has altered elimination due to incontinence of bladder. Interventions include:-Goal- Skin will remain clean, dry and free of breakdown related to incontinence - goal 2/17/26.-Perineal cleansing and apply protective skin barrier after each incontinent episode - dated 7/7/23.-Provide adult incontinent products and monitor for incontinence - dated</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>7/7/23.-Assess and report signs of impaired skin integrity or breakdown - dated 7/7/23. R2's CNA (Certified Nursing Assistant) worksheet dated 1/5/26 documents (in part) . Toileting: I need total assistance with 1 person staff support. I am incontinent of bladder and incontinent of bowel. I use briefs. Surveyor notes R2's care plan does not identify person-centered interventions for the frequency of turning and repositioning, or the frequency of checking and changing due to incontinence Review of R2's medical record revealed a history of pressure injuries on her buttocks. R2's wound physician note dated 4/16/25 documented a coccyx stage 3 pressure injury present greater than 82 days. On 5/7/25 the wound physician signed off on the patient as the pressure injury had healed.R2's medical record revealed a pressure injury to the sacrum/coccyx was identified on 12/11/25. The skin assessment summary documented: Pressure injury full thickness wound 1.0 x 0.5 cm (centimeters). Surveyor notes there was no other documentation of a comprehensive assessment to include depth or description of the wound bed. Color was entered as inapplicable. Stage was entered as Further assessment required. Treatment: Clean with NS (normal saline) and apply zinc covered with foam dressing.On 12/11/25 at 6:04 PM, nursing progress notes documented: Hospice nurse assess sacrum/coccyx wound. NOR (new order received) for tx (treatment) changed. Cleanse with normal saline wash, pat dry, apply barrier cream to non-open areas, cover with Mepilex tx in place. Surveyor reviewed R2's Hospice binder and was unable to locate a comprehensive assessment of the pressure injury. Surveyor notes there was no documentation at all regarding the pressure injury.R2's December 2025 Treatment Administration Record (TAR) documented the Mepilex treatment order to be done every 3 days was signed out as completed through 12/30/25.On 12/18/25, R2 was seen by [NAME] wound physician. Focused wound exam: Unstageable (due to necrosis) sacrum full thickness. Wound size 7 cm x 10 cm. Depth is unmeasurable due to presence of nonviable tissue and necrosis. Open ulceration area of 14.00 cm2 (squared). Moderate serous exudate. 20% thick adherent devitalized necrotic tissue. Intact normal skin 80%. No signs of infection. Dressing treatment plan: Primary dressing - Alginate calcium apply once daily and as needed. Collagen powder apply once daily and as needed. Secondary dressing - gauze island with border apply once daily and as needed.Surveyor noted the pressure injury was identified on 12/11/25 and the wound physician documentation indicated it was unstageable and larger on 12/18/25. The facility did not revise R2's care plan, R2's care plan still documented at risk for pressure injuries with no new interventions implemented after the pressure injury was identified. There was no indication as to how often R2 was to be turned and repositioned. In addition, R2 was always incontinent of bowel and bladder and R2's care plan was not personalized as to how often she was to be checked and changed for incontinence.Surveyor noted R2's December TAR documented the wound physician order; however, the order was not transcribed correctly. Collagen powder was not transcribed on the order. The treatment was signed out as having been completed 12/19/25 through 12/31/25. Surveyor noted that both treatments - Mepilex change every 3 days, and the daily treatment were both signed off as having been completed. Surveyor notes the facility did not clarify with the wound physician what treatment should be discontinued and which treatment should be completed.An assessment and measurements of R2's pressure injury was not completed again until 12/29/25 and was not completed by a Registered Nurse (RN). Documentation entered by Licensed Practical Nurse (LPN)-K on 12/29/25 included the same measurements and wording of the wound description as documented by the [NAME] wound physician on 12/18/25, 7 cm x 10 cm.On 1/5/26 at 11:30 AM, Surveyor spoke with Certified Nursing Assistant (CNA)-L and asked how often she does rounds. CNA-L reported they do rounds every 2-3 hours.On 1/5/26 at 2:30 PM, Surveyor spoke with Director of Nursing (DON)-B who reported the wound doctor comes weekly on Thursday. Surveyor noted R2's pressure injury was assessed by the wound doctor on 12/18/25 and was not comprehensively assessed and</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>measured again until 11 days later, on 12/29/25 and the documentation was entered by an LPN. Surveyor asked who is responsible for the weekly assessment and measurements of pressure injuries when the wound doctor is not here. DON-B reported it is the responsibility of the nurse working the floor. Surveyor asked how the nurses know they are supposed to assess and measure the wound in the absence of the wound doctor. DON-B stated, They are just told if the wound doctor won't be there. Surveyor confirmed there was nowhere to assign or sign out that the weekly assessment and measurements are to be completed in absence of the wound doctor. DON-B stated, It will be assessed and measured again on Thursday when the wound doctor comes in. Surveyor noted this would be 10 days after the last wound assessment and measurements. On 1/5/26 at 2:40 PM, Surveyor asked LPN-K to watch wound care. Surveyor asked to watch wound care and was advised that it wouldn't be done until later that evening. LPN-K stated, but it's twice a day, so you can watch tomorrow. Surveyor attempted to observe wound care several times but was unsuccessful. Surveyor asked to view the current (January 2026) TAR together to determine the current treatment order. LPN-K read the Mepilex order and stated. OK, it's every 3 days. Surveyor advised there were 2 different treatment orders and read the other order which documented the calcium alginate and border to be changed daily. Surveyor asked LPN-K which treatment she has been doing. LPN-K stated, I haven't been here since last week, but I have been doing the 3 times a week border dressing. I haven't been doing the calcium alginate because she (R2) complained that it burned so I haven't been using it. I left a message with her primary doctor. Surveyor asked if there was a reason she didn't contact the wound doctor. LPN-K stated, I didn't know she had a wound doctor. Surveyor asked if she was using any other treatment, beside the calcium alginate, such as a powder. LPN-K stated, No, she only has an order for calcium alginate, and she said it burns so I'm no using it anymore. Surveyor located no evidence in R2's medical record that the physician was notified of R2's complaint of treatment burning and that the treatment was not being completed as ordered. On 1/6/26 review of R2's skin/wound tracking report documented the following entered by LPN-K on 1/5/26, at 9:44 PM: Full thickness wound. Pressure injury. 1.0 x 1.0 cm. Tissue type: Granulation. Light exudate. Stage: Further assessment required. Treatment: Clean area with NS, pat dry, apply calcium alginate cover with gauze island w/border daily and PRN is soiled. On 1/6/26 at 10:45 AM, Surveyor spoke with RN-E about her documentation of R2's wound on 12/11/25. Surveyor advised the documentation didn't include a comprehensive assessment, description of the wound or staging. RN-E stated, We don't do that. If we find a new wound or there's a new admit with a wound, we just measure it, we don't stage it. Surveyor advised there was no documentation of an assessment, such as what the wound looked like, wound characteristics, exudate. RN-E stated, I don't think it had any of that. Surveyor asked why a comprehensive assessment of the wound wasn't documented. RN-E stated. We just measure, we don't stage wounds. On 1/6/26 at 10:51 AM, Surveyor spoke with RN/Unit manager-J. Surveyor asked if she remembered what R2's pressure injury looked like on 12/18/25 when seen by the wound doctor. RN/Unit manager-J stated, He measures as a cluster if there is more than one. There was a few, I can't remember how many, maybe 2 or 3, but he measures as a cluster not each separate. Surveyor advised physician recommended treatment included collagen powder, which was not added to the TAR. RN/Unit manager-J stated, I'm not sure how that got missed. On 1/6/25 at 2:30 PM, Nursing Home Administrator (NHA)-A was advised of concern: R2 has a history of stage 3 pressure injury on her buttocks. On 12/11/25 a facility acquired pressure injury was identified. R2's care plan was not revised with new interventions. The wound was not comprehensively assessed or staged until 1 week later by the wound physician which then documented the pressure injury as unstageable due to necrosis and was larger in size (decline). The physician recommended treatment was not transcribed or completed as ordered and there is</p> <p>(continued on next page)</p>		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	no evidence the physician was notified. In addition, the pressure injury was not comprehensively assessed weekly by an RN. No additional information was provided at the time of survey exit.		