STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016783	A. BUILDING: _____ B. WING _____	R-C 03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCIS HOUSE	3601 S CHICAGO 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 03/10/2026 with information gathered through 03/18/2026, Surveyor conducted a complaint investigation and verification visit for Statement of Deficiency (SOD) 8TU713, dated 09/19/2025 at Francis House, a Community-Based Residential Facility (CBRF) in South Milwaukee, WI. Seven deficiencies were identified. Three of the 7 violations are repeat violations. See SOD 8TU711, dated 04/17/2023, SOD 8TU712, dated 04/11/2025, and SOD 8TU713, dated 09/19/2025. Complaint substantiated. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 56	{N 000}		
N 165	83.12(4)(c) Reporting incidents with serious injury A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not submit a written report to the department within 3 working days after an incident or accident resulting in serious injury requiring emergency room treatment for 1 of 1 resident (Resident 21). Findings include:	N 165		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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N 165	Continued From page 1 On 02/20/2026, the Department received a complaint expressing concerns regarding facility not implementing any changes following resident falls to prevent subsequent falls. On 03/10/2026, Surveyor reviewed the provider's self-report history in the department's electronic file for the facility. The Department did not receive a self-report for Resident 21's falls that occurred on 02/18/2026 and 02/19/2026, which resulted in serious injury requiring emergency room treatment. On 03/10/2026, Surveyor reviewed Resident 21's record and identified the following: -Resident 21 was admitted to the facility on 02/16/2026. - Resident 21 had an activated healthcare power of attorney. - Resident 21's Fall Data Collection report, dated 02/19/2026 at 4:10 AM, written by Resident Assistant H, documented the following: "Date of fall: 02/18/2026 and 02/19/2026. Time of fall: 11:35 PM and 4:10 AM. Factors observed at time of fall: Resident lost their balance. Fall location: Resident apartment. Type of assistance at time of fall: Alone, unattended. Footwear at time of fall: Gripper socks." -Resident 21's Fall Data Collection report, dated 02/19/2026 at 8:45 AM, written by Resident Assistant I, documented the following: "Date of fall: 02/19/2026. Time of fall: 8:45 AM. Factors observed at time of fall: Resident slipped. Fall location: Resident apartment. Type of assistance at time of fall: Alone, unattended. What was	N 165		

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N 165	Continued From page 2 resident doing at or just prior to fall: Ambulating. Gait assistance device at time of fall: None. Footwear at time of fall: Bare feet. Tilting/Incontinence: Continent at time of fall." -Resident 21's After Visit Summary, dated 02/19/2026, stated the following: "Chief Complaint: Fall. Diagnoses: Laceration of scalp, initial encounter and Hospice care. Done Today: Suture Removal, Wound preparation irrigate and setup." -Resident 21's After Visit Summary, dated 02/19/2026, stated the following: "Chief Complaint: Fall. [Resident 21] presenting to the emergency department with scalp laceration after unwitnessed fall. Diagnoses: Unwitnessed fall. Laceration of scalp, initial encounter, Traumatic ecchymosis of face, initial encounter and Hospice care. Done Today: Laceration repair performed 2 times, Wound preparation irrigate and setup." On 03/10/2026, at approximately 12:35 PM, Surveyor interviewed Director of Nursing (DON) B. DON B reported s/he did not self-report Resident 21's falls to the Department. DON B reported s/he did not self-report to the Department due to Resident 21 not having a fracture. DON B reported it was his/her understanding that only a fracture was considered a serious injury.	N 165		
{N 189}	83.13(3)(b) Post house rules, resident rights, grievances The CBRF shall post all of the following: House	{N 189}		

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{N 189}	Continued From page 3 rules, resident rights and grievance procedures as required under s. DHS 83.32(2) (b). This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the grievance procedure was posted. This had the potential to affect 56 of 56 residents residing in the facility., This is a repeat deficiency. See Statement of Deficiency 8TU713, dated 09/19/2025. Findings include: On 03/10/2026, at approximately 8:25 AM, Surveyor toured the facility accompanied by Licensed Practical Nurse (LPN) E. No grievance procedure was posted in the facility. On 03/10/2026, at approximately 8:25 AM, Surveyor interviewed LPN E. LPN E confirmed the facility grievance procedure was not posted. On 03/10/2026, at approximately 9:44 AM, Surveyor interviewed Director of Nursing (DON) B. DON B confirmed the facility grievance procedure was not posted. DON B reported s/he would try to locate the grievance procedure to post it as soon as possible. DON B reported the posting of the grievance procedure was overlooked.	{N 189}		
N 195	83.14(1)(b) Licensee: caregiver background requirements. A licensee shall meet the caregiver background requirements under s. 50.065, Stats., and ch. DHS 12.	N 195		

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N 195	Continued From page 4 This Rule is not met as evidenced by: Based on record review and interview, the licensee did not comply with laws governing the requirements for entity background checks. Licensee G did not submit required entity background check to the Division of Quality Assurance pursuant to Wis. Stat. s.50.065 and ch. DHS 12. Findings include: On 03/10/2026, Surveyor conducted a complaint investigation and verification visit at this facility. On 03/10/2026, at approximately 12:15 PM, Surveyor interviewed Executive Director (ED) A. Surveyor asked ED A how involved Licensee F is with operations, staffing, and compliance requirements. ED A reported Licensee F was no longer with the company. ED A reported Licensee G should be listed as the new designated Licensee. On 03/10/2026, Surveyor completed a review of the Department facility folder and identified the following: -On 12/03/2024, at 12:51 PM, the Department received an email from ED A reporting Licensee F has left the organization. -On 01/23/2025, at 3:53 PM, the Department sent an email to ED A advising ED A of the required steps to change the licensee representative name for the business. The Department also advised ED A that whoever the new designated licensee will be will need to submit an entity background	N 195		

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N 195	Continued From page 5 check to the Office of Caregiver Quality (OCQ). ED A was provided with the link to access OCQ. As of 03/18/2026, the Department has not received the required entity background check for Licensee G.	N 195		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on observations, record review, and interview, the licensee did not ensure that the provider and its operation were compliant with all laws governing a community based residential facility. As a result of the verification visit, 7 deficiencies were identified. Three of the 7 deficiencies were repeat deficiencies. The provider did not follow special orders which resulted from previous Statement of Deficiency (SOD) 8TU713, dated 09/19/2025. Findings include: On 03/10/2026, Surveyor reviewed Department records and identified on 11/03/2025, SOD 8TU713 and a Notice and Order Letter containing special orders were issued to Executive Director A and Director of Nursing B via email with the following: "Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.03(5g)(b), EFFECTIVE UPON RECEIPT OF	N 196		

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N 196	Continued From page 6 THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Francis House: 1. Pursuant to Wis. Stat. § 50.03(5g)(b)6., effective immediately, the licensee shall provide a living environment that is safe, clean, comfortable, and homelike. The licensee will ensure environmental concerns identified in Statement of Deficiency (SOD) 8TU713 are resolved. Flooring, furniture, and fixtures that cannot be properly cleaned or repaired will be replaced. All potential health or safety hazards will be addressed immediately. WITHIN 7 DAYS of receipt of this notice, the licensee shall provide the legal representative and the case manager (if any) for Resident 16, Resident 17, Resident 18, Resident 19, and Resident 20 with a copy of SOD 8TU713 and a copy of this Notice and Order letter. The licensee shall retain evidence, acceptable to the department, to verify compliance with this Order. Acceptable documentation will be a signed, certified mail receipt or a verification letter or email from each legal representative and case manager. WITHIN 45 DAYS of receipt of this notice, the licensee's corrective measures shall include the development (or review) of a written procedure to address: Home Environment, how the licensee will ensure: a) Timely repairs and scheduled maintenance of the home; and b) Scheduled and 'as needed' housekeeping to maintain a safe, clean, homelike environment. The licensee shall provide training to all	N 196		

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N 196	Continued From page 7 managers and resident care staff on the written procedure required by Order #1. Training will be documented in personnel records and will include the date/duration of training, the signature/qualifications of the instructor, and an outline of course content. WITHIN 45 DAYS of receipt of this notice, the licensee shall conduct an emergency evacuation drill in accordance with Wis. Admin. Code § DHS 83.47(2)(e). Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. All documentation required by Order #1 will be made available to department representatives upon request." On 03/10/2026 with information gathered through 03/18/2026, Surveyor conducted a complaint investigation, and verification visit for SOD 8TU713, dated 09/19/2025, at Francis House. As a result of the survey, the provider was issued 7 deficiencies. Three of the 7 deficiencies were repeat deficiencies. The following 7 deficiencies, which includes this violation, were identified: N 165 83.12(4)c) - Reporting Incidents With Serious Injury N 189 83.13(3)(b) - Post House Rules, Resident Rights, Grievances - This is a repeat deficiency. N 195 83.14(1)(b) - Licensee: Caregiver Background Requirements N 196 83.14(2)(a) - Licensee Ensures Facility Complies With Laws N 385 83.35(2) - Temporary Service Plan N 481 83.43(1) - Environment Safe, Clean, And Comfortable - This is a repeat deficiency. N 526 83.41(2)(e) - Other Evacuation Drills - This is a repeat deficiency.	N 196		

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N 196	Continued From page 8 On 03/10/2026, at approximately 9:25 AM, Surveyor interviewed Director of Nursing (DON) B and confirmed receipt of SOD 8TU713 and the accompanying Notice and Order Letter. DON B reported s/he did not follow special orders. DON B confirmed s/he did not provide the legal representative and the case manager (if any) for Resident 16, Resident 17, Resident 18, Resident 19, and Resident 20 with a copy of SOD 8TU713 and a copy of the Notice and Order letter. DON B reported s/he did not realize there were special orders. DON B reported this was an oversight on his/her end. On 03/10/2026, at approximately 9:47 AM, Surveyor interviewed Executive Director (ED) A. ED A reported s/he did not review SOD 8TU713 and the accompanying Notice and Order Letter due to being out on medical leave. ED A reported DON B was responsible to review SOD 8TU713 and Notice and Order letter and follow special orders. ED A confirmed the provider did not follow special orders. On 03/13/2026, at approximately 4:57 PM, Surveyor interviewed DON B. DON B reported s/he sent emails to the above-mentioned residents case managers and legal representatives.	N 196		
N 385	83.35(2) Temporary Service Plan. Temporary service plan. Upon admission, the CBRF shall prepare and implement a written temporary service plan to meet the immediate needs of the resident, including persons admitted for respite care, until the individual service plan under sub. (3) is developed and implemented.	N 385		

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N 385	Continued From page 9 This Rule is not met as evidenced by: Based on record review and interview, the provider did not prepare and implement a written Temporary Service Plan (TSP) to meet the immediate needs for 1 of 1 resident (Resident 21) reviewed. Resident 21 had a history of falls and was on hospice. Resident 21's TSP did not identify Resident 21 as a fall risk and interventions implemented to prevent subsequent falls for Resident 21. Resident 21's TSP did not identify what Resident 21's needs were for hospice care. Findings include: On 03/10/2026, Surveyor reviewed Resident 21's record and identified the following: -Resident 21 was admitted to the facility on 02/16/2026 with diagnoses of Alzheimer's and muscle weakness. -Resident 21's Fall Risk assessment, dated 02/16/2026, documented the following: "Category: High Risk. History of falls within last six months: 1-2 times. Gait Analysis: Exhibits loss of balance while standing, uses an assistive device, wears poorly fitting shoes and decrease in muscle coordination." -Resident 21's TSP, dated 02/16/2026, documented the following: "Affect/Behavior: Wanderer. Transferring/Bed mobility: Independent. Mobility: Independent. Mobility device: 2 wheeled walker. Other needs: [Hospice Care Company]." Resident 21's TSP did not identify Resident 21 as a fall risk. Resident 21's TSP did not identify	N 385		

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N 385	Continued From page 10 interventions implemented to prevent subsequent falls for Resident 21. Resident 21's TSP did not identify what Resident 21's needs were for hospice care. On 03/13/2026, at approximately 4:57 PM, Surveyor interviewed Director of Nursing (DON) B. DON B reported s/he is responsible for care planning. DON B confirmed Resident 21's TSP did not identify Resident 21 as a fall risk and interventions implemented to prevent subsequent falls for Resident 21. DON B confirmed Resident 21's TSP did not identify what Resident 21's needs were for hospice care.	N 385		
{N 481}	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the facility was maintained in a safe clean, comfortable, and homelike environment. The facility needed cleaning and some repairs. This had potential to affect 56 of 56 residents. This is a repeat deficiency. See Statement of Deficiency (SOD) 8TU711, dated 04/17/2023, SOD 8TU712, dated 04/11/2025 and SOD 8TU713, dated 09/19/2025.	{N 481}		

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{N 481}	Continued From page 11 Findings include: The facility is licensed as a Class CNA (non-ambulatory) facility for up to 64 residents with programs in irreversible dementia/Alzheimer's. On 03/10/2026, at approximately 8:25 AM, Surveyor conducted a tour of the facility with Licensed Practical Nurse (LPN) E and observed the following: Front Entrance Area of Facility -Wall vent near front entrance door was caked with dust. -Hallway near front entrance showed significant signs of flooring cracks. -Hallway near front entrance door frames showed significant scratches and missing transition strip. Between 700/800 Neighborhood Common Area near fireplace -Missing ceiling tiles (2) had exposure to pipes and insulation. 700 Neighborhood Kitchen Area -Refrigerator doorframe and venting system displayed the appearance of dirt build-up. -Refrigerator/freezer displayed the appearance of dirt build-up. -Kitchen floor had the appearance of dirt build-up along refrigerator. -Flooring was dirty/stained. -Kitchen floor had the appearance of dirt build-up along the cabinetry. Common Area Near Kitchen -Wallpaper showed signs of peeling. -Walls showed significant signs of scraping.	{N 481}		

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{N 481}	Continued From page 12 -Walls had white chalklike substance. -Ceiling had brown substance splattered. -Ceiling fan was caked with dust. -Window ledge had spongy wood due to water damage. -3 of 5 light bulbs in ceiling fan did not operate to provide light. -Floor contained excessive hair shedding. 800 Neighborhood Hallway -Walls showed significant signs of scraping. -Ceiling diffuser showed signs of dust and rust. -Wallpaper showed significant signs of peeling. Kitchen Area -Walls showed significant signs of scraping. -Flooring was dirty/stained. -Ceiling diffusers showed signs of dust and rust. Common Area Near Kitchen -Walls showed significant signs of scraping. -Walls had white chalklike substance. -Walls were dirty. -White box fan was caked with dust. -Window ledge had spongy wood due to water damage. -White end table was dirty and contained sticky like substance. -Brown end table showed significant scratches and contained sticky like substance. Room 802 -Bedroom door/frame showed significant scratches. Resident 16 -Windows did not have insect-proof screens. -Bathroom toilet was leaking. -Bedroom carpet had significant brown substance	{N 481}		

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{N 481}	Continued From page 13 splattered. Resident 17 -Bedroom walls showed significant signs of scraping. -Bathroom door and doorframe showed significant scratches. -Shower was dirty. -Bathroom toilet was dirty. -Bathroom walls showed significant signs of scraping. -Bedroom door and doorframe showed significant scratches. Resident 19 -Bedroom door and doorframe showed significant scratches. -Bedroom walls showed significant signs of scraping. -Bedroom carpet contained dark wear patterns and areas of red stains. -Bedroom carpet near bathroom contained significant brown substance consistent with dried feces. Resident 22 -Bedroom door and doorframe showed significant scratches. Resident 23 -Bedroom door/frame showed significant scratches. Resident 24 -Bedroom door and doorframe showed significant scratches. Resident 25 -Bedroom door and doorframe showed significant scratches.	{N 481}		

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(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 481}	Continued From page 14 Resident 26 -Bedroom door/frame showed significant scratches. Resident 27 -Bedroom door/frame showed significant scratches. On 03/10/2026, at approximately 8:25 AM, Surveyor interviewed LPN E. LPN E confirmed there were homelike environment concerns throughout the facility. On 03/10/2026, at approximately 1:58 PM, Surveyor interviewed Director of Nursing (DON) B. DON B reported the maintenance team is responsible to help ensure the facility was maintained in a safe clean, comfortable, and homelike environment. DON B reported s/he did not know why the homelike environment concerns throughout the facility were not corrected.	{N 481}		
{N 526}	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure an other evacuation drill was completed since the last survey visit. This is a repeat deficiency. See Statement of Deficiency (SOD) 8TU711, dated 04/17/2023, SOD 8TU712, dated 04/11/2025, and SOD	{N 526}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016783	A. BUILDING: _____ B. WING _____	R-C 03/18/2026

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{N 526}	Continued From page 15 8TU713, dated 09/19/2025. Findings include: On 03/10/2026, at approximately 10:39 am, Surveyor requested to review other evacuation drills from Executive Director (ED) A. Evidence of an other evacuation drill was not received. On 03/10/2026, at 12:15 PM, Surveyor interviewed ED A regarding the other evacuation drills. ED A reported Plant Operations Director (POD) J did not conduct other evacuation drills since the last survey visit. ED A reported POD J was responsible for ensuring the other evacuation drills were completed. ED A reported s/he will be meeting with POD J and the maintenance team.	{N 526}		