STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525477	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Francis Health Services	1915 E Tripoli Ave Saint Francis, WI 53235

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253 Based on observations, interview, and record review, the facility did not ensure residents received adequate supervision to prevent accidents for 1 (R22) of 1 residents reviewed for falls. *R22 had three unwitnessed falls that were not thoroughly investigated to determine a root cause and develop interventions that addressed the cause and prevent future falls. Findings include: The facility policy and procedure titled Accidents and Supervision dated 7/14/2022 documents: Policy: The resident environment will remain as free of accident hazards as possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes: 1. Identifying hazard(s) and risk(s). 2. Evaluating and analyzing hazard(s) and risk(s). 3. Implementing interventions to reduce hazard(s) and risk(s). 4. Monitoring for effectiveness and modifying interventions when necessary. Policy Explanation and Compliance Guidelines: The facility shall establish and utilize a systematic approach to address resident risk and environmental hazards to minimize the likelihood of accidents. 1. Identification of Hazards and Risks-the process through which the facility becomes aware of potential hazards in the resident environment and the risk of a resident having an avoidable accident. a. All staff (e.g., professional, administrative, maintenance, etc.) are to be involved in observing and identifying potential hazards in the environment, while taking into consideration the unique characteristics and abilities of each resident. b. The facility should make a reasonable effort to identify the hazards and risk factors for each resident. c. Various sources provide information about hazards and risks in the resident environment. e. This information is to be documented and communicated across all disciplines. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Evaluation and Analysis-the process of examining data to identify specific hazards and risks and to develop targeted interventions to reduce the potential for accidents. Interdisciplinary involvement is a critical component of this process. a. Analysis may include, for example, considering the severity of hazards, the immediacy of risk, and trends such as time of day, location, etc. b. Both the facility-centered and resident-directed approaches include evaluating hazard and accident risk data, which includes prior accidents/incidents, analyzing potential causes for each hazard and accident risk, and identifying or developing interventions based on the severity of the hazards and immediacy of risk. c. Evaluations also look at trends such as time of day, location, etc. 3. Implementation of Interventions- using specific interventions to try to reduce a resident's risks from hazards in the environment. The process includes: a. Communicating the interventions to all relevant staff b. Assigning responsibility c. Providing training as needed d. Documenting interventions (e.g., plans of action developed by the Quality Assurance Committee or care plans for the individual resident) e. Ensuring that the interventions are put into action f. Interventions are based on the results of the evaluation and analysis of information about hazards and risks and are consistent with relevant standards, including evidence-based practice. i. Resident-directed approaches may include: i. Implementing specific interventions as part of the plan of care ii. Supervising staff and residents, etc. iii. Facility records document the implementation of these interventions . 5. Supervision- supervision is an intervention and a means of mitigating accident risk. The facility will provide adequate supervision to prevent accidents. Adequacy of supervision: a. Defined by type and frequency b. Based on the individual resident's assessed needs and identified hazards in the resident environment. 1.) R22 was admitted to the facility on [DATE] with diagnoses of intracerebral hemorrhage, atrial fibrillation, epilepsy, dementia with psychotic disturbance, mood disorder, depression, and psychosis. R22's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented R22 had severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 5, was frequently incontinent of bladder, and always incontinent of bowel. The MDS documented R22 had behaviors not directed toward others 1-3 days, rejection of care 1-3 days, and wandering 1-3 days in the seven day look-back period. R22 had an activated Power of Attorney. R22's Physical Functioning Deficit Care Plan initiated 4/11/2022 had the interventions of transfer with supervision with a wheeled walker, walking with assistance of one with a wheeled walker, and toileting assistance of one every 2-3 hours as needed. R22's At Risk for Falls Care Plan was initiated on 4/14/2022 with interventions in place on 11/30/2024: -Mark placed on the wall to alert staff on bed level. -Assess for pain. -Gait belt with transfers. -Grip strips next to the bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Keep environment well lit and free of clutter. -Keep walker within reach of resident at all times. -Observe for side effects of medications. -Safety checks during shifts. -Therapy referral. On 11/30/2024, at 1:54 PM in the progress notes, nursing documented R22 had an unwitnessed fall in the hallway sustaining abrasions to the forehead, a small laceration to the bridge of the nose, and superficial abrasions to the left hand fourth and fifth fingers. R22 complained of a headache and was sent to the hospital for evaluation and treatment. R22 returned to the facility later in the day with no new orders. The Post Fall assessment dated [DATE] documented R22 fell on [DATE], at 1:30 PM while walking in the hallway without the use of the walker or assistance. R22 had been seen a few minutes prior to the fall sitting at a table in the dining room. R22 was unable to state a reason for the fall. On the Risk Management tool, Director of Nursing (DON)-B documented R22 was reinterviewed after returning from the hospital to determine what R22 was doing at the time of the fall. R22 told DON-B R22 was going outside to pee. The Interdisciplinary Team (IDT) met on 12/2/2024 to review R22's fall and agreed with the initial intervention to change R22's toileting plan to every 1-2 hours. Surveyor noted the fall investigation did not include the last time R22 was toileted or if R22 was incontinent at the time of the fall. R22's Physical Functioning Deficit Care Plan was revised on 2/6/2025 with the intervention: toileting assistance of one every 1-2 hours as needed. Surveyor noted the intervention was added to the care plan two months after the fall. On 1/15/2025, at 7:43 PM, in the progress notes, nursing documented R22 had an unwitnessed fall in R22's room. The Post Fall assessment dated [DATE] documented the fall occurred while R22 was getting out of bed with the use of a walker. R22 had been seen approximately 15 minutes prior to the fall lying in bed. R22 was unable to state what R22 was attempting to do when the fall happened. An immediate intervention was to replace the soft touch gray small call light with a large flat white call light. On the Risk Management tool, Certified Nursing Assistant (CNA)-C stated CNA-C had given R22 a shower, toileted R22, and put R22 to bed. The IDT met on 1/15/2025 to review R22's fall and DON-B documented the IDT was in agreement to replace the small call light with the larger flat soft call light and staff is to attach the call light to the outside of the fitted sheet when R22 is in bed. Surveyor noted the fall investigation did not include if R22 was incontinent at the time of the fall and if R22 had the capacity to use a call light to request assistance. R22's At Risk for Falls Care Plan was revised on 1/15/2025 with the intervention: soft touch gray small call light replaced with large flat white call light; staff to attach call light to outside of fitted sheet when resident is in bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/1/2025, at 9:33 PM, in the progress notes, nursing documented staff noted R22 on the knees on the bedroom floor, holding onto the side of the bed. Vital signs were stable and R22's knees were starting to bruise. The Post Fall assessment dated [DATE] documented R22 stated R22 was trying to fix the sheets on the bed and had last been seen 15-30 minutes prior. Nursing documented a wheelchair was in use at the time of the fall. An immediate intervention was to have staff make sure sheets and blankets are straightened out when R22 is in bed and at night. The Risk Management tool documented the IDT met on 3/3/2025 and agreed with the intervention that was put in place to straighten out the sheets and blankets. Surveyor noted no documentation was found stating when R22 was last toileted or if R22 was incontinent at the time of the fall. R22's At Risk for Falls Care Plan was revised on 3/1/2025 with the intervention: staff to make sure sheets and blankets are straightened out when resident is in bed and at night. On 4/8/2025, at 9:52 AM, Surveyor observed R22 in bed. The bed was in a low position and grip strips were observed on the floor parallel to the bed. A flat white soft touch call light was attached to the outer side of the bed on the sheet within R22's reach. R22 was leaning to the left with R22's head resting on the wall. Two pillows were placed in the middle of the head of the bed, but R22 was not using either of the pillows. R22 declined to be interviewed at that time. On 4/9/2025, at 12:27 PM, Surveyor observed R22 in the dining room waiting for lunch to be served. The flat soft touch call light was in the middle of R22's empty bed. In an interview on 4/9/2025, at 2:56 PM, Surveyor asked Certified Nursing Assistant (CNA)-C if R22 ever pushes the call light for assistance. CNA-C stated no, R22 pushes the call light but only when R22 is playing with the pad. CNA-C stated R22 does not have any intention behind the use of the call light. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/10/2025, at 9:52 AM, Surveyor reviewed R22's falls with DON-B and Nursing Home Administrator (NHA)-A. Surveyor shared with DON-B and NHA-A the concern the falls were not thoroughly investigated, and information was not documented to help determine a root cause analysis for the falls. Surveyor asked DON-B and NHA-A when R22 fell on [DATE], where was the walker that R22 walks with per care plan. NHA-A stated the walker was most likely left behind in the dining room. NHA-A stated all staff know spontaneously getting up, walking, and leaving everything behind is something R22 would do. Surveyor shared with NHA-A and DON-B the Risk Management tool documented DON-B interviewed R22 after R22 returned from the hospital and R22 needed to urinate. Surveyor shared the concern the facility did not know when R22 was last toileted or what R22's incontinence status was at the time of the fall. Surveyor shared the concern the toileting care plan was not revised until 2 months after the fall, on 2/6/2025. DON-B stated DON-B revised the care plan right away. DON-B stated the care plans are updated during the IDT meeting. DON-B stated DON-B would look into the care plan revision. Surveyor shared with DON-B and NHA-A the concern when R22 fell on [DATE], the Post Fall Assessment documented R22 fell when getting out of bed using the walker and there is no further documentation of where the walker was prior to the fall or after the fall. Surveyor shared the concern the documentation did not indicate if R22 rolled out of bed or was attempting to ambulate at the time of the fall, if R22 was incontinent at the time of the fall, or when R22 was last toileted; the CNA statement indicated R22 had a shower, was toileted, put to bed, and had last been seen 15 minutes prior, but did not document the time R22 was assisted with ADLs. The care plan intervention was to provide R22 with a flat soft touch call light. Surveyor shared with DON-B and NHA-A the interview with CNA-C stating R22 does not have the capacity to use a call light to ask for assistance. NHA-A stated the call light that was in place was a round bulb call light and the flat soft touch call light is to be attached to the outer side of the bed so when R22 moves, the touch call light is touchy and would be bumped by the body when moving to prevent another fall. Surveyor noted the call light was being used as an alarm rather than the facility increasing the amount of supervision. Surveyor asked NHA-A and DON-B to clarify what R22 was doing when R22 fell on [DATE] because nursing documented R22 was using a wheelchair at the time of the fall. NHA-A stated NHA-A and DON-B would have to look into the documentation from that fall. On 4/10/2025, at 10:34 AM, NHA-A and DON-B requested Surveyor come to DON-B's office so DON-B could show Surveyor the computer system and how care plans are updated and reviewed. DON-B brought up R22's Physical Functioning Deficit Care Plan with the toileting intervention. After Surveyor reviewed the care plan with DON-B, DON-B agreed the toileting intervention had not been revised until 2/6/2025 when the fall occurred on 11/30/2024. DON-B stated DON-B did not know why the care plan was not revised until 2/6/2025 and that it did not make any sense to either DON-B or NHA-A why it had not been revised right after the fall. NHA-A stated the fall on 3/1/2025 indicated a wheelchair had been involved with the fall, which did not make sense because R22 uses a walker and the only wheelchair in the room was the roommates. NHA-A agreed the staff checked the wheelchair was in use and NHA-A and DON-B sign the Post Fall Assessment and they should have caught that. Surveyor shared with NHA-A and DON-B the concern the falls were not thoroughly investigated to determine a root cause and develop an appropriate intervention to prevent future falls.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 49011 Based on observation, interview and record review, the facility did not ensure food was prepared and served in a form designed to meet individual needs for 1 (R15) of 1 residents reviewed for a mechanically-altered diet. R15 has a puree diet order (level 1), R15 was served a meal tray with a banana cut in half, not pureed as per R15's diet order and meal ticket specification. Findings include: The Facility Diet/Texture Conversion Chart states in part: L1/Puree . follows the regular diet when possible and menu items are pureed . According to the Swallowing Disorder Foundation a Level 1: Pureed Nutrition Therapy diet consists of pureed, homogenous, and cohesive foods. Food should be pudding-like. No coarse textures, raw fruits or vegetables, nuts, and so forth are allowed. The diet recommendation is that fresh bananas be served well-mashed. On 4/9/25, at 08:52 AM, during the kitchen task, Surveyor observed R15's breakfast meal being prepared, the toast, omelet and oatmeal were individually pureed and plated for service. The plate was placed on a food service tray which had half of a banana, in the peel, on it. Per R15's meal ticket the banana should be L1/Puree. Surveyor observed the tray being picked up by staff. On 04/09/25, at 09:19 AM, Surveyor interviewed Food Service Manager-D regarding R15's meal ticket reading L1/Puree Banana and the banana served cut in half still in the peel. Food Service Manager-D stated that the banana should have been pureed. On 04/09/25, at 09:38 AM, Surveyor went to R15's room and observed R15 had eaten the pureed toast and a couple bites of the pureed oatmeal. The half of banana was laying on R15's bedside table and R15 was sleeping. On 04/09/25, at 09:39 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-E and asked CNA-E to look at the food served to R15 with the Surveyor. CNA-E stated R15 has a diet of puree but the banana is not. R15's physician order with a start date of 3/18/25 documents L1/Puree texture, Honey consistency, for may have thin soda. & ice cream related to dysphagia . R15's care plan documents at nutritional risk r/t (related to) altered texture diet (pureed, . r/t dysphagia), Wt (weight) gain complicated by having thin liquids. swallowing difficulties r/t dysphagia, edentulous aeb (as evidenced by) altered diet. R15's care plan documents the following pertinent goals: (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Follow RD (Registered Dietician) recommendation and MD (Medical Doctor) orders for diet type and texture Diet as ordered -Monitor tolerance to food textures and fluid consistencies during meals and report increased chewing or swallowing difficulties -Pureed diet with honey thickened liquids. May have cold soda on ice by straw. Pt (patient) to eat & (and) drink sitting upright @ (at) midline (Not leaning to R15's left or right side). Remind R15 small sips, turn head to right with swallow and cough and clean after several sips. On 04/09/25, at 03:01 PM, during the end of day meeting with Director of Nursing-B and Nursing Home Administrator-A, Surveyor relayed the concern of R15's puree diet not being adhered to due to the banana being served in whole form. A Summary Report of Meeting was provided to Surveyor that documented training being completed on 4/9/25, at 10:05 am, by Food Service Manager-D and Dietician-F.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49011 Based on observation, interview, and record review, the Facility did not ensure food was prepared and served in a sanitary manner. This practice affected 1 of 2 residents with a mechanically-altered diet. R15 was served pureed food that was not brought up to the correct temperature to prevent bacteria growth in the danger zone (below 135 degrees F) The [NAME] was observed changing gloves with no handwashing after gloves were removed, before a new pair of gloves were put on. Findings include: The Facility Policy and Procedure titled, Food: Preparation last revised 9/2017, states in part: Policy Statement All foods are prepared in accordance with FDA (Food and Drug Administration) Food Code. Procedures 1. All staff will practice proper hand washing techniques and glove use. 2. Dining Services staff will be responsible for food preparation procedures that avoid contamination by potentially harmful physical, biological, and chemical contamination . 4. The Dining Services Director/Cook(s) will be responsible for food preparation techniques which minimize the amount of time that foods are exposed to temperatures greater than 41 degrees and/or less than 135 degrees, or per state regulation . 11. When hot pureed, ground, or diced food drop into the danger zone (below 135 degrees), the mechanically altered food must be reheated to 165 degrees for 15 seconds if holding for hot service. 12. When reheating, foods will be rapidly heated to 165 degrees for 15 seconds. If the food is not reheated within 2 hours it must be discarded . The Facility Culinary Professionals Training titled, Gloves with no revision or review date, states in part: How to Properly Put On Gloves -Start with properly washed and dried hands -Remove gloves from box by their cuffs (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-While hanging onto the cuff, place your hand in the glove while pushing your hand down while pulling the glove up . **You must remember to always wash your hands in between gloves.** **Gloves do not give you the right to not wash your hands-do not keep them on, reuse them or anything else. Change gloves, wash hands and let's keep our patients/residents and coworkers safe.** 1) On 04/09/25, at 09:15 AM, Surveyor observed Cook-G take the temperatures of individually pureed foods that were just prepared for R15. Cook-G used the temperature probe and took the temperature of the pureed toast, the temperature read 102 degrees. Cook-G proceeded to take the temperatures of the pureed eggs which read 106 degrees and the pureed oatmeal which read 108 degrees. Cook-G then placed the plated food onto a serving tray, put a lid over R15's plate and staff took tray out of kitchen. On 04/09/25, at 09:19 AM, Surveyor interviewed Food Services Manager-D about taking the temperature of food after preparing, before serving to a resident. Food Service Manager-D stated the temperature was done before the food was served. Surveyor stated none of the temperatures reached 135 degrees. On 04/09/25, at 03:01 PM, during the end of day meeting with Director of Nursing-B and Nursing Home Administrator-A, Surveyor relayed the concern of R15's puree diet not being served at a temperature to prevent bacteria growth in the danger zone (below 135 degrees F). 2) While completing the kitchen task, Surveyor observed R15's pureed breakfast meal being prepared. On 04/09/25, at 08:58 AM, Surveyor observed Cook-G remove gloves being worn and put on a new pair with no handwashing being completed before the new pair was put on. On 04/09/25, at 09:06 AM, Surveyor observed Cook-G take gloves off, then at 09:11 AM, Surveyor observed Cook-G put new gloves on with no handwashing between. On 04/09/25, at 09:11 AM, Surveyor observed Cook-G take one glove off and open a drawer to gets out tongs, Cook-G then reapplied the same glove with no handwashing or new glove used. On 04/09/25, at 09:19 AM, Surveyor interviewed Food Services Manager-D about the expectation of handwashing when staff change gloves. Food Services Manager-D stated staff should wash hands before putting gloves on and when changing gloves. Surveyor let Food Services Manager-D know there were several observations of glove changes by Cook-G without handwashing i between. On 04/09/25, at 03:01 PM, during the end of day meeting with Director of Nursing-B and Nursing Home Administrator-A, Surveyor relayed the concern of Cook-G performing glove changes with no handwashing between. A Summary Report of Meeting was provided to Surveyor that documented training being completed on 4/9/25, at 10:05 am, by Food Service Manager-D and Dietician-F.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 22692 Based on staff interview, and record review, the facility did not maintain an effective infection control program under which it investigates, controls, and prevents infections in the facility. * Total infection rates were not calculated accurately and rates of infection for individual infection types were not calculated. Since infection rates were not calculated it was not possible to analyze the data to determine if there was a rise in the prevalence of infections from month to month with a potential to affect 29 of 29 residents. Findings include: 1.) On 4/9/25, at 1:30 PM., Surveyor interviewed Director of Nursing (DON)-B, who is in charge of the infection control program. DON-B indicated she does not calculate individual rates of infection and will count an infection in more than 1 month if it continues to the next month or is chronic. DON-B indicated she does not separate the facility associated infection from the community based infections. On 4/9/25 the facility's monthly infection rate surveillance summary reports from 10/24 to 3/25 were reviewed and did not include calculations for each individual type of infection only the numbers of infections. The total infection rates included community based infections and facility associated infections included in the total rate of infections. The facility's monthly infection surveillance logs from 10/24 to 3/25 were reviewed and infections included in the rates of infection included infections from previous months and residents that have chronic infections due to multiple drug resistant organisms. On 4/9/25, DON-B was asked for the facility policy for calculating infection rates or a standard of practice for which they are calculating infection rates. None was provided. On 4/9/25, at 3:00 PM, Surveyor notified Nursing Home Administrator (NHA)-A and DON-B of the above findings. Additional information was requested if available, however none was provided as to why the facility did not calculate rates of infection for each type of infection and only use new infections/health-care associated infections in their infection rate calculations.