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	02/18/2026

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the Facility did not ensure that residents with a pressure injury or at risk for pressure injuries received necessary treatment and services, consistent with professional standards of practice, to prevent the development of pressure injuries and to promote healing for 2 (R43 & R4) of 3 Residents reviewed for pressure injuries. *R43 is dependent for all cares, requires substantial/maximal assistance with bed mobility and is at risk for developing pressure injuries. On 12/24/2025, the Facility implemented a care plan for R43's risk for pressure injuries with interventions not supportive of R43's needs. On 1/27/2026, R43 developed a Deep Tissue Injury (DTI) (an injury which occurs with prolonged pressure and shear forces) to R43's bilateral heels. On 2/18/2025, R43's right heel DTI almost doubled in size and observations of improper wound treatment were observed in place. *R4 was admitted with pressure injuries to the coccyx and right heel. The pressure injury to the coccyx was not staged appropriately and the pressure injuries were not comprehensively assessed weekly. Findings: 1.) R43 was admitted to the facility on [DATE] after a fall at home resulting in multiple rib fractures. R43 was admitted with diagnoses including multiple fractures (crack or break in a bone) of right side, weakness and dementia (a progressive decline in memory). R43's admission Minimum Data Set (MDS), dated [DATE], indicates R43 has a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition, no rejection of care, taking narcotic pain medication, is dependent on staff for toileting hygiene, shower/bathing, upper/lower body dressing, putting on/taking off footwear, sit to lying, lying to sit at side of bed, sit to stand, chair/bed to chair transfer, toilet transfer, requires substantial/maximal assistance rolling left to right, is at risk for developing pressure injuries and has moisture associated skin damage with application of ointments to other than feet. Surveyor reviewed the Facility provided document, titled Physical Therapy, with a date of service of 12/24/2025 through 1/2/2026 and indicates R43 admitted to the facility after 2 falls at home resulting in rib fractures and traumatic pneumothorax (a partial or complete lung collapse caused by air entering the pleural space due to chest injury). Skilled interventions provided include direct, hands on care with R43 focused on increased strength, range of motion bilateral lower extremities along with trunk for improved functional mobility. R43 was readmitted to the hospital on [DATE] for unrelated medical condition. R43 returned to the (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0686 Level of Harm - Actual harm Residents Affected - Few	facility on 1/6/2026. Surveyor reviewed the Facility provided document, titled readmission Evaluation, dated 1/6/2026, which indicates the following: R43 requires extensive assistance of 1 for bed mobility, requires extensive assist of 1 for transfers and total lift dependent. Scored 17 on a Braden scale, indicating R43 is at risk for skin integrity, with no skin impairments present and is taking narcotic pain medication. A progress note, dated 1/28/2026, at 2:03 AM, in R43's medical record, notes that upon answering R43's call light, blood was noted on the bedsheet from R43's right heel, which appears to have a blood blister. A progress note, dated 1/28/2026, at 2:13 PM, indicates during wound rounds, a DTI to left heel was identified. Recommendations for interventions included -Air Mattress -offloading as tolerated -off loading heel shoes to continue therapy to improve strength and mobility -liquid protein -skin prep three times a day -repositioning every 1-2 hours R43's Pressure Injury Weekly Tracker for R43, dated 1/28/26 documents: Pressure injury 1- right heel- suspected DTI- -8.0 centimeters (cm) x 6.0cm x 0.2cm (length x width x depth) -surface area greater than 24cm2 (l x w) -Tissue Type- epithelial tissue -Skin %- 100% -light bloody drainage -Peri-wound- Pink and normal for ethnic group -Wound edges- distinct, outline clearly visible, attached, even with wound base -Summary- improving -Plan/treatment- monitor in treatment administration record, heel protectors, turn and reposition, treatment as ordered and wound nurse to measure weekly. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Pressure injury 2- left heel- suspected DTI- -6.0 cm x 4.0 cm x 0 -surface area 12.1 – 24.0 cm2 -Tissue Type- closed -no drainage -Peri-wound- Pink and normal for ethnic group -Wound Edges- blank -Summary- first observation, Plan/treatment- monitor in treatment administration record, assess signs/symptoms of infection, float heels, heel lift boot, specialty mattress, pressure reduction device for bed, maintain correct wheelchair position, treatment as ordered, medications as ordered, and wound nurse to measure weekly. Surveyor noted the above wound assessment did not document a wound bed description, wound edges or skin color of wound. Per the State Operation Manual (SOM), the following is the guidance for staging a Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure ulcer. Once a deep tissue injury opens to an ulcer, reclassify the ulcer into the appropriate stage. Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions The Facility provided document, titled Care Plan Report, indicates R43 has an actual DTI to the right and left heel, with interventions of: -Administer treatment per orders, initiated 1/28/2026 -Air Mattress, initiated 1/28/2026 -Diet and supplements per order, initiated 1/28/2026 -Educate resident/representative on wound care procedure. Observe return demonstration until comfort level achieved, initiated 1/28/2026 (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Encourage and assist as needed to turn and reposition; use assistive devices as needed, initiated 1/28/2026 -Enhanced Barrier precautions, initiated 2/6/2026 -Float heels as able, initiated 1/28/2026 -Follow up with doctor as ordered, initiated 1/28/2026 -Report evidence of infection such as purulent drainage, swelling, localized heat, increased pain, etc., notify doctor as needed, initiated 1/28/2026 -Reposition every 1-2 hours and as needed, initiated 1/28/2026 -Reposition every 1-2 hours, encourage to stay off back, initiated 2/11/2026 -Therapy to eval at treat as ordered, initiated 1/28/2026 -Toileting program as indicated, initiated 1/28/2026 -Use pillows and/or positioning devices as needed, initiated 1/28/2026 The Facility provided document, titled Care Plan Report, indicates R43 is at risk for alteration to skin integrity, with interventions of: -Barrier cream to peri area/buttocks as needed, initiated 12/24/2025 -Diet and supplements per order, initiated 1/15/2026 -Encourage to reposition as needed; use assistive devices as needed, initiated 12/24/2025 -Float heels as able, initiated 12/24/2025 -Observe skin condition with daily cares, repost abnormalities, initiated 1/15/2026 -Obtain labs as ordered and notify doctor of results, initiated 1/15/2026 -Podiatric care as needed, initiated 1/15/2026 -Pressure redistributing device to bed/chair, initiated 12/24/2025 -Provide preventative skin care daily, initiated 1/15/2026 -Therapy eval and treat as ordered, initiated 1/15/2026 The Facility provided document, titled Order Summary Report for R43, includes: -Soft boots on when in bed. Every shift, start date 1/28/2026 (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Surveyor noted R43's order for Soft boots on while in bed, is not listed in R43's care plan or the Certified Nursing Assistant (CNA) Kardex. Surveyor noted the following interventions listed on the Pressure Injury Tracker, are not part of R43's care plan or Certified Nursing Assistant (CNA) Kardex: -heel lift boot for R43's left heel -heel protector for R43's right heel -maintain correct wheelchair position R43's Pressure Injury Weekly Tracker for R43, dated 2/4/2026 documents: Pressure injury 1- right heel- suspected DTI- -8.0 cm, x 6.0 cm x 0.2 cm -surface area greater than 24cm2 (l x w) -Tissue Type- granulation tissue -Skin %- 100% -Drainage- bloody -Amount- light -Peri-wound tissue- Pink or normal for ethnic group -Wound Edges- Distinct, outline clearly visible, attached, even with wound base -Summary- improving. -Plan/Treatment- monitor in treatment administration record, assess signs/symptoms of infection, complete nutritional risk, heel protectors, specialty mattress, pressure reduction device for bed, nutrition or hydration intervention to manage skin problems, turning/repositioning, treatment as ordered, and wound nurse to measure weekly. Pressure injury 2- left heel- suspected DTI- -6.0 cm x 4.0 cm x 0 cm -Surface area 12.1 – 24.0 cm2 -Tissue Type- closed -Drainage- none (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Peri-wound tissue- Pink or normal for ethnic group -Wound Edges- blank -Summary- improving -Plan/Treatment- monitor in treatment administration record, assess signs/symptoms of infection, complete nutritional risk, heel lift boot, float heels off bed, specialty mattress, pressure reduction device for bed, maintain correct wheelchair position, treatment as ordered, medications as ordered and wound nurse to measure weekly. Surveyor noted the above wound assessment did not document a wound bed description, wound edges or skin color of wound and that the above interventions were still not listed on R43's skin plan of care. R43 was readmitted to hospital for an unrelated medical condition on 2/7/2026 through 2/11/2026. Surveyor reviewed the Facility provided document, titled readmission Evaluation, dated 2/11/2026 and indicates R43 has impairment to skin which included a right heel unstageable pressure injury and a left heel suspected DTI. R43's Pressure Injury Weekly Tracker for R43, dated 2/11/2026 documents: Pressure injury 1- right heel- unstageable- -5.0 cm x 5.0 cm x depth is blank -Surface area 2.1 – 3.1 cm2 -Tissue Type- necrotic -Drainage- none -Peri-wound tissue- Pink or normal for ethnic group -Wound Edges- Distinct, outline clearly visible, attached, even with wound base -Summary- first observation upon readmission to Facility from hospital. -Plan/Treatment- monitor in treatment administration record, assess signs/symptoms of infection, complete nutritional risk, heel protectors, specialty mattress, pressure reduction device for bed, nutrition or hydration intervention to manage skin problems, turning/repositioning, treatment as ordered, medications as ordered and wound nurse to measure weekly. Pressure injury 2- left heel- suspected DTI, 8.0 cm x 5.0 cm x 0 -Surface area- greater than 24.0 cm2 -Tissue Type- closed (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Drainage- none -Peri-wound tissue- Pink or normal for ethnic group -Wound Edges- blank Summary- improving -Plan/Treatment- monitor in treatment administration record, assess signs/symptoms of infection, complete nutritional risk, heel lift boot, float heels off bed, specialty mattress, pressure reduction device for bed, maintain correct wheelchair position, treatment as ordered, medications as ordered and wound nurse to measure weekly. Surveyor noted the above wound assessment did not document a depth measurement, a wound bed description, wound edges or skin color of wound. Surveyor noted R43's right heel wound had decreased in size but changed in staging from a DTI to an unstageable pressure injury. Surveyor noted that R43's left heel wound had increased in size since returning from the hospital. The Facility provided document, titled Care Plan Report, indicates R43 has an actual DTI to the right and left heel, with interventions of: -Administer treatment per orders, initiated 1/28/2026 -Air Mattress, initiated 1/28/2026 -Diet and supplements per order, initiated 1/28/2026 -Educate resident/representative on wound care procedure. Observe return demonstration until comfort level achieved, initiated 1/28/2026 -Encourage and assist as needed to turn and reposition; use assistive devices as needed, initiated 1/28/2026 -Enhanced Barrier precautions, initiated 2/6/2026 -Float heels as able, initiated 1/28/2026 -Follow up with doctor as ordered, initiated 1/28/2026 -Report evidence of infection such as purulent drainage, swelling, localized heat, increased pain, etc., notify doctor as needed, initiated 1/28/2026 -Reposition every 1-2 hours and as needed, initiated 1/28/2026 -Reposition every 1-2 hours, encourage to stay off back, initiated 2/11/2026 (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Therapy to eval at treat as ordered, initiated 1/28/2026 -Toileting program as indicated, initiated 1/28/2026 -Use pillows and/or positioning devices as needed, initiated 1/28/2026 The Facility provided document, titled Care Plan Report, indicates R43 is at risk for alteration to skin integrity, with interventions of: -Barrier cream to peri area/buttocks as needed, initiated 12/24/2025 -Diet and supplements per order, initiated 1/15/2026 -Encourage to reposition as needed; use assistive devices as needed, initiated 12/24/2025 -Float heels as able, initiated 12/24/2025 -Observe skin condition with daily cares, repost abnormalities, initiated 1/15/2026 -Obtain labs as ordered and notify doctor of results, initiated 1/15/2026 -Podiatric care as needed, initiated 1/15/2026 -Pressure redistributing device to bed/chair, initiated 12/24/2025 -Provide preventative skin care daily, initiated 1/15/2026 -Therapy eval and treat as ordered, initiated 1/15/2026 The Facility provided document, titled Order Summary Report for R43, includes: -Soft boots on when in bed. Every shift, start date 1/28/2026 Surveyor noted R43's order for Soft boots on while in bed, is not listed in R43's care plan or the Certified Nursing Assistant (CNA) Kardex. Surveyor noted, the following interventions listed on the Pressure Injury Tracker, are not part of R43's care plan or Certified Nursing Assistant (CNA) Kardex: -heel lift boot for R43's left heel -heel protector for R43's right heel -maintain correct wheelchair position On 02/18/2026, at 9:10 AM, Surveyor observed Director of Nursing (DON)-B, Licensed Practical Nurse (LPN)-D and Certified Nursing Assistant (CNA)- J provide wound care for R43. Surveyor observed R43 to have only white tape covering R43's bilateral heels. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	DON-B checked R43's order and informed Surveyor that R43 does not have the correct dressings in place for R43's heel wounds and indicated foam dressings should be in place. DON-B measured the wounds, stating them out loud. Surveyor noted the following measurements provided by DON-B: -left heel- measured in cm- 5 x 5.5 x 0 -right heel- measured in cm- 5.5 x 5 x 0 and 3.5 x 3 x 0 Surveyor observed DON-B measure 2 wounds for R43's right heel. Surveyor observed R43's right heel wound, which appears to be in a shape similar to an oval, with a smaller diameter near the center. Surveyor noted the wound to be dark in color compared to R43's skin complexion, appearing dark purple/black, non-blanchable. Surveyor clarified with DON-B if there is two right heel wounds or 1. DON-B indicated she would get back to surveyor with that information but is measuring the right heel as 2 wounds for now. Surveyor asked DON-B to provide Surveyor with a copy of the wound assessment once DON-B has completed it. R43's document titled Order Summary Report indicates an active order with a start date of 2/12/2026 for every day shift: Wash right and left heels with soap and water, pat dry. Left posterior heel apply Betadine, cover with foam dressing. Right posterior heel apply Betadine, cover with foam dressing. Surveyor observed R43 with white tape covering R43's left and right heel wounds prior to the start of wound care, which did not match with R43's prescribed pressure injury treatment. R43's Pressure Injury Weekly Tracker for R43, dated 2/18/2026 documents: Pressure injury 1- right heel- unstageable- -5.5 cm x 5.0 x depth is blank -Surface area- greater than 24.0 cm2 -Tissue Type- necrotic (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Slough- 100% -Drainage- none -Peri-wound tissue- Pink or normal for ethnic group -Wound Edges- Distinct, outline clearly visible, attached, even with wound base Summary- improving. -In the additional interventions/plan section- DON-B indicates the pressure injury contains 2 areas. Actual eschar which is 5.5 cm x 5.0 cm and extended to 3.5 cm x 3.0 cm DTI with a wound clinic appointment on 2/24/2026. Pressure injury 2- left heel- suspected DTI- -5.5 cm x 5.0 cm x 0 -Surface area- greater than 24.0 cm2 -Tissue Type- closed -Drainage- none -Peri-wound tissue- Pink or normal for ethnic group -Wound Edges- Distinct, outline clearly visible, attached, even with wound base -Summary- improving - monitor in treatment administration record, assess signs/symptoms of infection, complete nutritional risk, heel lift boot, float heels off bed, specialty mattress, pressure reduction device for bed, maintain correct wheelchair position, treatment as ordered, medications as ordered and wound nurse to measure weekly. Surveyor noted R43's right heel surface area approximately doubled in size and the depth measurement is blank. Surveyor noted that the wound had progressed from a DTI to unstageable since R43 returned from the hospital. On 02/18/2026, at 1:20 PM, Surveyor interviewed DON-B and VP of Success-C. VP of Success-C indicated R43 appears to have a baseline care plan for skin which was initiated upon admission. DON-B informed Surveyor that DON-B is counting the right heel as 1 wound and will add in the comments an extension of the wound and include the additional measurements. DON-B indicated the treatment will be the same and R43 has a referral for the wound clinic. DON-B informed Surveyor that they discussed therapy, upon discovery of the bilateral heel DTI's, and believed the cause was due to R43 self-propelling in wheelchair excessively using R43's heels. Surveyor noted, no documentation or evidence provided by the Facility to support the Facility addressing R43 using R43's heels to self-propel in R43's wheelchair and/or what interventions the (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Facility took to prevent R43's wound from deteriorating due to this concern. On 02/18/2026, at 1:51 PM, Surveyor interviewed Occupational Therapy Assistant (OTA)-M who indicated, R43 was a moderate/max assist of 2 using a Sara lift with transfers on unit. R43 has significant posterior center of gravity and did self-propel in wheelchair and were working on it in therapy but only with hands. R43's feet were always up on foot pedals and do not believe R43's heel wounds were caused by propelling in wheelchair. OTA-M described the way R43 would stand up and tend to lean back due to prior use of a lift chair at home. This would cause R43's feet to come forward. OTA-M indicated they could not get shoes on R43's feet for a long time due to swelling and would only get to partial standing and then sit. After evaluations, OTA-M would fill out what therapy would want done for R43 and the DON or nursing would add to care plan, indicating therapy does not have access to add to care plans. Surveyor noted, no documentation or evidence provided by the Facility to support the Facility addressing R43 using R43's heels to self-propel in R43's wheelchair and/or what interventions the Facility took to prevent R43's wound from deteriorating due to this concern. On 02/18/2026, at 2:02 PM, Surveyor interviewed NHA-A. Surveyor asked NHA-A what NHA-A's expectations are as to when a residents care plan should become patient centered following a baseline care plan, NHA-A did not respond. Surveyor asked NHA-A what R43's interventions of float heels as able and encourage repositioning mean. NHA-A indicated R43 should be repositioned every 2-3 hours, or more frequently if needed, and wear boots as R43 can tolerate. NHA-A made aware of the above concerns regarding the care and treatment of R43's Facility acquired pressure injuries. NHA-A administrator encouraged Surveyor to speak with the Rehab Director regarding R43. On 02/18/2026, at 2:41 PM, Surveyor interviewed Rehab Director-N. Rehab Director-N indicated that on occasion she would catch R43 using feet to propel across the dining room floor but no more than that and someone was usually pushing R43 in the wheelchair. R43 has a posterior center of gravity causing R43 to bear weight onto R43's heels when trying to stand. R43 was receiving therapy 5 times per week but switched to 3 times per week when Rehab Director-N found out about wounds and was not getting therapy as often. Surveyor asked Rehab Director-N about who is responsible for R43's interventions, Surveyor was informed that Surveyor would have to ask nursing. No additional information was provided. 2.) R4 was admitted to the facility on [DATE] with diagnoses of acute cystitis (inflammation of the bladder), pressure ulcer to the right heel and right buttock, anxiety, depression, and obesity. R4's Significant Change Minimum Data Set (MDS) assessment dated [DATE] documented R4 had moderate cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 12, needed maximum assistance for bed mobility, had a Stage 3 pressure injury on admission, and had an Unstageable pressure injury on admission. R4's Activities of Daily Living (ADL) Care Plan was initiated 12/5/2025 with the intervention of two assist for bed mobility and was revised on 12/26/2025 with assist of two and a sit to stand lift for transfers. R4's At Risk for Alteration in Skin Integrity Care Plan was initiated 12/5/2025 with interventions: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Barrier cream to peri area/buttocks as needed. -Encourage to reposition as needed; use assistive devices as needed. -Float heels as able. -Pressure redistributing device on bed/chair. -Use pillows/positioning devices as needed. R4's Actual Stage 3 Pressure Injury to coccyx; Unstageable Pressure Injury to Right Heel Care Plan was initiated 12/5/2025 with interventions: -Administer treatment per physician orders. -Air mattress/cushion on bed/wheelchair. -Encourage and assist as needed to turn and reposition; use assistive devices as needed. -Float heels as able. -Follow up care with physician as ordered. -Reposition every 1-2 hours; encourage to stay off of back; protective boots on at all times as tolerated. (added to Care Plan 12/6/2025) -Use pillows and/or positioning devices as needed. -Vicair cushion (name brand of cushion used for pressure reducing characteristics). (added to Care Plan 12/6/2025) On 12/5/2025 on the admission Evaluation, Registered Nurse (RN)-L documented R4 had a Stage 2 pressure injury to the right buttock measuring 2 cm x 2 cm with no depth or wound description documented, a Stage 2 pressure injury to the left buttock measuring 0.5 cm x 1 cm with no depth or wound description documented, and an Unstageable pressure injury to the right heel measuring 4 cm x 2 cm with no depth or wound description documented. COCCYX PRESSURE INJURY On 12/5/2025 on the Pressure Injury Weekly Tracker form, RN-L documented R4 had a Stage 3 pressure injury to the coccyx measuring 3.5 cm x 2 cm x 0 cm with 100% necrotic slough and no drainage with exposed muscle. RN-L documented in the narrative section of the form the left buttock had an open area that measured 0.5 cm x 1 cm and the right buttock had an open area that measured 2 cm x 2 cm. Surveyor noted the two wounds were measured as one wound with both exposed muscle and 100% necrotic tissue covering the wound base; the wound would be classified as Unstageable or Stage 4 depending on the characteristics of the wound, not a Stage 3. On 12/6/2025 on the Pressure Injury Weekly Tracker form, Director of Nursing (DON)-B documented R4's coccyx Stage 3 pressure injury measured 4 cm x 3 cm x 0.3 cm with 100% necrotic slough and no (continued on next page)

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	drainage. This was DON-B's initial observation of R4's wound. DON-B did not document the wound had two separate open areas. Surveyor noted R4's coccyx pressure injury was inaccurately staged as a Stage 3 pressure injury with 70% to 100% necrotic tissue documented weekly from admission through 1/28/2026. On 2/4/2026, R4's coccyx pressure injury was not comprehensively assessed or documented. RIGHT HEEL PRESSURE INJURY On 12/5/2025 on the Pressure Injury Weekly Tracker form, RN-L documented R4 had an Unstageable pressure injury to the right heel measuring 4 cm x 2 cm x 0 cm with 100% necrotic tissue and no drainage. On 12/6/2025 on the Pressure Injury Weekly Tracker form, DON-B documented R4's right heel Unstageable pressure injury measured 4 cm x 2.5 cm x 0 cm with 100% necrotic tissue, no drainage, and loose eschar. This was DON-B's initial observation of R4's wound. On 2/4/2026, R4's right heel pressure injury was not comprehensively assessed or documented. On 2/16/2026 at 10:31 AM, Surveyor observed R4 sitting in a wheelchair in R4's room. R4 had a heel boot on the right foot. R4 had an air mattress on the bed and six pillows piled on at the head of the bed. Surveyor asked R4 about the pillows on the bed. R4 stated R4 had a sore on the heel of the right foot, and the staff use the pillows to keep the foot up off the bed. R4 stated R4 had a sore on the back, too, that the nursing staff puts a dressing on. In an interview on 2/17/2026 at 1:51 PM, Surveyor asked Licensed Practical Nurse (LPN)-D if R4 is seen by a wound physician for the pressure injuries. LPN-D stated R4 goes to a wound clinic. Surveyor asked how often R4 was seen at the wound clinic. LPN-D stated that it depends on when the wound clinic wants to see R4, not every week but maybe every other week or once a month. Surveyor reviewed the wound clinic consult sheets. R4 was seen at the wound clinic on 12/17/2025, 1/7/2026, and 2/4/2026. The consult sheets did not document an assessment of the wounds. On 2/18/2026 at 7:37 AM, Surveyor accompanied LPN-D and DON-B to provide wound care to R4. R4 had a circular foam ring around the right ankle to keep the heel from touching the bed. R4 rolled to the left independently to provide LPN-D access to the coccyx wound. No dressing was in place to the wound. DON-B did a comprehensive assessment of the wound. The Stage 3 coccyx wound measured 1.5 cm x 1.5 cm x 0.5 cm with 70% granulation tissue and 30% slough. The treatment was applied to the wound. The right heel dressing was dated 2/16/2026 which was accurate because the wound treatment was every Monday, Wednesday, and Friday. DON-B did a comprehensive assessment of the wound. The Unstageable right heel wound measured 3.5 cm x 2.5 cm x 0 cm. The wound was a large open area with eschar in the center. The treatment was applied to the wound. DON-B stated R4 goes to the wound clinic, and the treatments are done as ordered by the wound clinic. In an interview on 2/18/2026 at 9:12 AM, Surveyor shared with DON-B the documentation on 12/5/2025 by RN-L of R4's coccyx pressure injury. RN-L documented R4 had two open areas, one to the right buttock and one to the left buttock and had muscle showing. DON-B stated DON-B did R4's assessment the next day and believed DON-B's measurements were correct. Surveyor showed DON-B (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	the documentation by DON-B of the coccyx wound having 100% slough or necrotic tissue and staging the wound at a Stage 3. DON-B stated DON-B should have documented that as Unstageable. Surveyor asked DON-B who does the comprehensive assessment of wounds when DON-B is not working that day. DON-B stated the RN on the unit will do the measurements and DON-B will look at the wound the next day. Surveyor shared with DON-B the concern R4's coccyx and right heel pressure injuries were not comprehensively assessed on 2/4/2026. DON-B stated R4 may have been at the wound clinic that day and would get more information to Surveyor regarding that date. On 2/18/2026 at 9:29 AM, DON-B told Surveyor R4 went to the wound clinic on 2/4/2026 so DON-B did not do an assessment that day. DON-B stated since R4 went to the wound clinic, they looked at the wound and put a clean dressing on it. Surveyor shared the concern with DON-B that there was nothing in the wound clinic consult notes that documented an assessment with measurements or description of the wound. DON-B agreed the wound should have been assessed by DON-B on 2/4/2026. On 2/18/2026 at 11:06AM, Surveyor shared with Nursing Home Administrator (NHA)-A the concerns R4's coccyx pressure injury was not accurately staged, and the coccyx and right heel pressure injuries were not comprehensively assessed and documented on 2/4/2026. No additional information was provided at that time.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on record review and interview, the facility did not ensure that it did not employ individuals who were found guilty of abuse, neglect, exploitation or mistreatment by failing to conduct a background information disclosure every four years for 1 (Social Services (SS)-G) of 8 facility staff reviewed.This deficient practice has the potential to affect residents who may receive care from SS-G. Findings include:The facility policy titled Abuse, Neglect, and Exploitation with implemented date 3/2018 and revised date 7/15/2022 documents:Policy: it is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Screening . potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. background, reference, and credentials' checks shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers, and consultants. Background checks, including re-checks, will be completed consistent with applicable state laws and regulation. Responsibility of performance of compliance checks on contracted temporary staff will be established via contractual agreement. screenings may be conducted by the facility itself, third-party agency or academic institution. the facility will maintain documentation of proof that the screening occurred. On 2/16/26, Surveyor requested employee files for 8 randomly selected employees from Nursing Home Administrator (NHA)-A. On 2/17/26 at 8:11 AM, Surveyor reviewed facility employee files to ensure completed background checks, including background information disclosure (BID) with Department of Justice (DOJ) response and Integrated Background Information system (IBIS) letter, which are to be completed every four years by State of Wisconsin regulation. Surveyor reviewed the employee file for SS-G, with hire date documented as 12/1/2016, and located a BID form, DOJ response, and IBIS letter all dated 2/16/26. Surveyor notes this is the date of the start of the survey, and the date Surveyor requested SS-G's BID from NHA-A. In an interview on 2/17/26 at 8:40 AM, NHA-A stated SS-G's previous BID with DOJ response and IBIS letter was completed in 2021, so a new one was completed yesterday 2/16/26. Surveyor requested SS-G's previous BID from 2021. NHA-A provided Surveyor with SS-G's previous BID, DOJ response, and IBIS letter, which all document a completed date of 4/26/2021. On 2/17/26 at 10:18 AM, Surveyor shared concern with NHA-A that SS-G did not have a BID, DOJ response, and IBIS letter completed every four years per state regulation. NHA-A stated NHA-A understood the four-year timeline was missed for SS-G, and no other information was provided.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility did not ensure medications were stored in accordance with facility policy and procedures for 1 of 1medication room reviewed for medication storage.*On 2/17/2026, at 7:29 AM, Surveyor observed the door to the medication room wide open, and the door propped open with a doorstop. Surveyor noted an open plastic bin with medication packages inside and easily accessible.*On 02/17/2026, at 1:52 PM, Surveyor observed the vaccine refrigerator to read 30 degrees Fahrenheit with frost build up on the inside of refrigerator.Findings:The Facility's policy, titled Medication Storage dated 1/2025, indicates the following, . 3. In order to limit access to prescription medications, only licensed nurses, pharmacy staff, and those lawfully authorized to administer medications (such as medication aids) are allowed access to medication carts. Medication rooms, cabinets and medication supplies should remained locked when not in use or attended to by persons with authorized access.13. The refrigerator should be kept clean and frost-free. On 02/17/2026, at 7:29 AM, Surveyor observed medication pass with Licensed Practical Nurse (LPN)-K. During medication pass, LPN-K went to the medication room to retrieve the medication. Surveyor followed LPN-K and noted the door to the medication room to already be wide open and was held open with a doorstop. LPN-K closed the door and informed Surveyor that the door should not be left open and she is unsure who left it like that. LPN-K indicated that only the nurses and the Director of Nursing (DON) have keys to the medication room.On 02/17/2026, at 1:52 PM, Surveyor asked LPN-K to tour the medication room with Surveyor. Surveyor noted the door to the medication room was now closed and LPN-K had to unlock the door using her key. Surveyor observed the vaccine fridge with LPN-K. LPN-K and Surveyor noted the refrigerator to be at 30 degrees Fahrenheit with frost build up. LPN-K was unsure what the ranges should be and that DON-B would be a good person to ask. Surveyor encouraged LPN-K to follow up and clarify with administration.On 02/17/2026, at 3:03 PM, during the daily exit conference, Surveyor informed the Nursing Home Administrator (NHA)-A and DON-B of the above concerns.On 02/18/2026, at 7:51 AM, NHA-A informed Surveyor that after they were notified of the concern, they have added ranges to the temperature log sheets and will be reaching out to pharmacy regarding the vaccines that are in the fridge.On 02/18/2026, at 8:05 AM, DON-B and Surveyor went to check the vaccine refrigerator in the medication room. Surveyor noted the medication room door to be closed and locked. DON-B used a key to access the medication room. DON-B and Surveyor noted there to still be frost build up in the vaccine refrigerator and the refrigerator reading at 40 degrees Fahrenheit.On 2/18/2026, at 10:57 AM, VP of Success-C provided Surveyor with the pharmacy consult regarding the vaccine refrigerator and indicated the flu vaccines have now been discarded.Surveyor reviewed the Facility provided email from the pharmacy, dated 2/18/2026 at 10:41 AM. Surveyor noted the email indicates, in part, that the influenza vaccines (Fluad) are likely to be affected by potential freezing and should be discarded.No additional information was provided.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not complete a significant change in status Minimum Data Set (MDS) assessment for 1 (R30) of 1 resident reviewed for hospice. R30 enrolled in hospice services on 12/26/25. The facility did not complete a Significant Change MDS until 1/26/26. Findings include:The Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual version 1.19.1 dated 10/2024 documents:A Significant Change in Status Assessment (SCSA) is required to be performed when a terminally ill resident enrolls in a hospice program . the Assessment Reference Date (ARD) must be within 14 days from the effective date of the hospice election. R30 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, dementia, anxiety, depression, and congestive heart failure. A progress note in R30's electronic health record (EHR) dated 12/29/25 at 9:15 AM documents: [R30] was evaluated by hospice on 12/26/25 and was re-admitted on to services that day. Surveyor located a SCSA MDS dated [DATE] in R30's EHR. On 2/17/26 at 1:24 PM, Surveyor interviewed MDS Licensed Practical Nurse (LPN)-E who stated team leaders at the facility inform MDS LPN-E of any significant changes in residents daily, and the interdisciplinary team (IDT) would determine if a significant change MDS needs to be completed. MDS LPN-E stated if a resident enrolls in hospice, a significant change MDS would be completed within 7 days, and the ARD on the MDS should capture the day of admission on to hospice services. Surveyor shared concern with MDS LPN-E that R30 enrolled in hospice services on 12/26/25 and did not have a SCSA MDS completed until 1/26/26. MDS LPN-E stated R30's significant change MDS was late because MDS LPN-E was not notified that R30 was enrolled in hospice on 12/26/25, as MDS LPN-E was off during that time and a different MDS coordinator was covering the facility, and it got missed. On 2/17/26 at 3:03 PM, Surveyor informed Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, and [NAME] President of Success-C that R30 admitted on to hospice services on 12/26/25 but did not have a significant change MDS completed until 1/26/26. No additional information was provided.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not transmit a discharge assessment within 7 days after completion for 1 (R19) of 1 residents reviewed for late Minimum Data Set (MDS) assessments.*R19 discharged to the hospital on 8/30/2025. The Discharge Return Anticipated (DCRA) MDS assessment dated [DATE] was completed but not submitted.Findings include:1.) R19 was admitted to the facility on [DATE] after hospitalization for acute on chronic neck pain. On 8/30/2025 at 11:10 AM in the progress notes, nursing documented R19 was in bed with complaints of pain to the neck and back. R19's family indicated R19 was not responding as they normally would. R19's vital signs were abnormal, R19 was placed on 3 liters of oxygen and transferred to the hospital.R19's DCRA MDS assessment dated [DATE] was completed. The assessment was not submitted.In an interview on 2/17/2026 at 1:24 PM, Surveyor shared with MDS Licensed Practical Nurse (LPN)-E the concern R19's DCRA assessment dated [DATE] had not been submitted as documented in R19's medical record. MDS LPN-E reviewed R19's medical record and agreed the assessment was coded as completed but not accepted. MDS LPN-E reviewed four batches of assessments that had been submitted in that timeframe and R19's DCRA assessment was not included in any of the batches. MDS LPN-E called the supervisor [NAME] President of Clinical Reimbursement (VP of CR)-F to explain Surveyor's concern with R19's DCRA assessment. MDS LPN-E stated VP of CR-F agreed the assessment had not been submitted and would submit it at that time.On 2/17/2026 at 3:03 PM, Surveyor informed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B the concern R19's DCRA assessment dated [DATE] had not been submitted after completion. NHA-A stated MDS LPN-E had discussed this with NHA-A and understood that it had been missed.No additional information was provided.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility did not ensure residents with hearing impairment received proper treatment and assistive devices to maintain hearing abilities for 1 of 1 (R2) residents reviewed for hearing.* Surveyor observed R2 to be very hard of hearing and not wearing hearing aids. According to R2's most recent audiology consult, and R2's annual Minimum Data Set (MDS), R2 uses hearing aids. The facility failed to ensure R2 received treatment and assistive devices to maintain hearing abilities. Findings include:R2 was admitted to the facility on [DATE] with a primary diagnosis of Chronic Obstructive Pulmonary Disease (COPD) (a progressive lung disease with long term breathing problems).R2's Annual Minimum Data Set (MDS), dated [DATE], documents a Brief Interview for Mental Status (BIMS) score of 15 indicating R2 is cognitively intact, has adequate hearing and uses a hearing aid.On 02/16/2026, at 9:52 AM, Surveyor interviewed R2. Surveyor noted R2 to be very hard of hearing. R2 indicated that R2 has hearing aids but they disappeared. R2 informed Surveyor that R2 followed up about R2's hearing aids to a staff member and was told they were following up with Veterans Hospital regarding R2's hearing aids.Surveyor reviewed the Facility provided document, titled Consultation/Clinic Referral, dated 6/11/2024 and indicated R2 has bilateral hearing loss with the following recommendations: Microphones on hearing aids should be brushed daily and the wax guard needs to be changed at least once per month in the left hearing aid, or as needed.Surveyor reviewed the Facility provided document, titled Order Summary Report for R2 and noted there are no orders regarding R2's hearing aids.Surveyor reviewed the Facility provided document, titled Care Plan Report for R2 and noted a focus area for R2's independent activities with an intervention of speak into left ear as this is the better ear initiated 2/2/2026.On 02/17/2026, at 11:32 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-H. CNA-H indicated R2 does use hearing aids but they are in the process of getting fixed. CNA-H was not sure where the hearing aids are in the process and encouraged Surveyor to follow up with R2's Hospice Nurse.On 02/17/2026, at 11:35 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-D. LPN-D indicated one of R2's hearing aids do not work. R2 is on hospice, and the Hospice Nurse is working on getting R2's hearing aids replaced. LPN-D informed Surveyor that R2's hearing aid has been broken for maybe 6 months but R2 does not complain about it.On 02/17/2026, at 12:31 PM, Surveyor interviewed Director of Nursing (DON)-B and VP of Success-C. DON-B informed Surveyor that a request was called into to VA audiology regarding R2's hearing aids and will get back to surveyor regarding this. Surveyor asked DON-B if R2 should be care planned to have hearing aids. DON-B indicated R2 has a care plan under Activities but should have a care plan indicating R2 has hearing aids and should have a care plan in place, which nursing should implement. VP of success-C indicates the care plan for R2's hearing is appropriate for activities but doesn't clarify, with or without hearing aids and if R2 has hearing aids, that should be in the care plan.On 02/17/2026, at 12:39 PM, Surveyor interviewed MDS Coordinator-E. MDS Coordinator-E indicates that R2's annual MDS, dated [DATE], has hearing aids for R2 but believes the hearing aids broke and thinks family took them home. MDS Coordinator-E informed Surveyor it would trigger under the communication Care Area Assessment (CAA) but R2 does not have current communication care plan. MDS Coordinator-E was out during and someone else was doing the MDS during that time. If something triggers or is missing and it doesn't pull up on care plan the system gives an opportunity to use what pops up and personalize it. The person who did MDS at that time would have been responsible for implementing triggered CAAs for R2. On 02/17/2026, at 1:34 PM, DON-B and Social Services-G informed Surveyor that they found 2 pairs of hearing aids in R2's room. They replaced the batteries and R2 can hear better now and is able to respond better to staff.On 02/17/2026, at 1:49 PM, MDS Coordinator-E informed Surveyor that R2's care plan has now been updated to include R2's communication need.On 02/17/2026, at 3:03 PM, Surveyor informed NHA-A and DON-B of the above findings. No additional information was provided.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility did not always ensure that 1 out of 1 residents (R6) reviewed for urinary incontinence received the necessary care and services to maintain or restore bladder incontinence. R6 experienced a decline from frequently incontinent of urine to always being incontinent of urine and the facility did not implement interventions in place to help restore R6's urinary continence. This is evidenced by: R6 was admitted to the facility on [DATE] with diagnosis that included Nontraumatic intracerebral hemorrhage, epilepsy, dementia, mood disorder, hypertension, hyperlipidemia and unspecified psychosis.R6's most recent annual MDS (Minimum Data Set) dated 4/19/25 documents that R6 is frequently incontinent of urine and a trial of a toileting program, prompted voiding or bladder training has not been attempted.R6's Urinary Incontinence and Indwelling Catheter CAA (Care Area Assessment), dated 4/19/25, was triggered r/t (related to) need for assistance with toileting impaired mobility dementia and incontinence. The CAA questions if urinary incontinence will be addressed on care plan. The facility answered yes. The objective was listed to have improvement and avoid complications. R6 requires moderate assistance with toileting and is occasionally incontinent of bladder. Therapy is working with R6 to improve toileting function. Goal is to ensure R6 will be dry, clean odor free and comfortable.A review of R6's quarterly MDS, dated [DATE] documents that R6 is now always incontinent of urine and there is no toileting program in place.R6's most recent quarterly MDS dated [DATE] documents that R6 is always incontinent of urine and in addition, no toileting program for bladder is documented. A review of R6's individual plan of care notes that R6 has incontinence due to: cognitive deficit secondary to neurological deficit, decreased mobility. Interventions include: Will attain/maintain continence, based upon usual voiding pattern . Provide assistance with toileting as needed. Report changes in skin integrity found during daily care Report S&S of UTI such as flank pain, c/o burning/pain, fever, hematuria, change in mental status, etc.R6 experienced a decline in his urinary incontinence from 4/19/25 to 10/20/25 MDS assessments. The plan of care did not include individualized interventions to help R6 attain urinary incontinence, including trial voiding patterns.The Certified Nursing Assistant (CNA) care card did not document any information/ interventions for R6's bladder incontinence. On 2/17/26, Surveyor asked to review the most recent bowel and bladder assessment for R6. A copy of the Quarterly Clinical Review dated 1/17/26 was provided by Administrator- A on 2/18/26 at 8:00 AM. Section J- Bladder/ Bowel documents that R6 is incontinent of bladder and there is no change in this status since last assessment. The assessment asks how long R6 has been incontinent of bladder- answered unknown. How often is R6 wet? Answer: 1-2 x daily during day and nighttime. The assessment documents that R6 is continent of stool and there is no change in bowel incontinence status since the last assessment. Bowel pattern is normal formed stool. This section was completed by a Licensed Practical Nurse on 1/17/26. 2/18/26 at 12:10 PM, Surveyor conducted an interview with DON (Director of Nursing) - B regarding R6's decline in urinary incontinence. DON- B was unable to provide any additional information regarding the assessments for bladder for R6. Surveyor shared concerns regarding R6's decline and that the plan of care is not individualized and does not address type of incontinence and interventions to maintain continence. No additional information was provided.

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	02/18/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not maintain an infection prevention and control program designed to reduce the transmission of disease and infection for 1 (R3) of 12 residents observed. During observation of catheter care for R3, certified nursing assistant (CNA)-I did not perform appropriate hand hygiene or wear a gown when enhanced barrier precautions (EBP) were in place for R3.Findings include:The facility's policy titled Enhanced Barrier Precautions with implemented date 3/25/24 and revised date 8/8/24 documents: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms (MDROs).All staff receive training on enhanced barrier precautions and the definition of high-contact resident care activities upon hire and at least annually . all licensed nursing staff receive training on high-contact care activities and common organisms that require enhanced barrier precautions . An order for enhanced barrier precautions . will be initiated for residents with any of the following: . indwelling medical devices (e.g., . urinary catheters.) even if the resident is not known to be infected or colonized with a MDRO. PPE (personal protective equipment) for enhanced barrier precautions is only necessary when performing high-contact care activities . High-contact resident care activities include: . device care or use: . urinary catheters . Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until . discontinuation of the indwelling medical device that placed them at higher risk. The facility's policy titled Hand Hygiene with review date 11/2/2022 documents: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. the use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves.R3 admitted to the facility 1/23/26 with diagnoses including chronic kidney disease with heart failure (long term weakness of the kidneys and heart), retention of urine (inability to fully empty the bladder resulting in urine buildup), and benign prostatic hyperplasia with lower urinary tract symptoms (an enlarged prostate causing blockage of the flow of urine).R3's admission Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition for R3. The MDS documents that R3 is dependent for toileting hygiene and that R3 has an indwelling urinary catheter. R3's Care Area Assessment (CAA) for Urinary Incontinence and Indwelling Catheter dated 1/29/26 documents [R3] has an indwelling foley catheter related to urinary retention. Staff provide routine catheter care and observe for any changes in urine output or appearance . Proceed to care plan. R3's indwelling urinary catheter care plan documents the following interventions with implemented date 1/27/26:-enhanced barrier precautions-change urinary collection bag as neededR3's physician order dated 1/23/26 documents: Catheter care every shift and as needed.R3's physician order dated 1/30/26 documents enhanced barrier precautions due to Foley catheter every shift. On 2/17/26 at 8:43 AM, Surveyor observed an Enhanced Barrier Precautions sign posted on R3's door. The sign documents: Everyone must: Clean their hands, including before entering and when leaving the room. Providers and staff must also: wear gloves and a gown for the following high-contact resident care activities. device care or use: . urinary catheter On 2/18/26 at 8:13 AM, Surveyor observed CNA-I complete catheter care for R3. Surveyor observed CNA-I exit R3's room to obtain alcohol wipes, then CNA-I returned to R3's room and donned gloves without performing hand hygiene. Surveyor observed CNA-I complete the process of emptying R3's catheter without donning a gown. On 2/18/26 at 8:25 AM, Surveyor shared concern with CNA-I that Surveyor did not observe CNA-I perform hand hygiene prior to donning gloves, and Surveyor did not observe CNA-I wear a gown while providing catheter cares to R3. CNA-I replied CNA-I was not aware a gown was supposed to be worn. In an interview on 2/18/26 at 9:01 AM with Licensed Practical Nurse (LPN)-D, LPN-D stated a resident who has a catheter should be on enhanced barrier precautions. LPN-D stated staff would be (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	expected to wear a gown and gloves when performing catheter care for a resident. In an interview on 2/18/26 at 9:12 AM with Director of Nursing (DON)-B, DON-B stated a CNA should wear a gown and gloves when doing catheter care and follow enhanced barrier precautions. Surveyor shared concern with DON-B and [NAME] President of Success-C of observations of CNA-I not performing hand hygiene prior to donning gloves and not wearing a gown when performing catheter care for R3. On 2/18/26 at 10:37 AM, Surveyor informed Nursing Home Administrator (NHA)-A of observations of CNA-I not performing hand hygiene prior to donning gloves and not wearing a gown when performing catheter care for R3. No additional information was provided.