STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020393	A. BUILDING: _____ B. WING _____	C 04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN PLACE MEMORY CARE	**9201 W DREXEL AVE FRANKLIN, WI 53132**

(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 04/02/2025, Surveyor conducted 4 complaint investigations at Franklin Place Memory Care. One deficient practice was identified. One complaint was substantiated. Three complaints were unsubstantiated. Census: 27	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 ensure the Department was notified within 3 working days of an incident resulting in serious injury requiring emergency room treatment of a resident for 1 of 1 resident reviewed (Resident 2). Resident 2 had a fall on 03/17/2025 resulting in an injury which required emergency room treatment. Findings include: -On 03/18/2025, the Department received a complaint expressing concerns Resident 2 had fallen out of bed and was left crawling on the floor. -On 03/31/2025, Surveyor reviewed Department records and identified there were no self-reports received from the provider regarding Resident 2	N 165		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020393	A. BUILDING: _____ B. WING _____	C 04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN PLACE MEMORY CARE	**9201 W DREXEL AVE FRANKLIN, WI 53132**

(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 165	Continued From page 1 being treated at the hospital due to a fall. On 04/02/2025, Surveyor reviewed Resident 2's record and identified the following: -Resident 2 was admitted to the facility on 10/19/2022 as non-ambulatory requiring a 2-person assist into a wheelchair and was currently being seen as a hospice patient by Legacy Hospice. -Resident 2's facility incident report, dated 03/17/2025, identified Resident had an "unwitnessed fall with a head strike and was sent out to the hospital." On 04/02/2025, at approximately 2:56 PM, Surveyor interviewed Administrator A and Clinical Services Director B regarding Resident 2's fall on 03/17/2025. Clinical Services Director B confirmed s/he did not file a report with the Department because s/he was not aware it was required when a resident goes to the hospital for treatment. Surveyor reviewed the DHS 83 reporting requirements with Licensee A and Clinical Services Director B who confirmed they would report in the future.	N 165		