

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016782	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 07/28/2026
NAME OF PROVIDER OR SUPPLIER FRANCISCAN GARDENS		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WILLIAMS AVE SOUTH MILWAUKEE, WI 53172		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 000}	Initial Comments On 07/28/2026, Surveyor completed 2 complaint investigations, and a verification visit at Franciscan Gardens for Statement of Deficiency (SOD) X86K11, dated 09/19/2025 and SOD FXT314, dated 10/22/2025. Two deficiencies were identified. Two of 2 deficiencies were repeat deficiencies identified in the following SODs: X86K11, dated 09/19/2025, 1 of 2 deficiencies was a repeat cite. FXT314, dated 10/22/2025, 1 of 2 deficiencies is being cited for a third time. Under statutory provisions of Wis. Stat. C. 50, a \$200 revisit fee is being assessed. Census: 44	{N 000}		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by:	N 389		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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N 389	Continued From page 1 Based on record review and interview, the provider did not ensure 1 of (Resident 1) 1 resident reviewed had an updated individual service plan (ISP) when there was a change in her/his needs. Resident 1's ISP did not address the care of Resident 1's wound. Resident 1's ISP was not updated to reflect current use of durable medical equipment. Resident 1's ISP did not address behaviors Resident 1 exhibited. This is a repeat deficiency. See Statement of Deficiency X86K11, dated 09/19/2025. Findings include: On 12/18/2025, the Department received a complaint alleging lack of reassessment upon change of condition. On 07/28/2026 at approximately 11:00 AM, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 09/06/2025. Resident 1's record indicated Resident 1 was their own legal decision maker. Resident 1's progress note, dated 09/06/2025, at 12:18 PM stated, "...does have an oa (open area) to the right side of buttock crease ...Writer did pull back the DuoDERM that was in place no drainage noted will monitor and will ask family when they arrive if home health is in place for this." Resident 1's record contained a 1-page document titled, "Individualized Service Plan," which had a date of 10/02/2025. The ISP indicated Resident 1 received nursing services for wound care. Resident 1's record contained a 6-page document titled, "Resident Care Plan," which had a date of 09/06/2025. The Resident Care Plan Indicated Resident 1 had an open	N 389		

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N 389	Continued From page 2 area. Resident 1's ISP or Resident Care Plan did not indicate who was responsible for the care of the wound or what treatment was being done for the wound. Progress note dated, 12/03/2025, at 1:34 PM stated, resident c/o (complained of) leg swelling and pain, as needed (PRN) tramadol and PRN Lasix given. Also educated resident to elevate [his/her] legs in recliner while sitting all day and resident refused stated [he/she] will elevate legs at night ..." Resident 1's Resident Care Plan stated, "Preventative skin care measures: Elevate/float heels when in bed as resident allows ..." Resident 1's ISP did not address Resident 1's refusal of elevating his/her feet. Resident 1's Resident Care Plan stated, "Mobility, impaired ...Mobility: Uses wheelchair for mobility ...Fall, Potential for r/t (related to) history of falls ...Remind resident to keep walker within reach ..." Resident 1's ISP did not address Resident 1 using both a wheelchair and walker for mobility. On 07/28/2026 at 2:39 PM, Surveyor interviewed Administrator A and Director of Nursing (DON) C. DON C disclosed the document titled Individual Service Plan was for the resident and resident's family. This document is discussed during care conferences and shows what services the residents receive. The document titled Resident Care Plan was meant for the staff. The Resident Care Plan provided more details of the services the resident received. DON C believes Resident 1 received home health care for wound care but acknowledged that both Resident 1's ISP and Resident Care Plan did not address who was caring for the wound and/or what the treatment was for Resident 1's wound. DON C acknowledged Resident 1 did not like to elevate	N 389			

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N 389	Continued From page 3 their feet, which could have assisted with Resident 1's edema and/or pain. DON C confirmed Resident 1's ISP did not address Resident 1's continued refusal to elevate his/her feet. DON C disclosed Resident 1 used a wheelchair and walker to assist with his/her mobility. DON C confirmed Resident 1's care plan stated Resident 1 only ambulated with a wheelchair. DON C reported he/she would ensure all other ISPs provided all required information.	N 389		
{N 654}	83.59(4)(f) Delayed egress: department approval Delayed egress door locks are permitted with department approval only in facilities with a supervised automatic fire sprinkler system and a supervised interconnected automatic fire detection system and shall comply with all of the following: To obtain department approval, the CBRF shall demonstrate that delayed egress equipment is necessary to ensure the safety of residents served by the CBRF, specifically persons at risk of elopement due to behavioral concerns, cognitive impairments or dementia, including Alzheimer ' s disease. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure approval from the department was received for 1 of 1 delayed egress door within the facility. This had the potential to affect 44 residents. This deficiency is being cited for the third time. See Statement of Deficiencies (SOD) FXT313, dated 07/07/2023, and SOD FXT314, dated 10/22/2025.	{N 654}		

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{N 654}	Continued From page 4 Findings include: The provider was licensed on 08/14/2017 to provide services to up to 60 non-ambulatory residents with a primary diagnosis of irreversible dementia/Alzheimer's Disease. On 07/28/2026, Surveyor reviewed department documents and did not find a delayed egress approval by the department. A review of the department documents indicated SOD FXT314, dated 10/22/2025, was sent and received by the provider on 01/15/2026. SOD FXT314, dated 10/22/2025, included a Notice of Special Orders. The Special Orders stated, "Based on the Department's investigation, and pursuant to Wis. Stat 50.03(5g)(b), EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Franciscan Gardens: "1.Pursuant to Wis. Stat. 50.03(5g)(b)3. And (b)6., effective immediately, the licensee shall comply with all requirements specified by Wis. Admin. Code DHS 83.59(4). That is, delayed egress door locks will have department approval prior to use ... "WITHIN 10 DAYS of receipt of this notice, the licensee shall request approval from the Bureau of Assisted Living (BAL) Regional Director in the southeastern regional office ...Requests that are approved may progress to plan review ..." On 07/28/2026, at approximately 10:39 AM, Surveyor toured the facility, accompanied by Administrator A. Surveyor observed the main entrance into the community based residential facility (CBRF) was a delayed egress door.	{N 654}		

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{N 654}	Continued From page 5 On 07/28/2026 at 2:39 PM, Surveyor interviewed Administrator A and Director of Nursing (DON) C. DON C reported Administrator A was working on the delayed egress door to ensure it was inspected by the appropriate companies. Administrator A reported the delayed egress door was inspected by a door company and the fire department. Administrator A could not state why an approval request was not sent to the regional office, as instructed in the Special Orders. Prior to Surveyor leaving the facility, Administrator A provided the Surveyor with a copy of the approval form he/she completed while this Surveyor was onsite to be sent to the regional office.	{N 654}		