STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525526	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chi Franciscan Villa	3601 S Chicago Ave South Milwaukee, WI 53172

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility did not ensure that 1 (R7) of 7 residents reviewed was treated with respect and dignity.On 2/17/26, at 9:58 AM, Surveyor observed R7 being wheeled down the hallway in a shower chair to the shower room wearing a hospital gown with R7's left hip and side of buttocks exposed.Findings include:The facility's policy titled, Dignity, not dated, documents the following:Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem.Residents are treated with dignity and respect at all times.Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.R7 was admitted to the facility on [DATE], with diagnoses that include Congestive Heart Failure (weakened heart muscle), lymphedema (chronic buildup of fluid in the arms or legs causing swelling), morbid obesity, Peripheral Vascular Disease (PVD) (circulation disorder), and history of falls. R7's Quarterly Minimum Data Set (MDS) dated [DATE], documents R7 requires partial/moderate assistance with showering and supervision from staff with tub/shower transfers. R7 requires set up assistance with ambulating 10 feet. R7 was documented as having a Brief Interview of Mental Status (BIMS) score of 14, indicating R7 is cognitively intact.R7's care plan dated 6/4/25 documents:R7 has an Activities of Daily Living (ADL) self-care performance deficit related to pain, increased weakness, decreased mobility, Obstructive Sleep Apnea (OSA), and lack of motivation (dated 6/6/25, last revised 10/16/25).Interventions include:Ambulation: 5 feet with 4 wheeled walker and minimal assist with one person (created on 6/6/25, last revised 10/16/25).Transfer: Assist R7 with one person and a 4 wheeled walker. R7 requires partial to moderate assistance (dated 6/6/25, last revised 10/16/25).Dressing: R7 requires supervision or touching assistance for upper body dressing. R7 requires substantial to maximal assistance by one staff member for lower body dressing (dated 6/6/25, last revised 10/16/25).Bathing: R7 requires partial to moderate assistance on staff to provide a bath as necessary (dated 6/6/25, last revised 10/16/25).Bathing: Provide R7 with a sponge bath when a full bath or shower cannot be tolerated (dated 6/6/25, last revised 10/16/25).On 2/17/26, at 9:58 AM, Surveyor observed Certified Nursing Assistant (CNA)-C wheeling R7 down the South hallway, past the main entrance, and halfway down the North hallway to the shower room. Surveyor observed R7 wearing a hospital gown, sitting in a shower chair with R7's left hip and the side of R7's buttocks exposed.On 2/17/26, at 10:24 AM, Surveyor interviewed R7 who states she was not happy that R7's skin was exposed while being wheeled down the North and South hallway, past the main entrance to get a shower. R7 stated that R7 did not know skin was exposed and R7 states R7 is not an exhibitionist.On 2/17/26, at 3:14 PM, Surveyor notified Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B of dignity concerns listed above. NHA-A and DON-B acknowledged concerns. No additional information was provided.

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights, ensuring that all written grievance decisions include the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, and any corrective action taken or to be taken by the facility as a result of the grievance for 1 of 2 (R4) residents reviewed for grievances.R4's family filed a grievance on 8/14/25. There was no evidence of follow-up or resolution of the grievance with R4's family.Findings include:R4 admitted to the facility on [DATE] and has diagnoses that include anoxic brain damage, acute respiratory failure with hypoxia, tracheostomy and gastrostomy status, morbid obesity, congestive heart failure, major depressive disorder and anxiety.R4's Brief Interview for Mental Status (BIMS) documented a staff assessed score of 99. Resident comatose.The facility policy titled Resident and Family Grievances dated last approved 2/11/26 documents (in part):It is the policy of this facility to support each resident's and family member's right to voice grievances without discrimination, reprisal or fear of discrimination or reprisal. 1. The administrator has been designated as the Grievance Official with the social services representative as backup designee.2. The Grievance Official is responsible for overseeing the grievance process; receiving and tracking grievances through to their conclusion; leading any necessary investigations by the facility; and issuing written grievance decisions to the resident.4. A resident or family member may voice grievances with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and other residents, and other concerns regarding their LTC (Long Term Care) facility stay.10. Procedure:b. The staff member receiving the grievance will record the nature and specifics of the grievance on the designated grievance form.i. Take any immediate action needed to prevent further potential violations of any resident right.d. The Grievance official will take steps to resolve the grievance and record information about the grievance and those actions, on the grievance form.ii. All staff involved in the grievance investigation or resolution should make prompt efforts to resolve the grievance and return the form to the grievance official. Prompt effort include the acknowledgement of the complaint/grievance and actively working toward a resolution of that complaint/grievance.g. In accordance with the resident's right to obtain a written decision, the Grievance Official will issue a written decision on the grievance to the resident or representative at the conclusion of the investigation. The written decision will include at a minimum: The date received, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the concern(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance and the date the written decision was issued.While reviewing the facility grievance log, Surveyor identified a grievance filed by R4's family (Guardian) on 8/14/25. The facility provided Surveyor a copy of the grievance which documented:Date: 8/14/25 - Family voiced concerns re (regarding): Cares, not being turned as frequently as she should be, feces on sheet and resident not being checked on as often as they would like and they think the trach is infected. Follow up/Resolution: SW (Social Worker) and DON (Director of Nursing) met with (Guardian). At this time, they wanted resident to be checked at Froedtert hospital to be sure her trach was not infected. Resolution: Was the concern/grievance resolved? X next to Yes, describe. Family satisfied with plan. Signed by DON on 8/14/25.On 2/16/26 at 3:00 PM, Surveyor asked DON-B if she had any information as to what (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the follow up or resolution of the grievance filed on 8/14/25 was. DON-B stated, That was the old DON, I don't know. I can't find any other information or documentation related to the grievance.On 2/17/26 at 9:30 AM, Surveyor spoke with R4's Guardian who reported she still has the same concerns: R4 is not turned and repositioned, does not get checked on often, is never wearing her boots and is getting bed sores. R4's Guardian reported there was no follow up or plan after the grievance was filed in August, No-one addressed or changed anything.On 2/18/26 Nursing Home Administrator (NHA)-A and DON-B were notified of concern regarding grievances. No additional information was provided.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act, the facility did not report 1 of 1 allegations of misappropriation to the State Survey Agency during the required timeframe.R1's spouse reported to the facility on [DATE] that R1's wedding ring was missing. The wife contacted the police department 12/3/25. This was delayed in being reported to the State Survey Agency until 12/9/25.Findings include:The Facility Policy titled Abuse, Neglect, and Exploitation, effective 5/22/25, documents (in part):IV. Identification of Abuse, Neglect and Exploitation.B. Possible indicators of abuse include, but are not limited to4. Resident reports of theft of property, or missing property.R1 was admitted to the facility on [DATE] with pertinent diagnoses that include Alzheimer's disease (a progressive, neurodegenerative brain disorder and the most common cause of dementia, characterized by memory loss, cognitive decline, and behavioral changes), delirium (an acute, fluctuating disturbance in attention, awareness, and cognition that develops rapidly (hours to days), often caused by underlying medical conditions, infections, or medication side effects), and chronic kidney disease stage 3B (kidneys are moderately damaged, filtering at 30-59% capacity).R1's Admission/Medicare 5 day Minimum Data Set (MDS) with an assessment reference date of 11/30/25, documents no Brief Interview for Mental Status (BIMS) being completed. R1 is coded as rarely/never understood and rarely/never understands others. The MDS documents that R1 was assessed to have behaviors of verbal behavioral symptoms directed toward others that occurred 1-3 days of the look back period. R1 was assessed to have other behavioral symptoms not directed towards others 1-3 days of the look back period.R1's wife called the facility on 12/2/25 and reported that R1's wedding ring was missing. The wedding ring was not with R1's belongings. Facility staff who took the call completed a Resident/Family Concern/Grievance Report form.R1's wife visited the South Milwaukee Police Department on 12/3/25 and reported that she contacted facility and spoke with admission Director who stated they did not have the ring. She believes she last saw the ring on R1's finger on Sunday, November 30th. She described the ring as a white gold men's wedding ring with diamonds.On 2/17/26, at 1:00pm, Surveyor interviewed Nursing Home Administrator (NHA)-A about R1's wife filing a grievance on 12/2/25 that R1's wedding ring was missing. R1's wife then reported this to the police on 12/3/25. Surveyor stated that the facility was informed twice that R1's wedding ring was missing and asked why R1's missing ring was not reported to the State Survey Agency. NHA-A replied that R1's wife never indicated it was stolen, just misplaced.On 2/17/26, at 3:07pm, Surveyor informed NHA-A of the concern related to R1's wife reporting the wedding ring missing and this qualifies as misappropriation and should have been reported on 12/2/25 to the State Survey Agency.On 2/18/26, at 10:48am, Surveyor spoke with Director of Nursing (DON)-B and stated that there is a concern that R1's missing wedding ring was not reported to the State Survey Agency in a timely manner.No additional information was provided regarding R1's allegation of misappropriation of the missing wedding ring's delay in being reported to the State Survey Agency.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, the facility did not develop and implement a comprehensive person-centered care plan for each resident to meet a resident's medical, nursing, mental and psychosocial needs for 1 of 9 (R5) residents reviewed. R5 has been sent to the hospital repeatedly for behavior of pulling out her own tracheostomy tube. A care plan with interventions for this behavior was not developed or implemented. In addition, tracheostomy care and treatment are not included in the Facility Assessment.Findings include:R5 admitted to the facility on [DATE] and has diagnoses that include chronic respiratory failure, tracheostomy (trach) status, laryngeal hypoplasia, epilepsy, anxiety disorder, obesity, functional quadriplegia, dysphagia and type 2 diabetes mellitus.The facility policy titled Care Plan Revisions Upon Status Change dated 5/22/25 documents (in part):The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change.The MDS (Minimum Data Set) Coordinator and the Interdisciplinary Team will discuss the resident condition and collaborate on intervention options. The team meeting discussion will be documented in the nursing progress notes. The care plan will be updated with the new or modified interventions. Staff involved in the care of the resident will report resident response to new or modified interventions.R5's care plan documents: The resident has a tracheostomy r/t (related to) impaired breathing mechanics she is at risk for sob (shortness of breath) - revised 11/24/25. Approaches include: Ensure that trach ties are secured at all times - initiated 10/27/25. Tube Out Procedures: Keep extra trach tube and obturator at bedside. If tube is coughed out, open stoma with hemostat. If tube cannot be reinserted, monitor/document for signs of respiratory distress. If unable to breathe spontaneously, elevate HOB (head of bed) 45 degrees and stay with resident. Obtain medical help immediately - initiated 10/27/25.The resident uses anti-anxiety medications r/t anxiety disorder. I pull out my trach often - initiated 10/27/25. Approaches: Administer anti-anxiety medications as ordered by physician. Monitor for side effects and effectiveness every shift. Monitor/record occurrence of for target behavior symptoms of pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression toward staff/others, etc. and document per facility protocol.R4's History and Physical (H&P) dated 6/10/25 documents (in part):Past medical history significant for chronic encephalopathy, recurrent UTI (urinary tract infection), sepsis, chronic respiratory failure status post chronic indwelling tracheostomy, dysphagia, history of posterior glottic stenosis status post lysis and Decadron injection. Patient has been weaned off the ventilator but due to super morbid obesity chronic respiratory failure sleep apnea the patient requires indwelling tracheostomy but remains in chronic encephalopathic state with delirium keeps pulling out tubes and tracheostomy at the nursing home.Surveyor noted that despite R5's H&P documenting repeated episodes of pulling out her tracheostomy tube, a care plan and interventions for this behavior were not created or implemented.Review of R5's progress notes documented that she has pulled out her trach tube at least 28 times since admission. Facility staff have been able to reinsert the tube at times, however when unable, 911 is called and R5 is sent to the emergency room (ER). Surveyor noted 911 has been called at least 18 times since admission due to R5's removal of her tracheostomy tube.On 2/16/26 at 2:25 PM, Surveyor spoke with Director of Nursing (DON)-B. DON-B reported R5 pulls out her trach tube daily, sometimes multiple times a day. Surveyor asked DON-B what interventions (besides Ativan), the facility has implemented for this behavior. DON-B reported her Ativan has been increased and the hospital uses wrist restraints, which can't be used in the facility. DON-B reported she thought the facility asked her son for a psych consultation, but he refused.DON-B was (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unable to provide evidence that a psychiatric consult was ordered and/or refused by R5's son. Surveyor advised DON-B of concern that R5 does not have a care plan or interventions for her repeated behavior of removing the trach tube. DON-B reported R5's room is close to the nurses' station, which allows for more frequent checks. Surveyor found no evidence that the facility implemented any interventions, aside from increasing the Ativan, for R5's repeated behavior of removing her trach tube. No additional information was provided.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 1 (R3) of 2 residents reviewed for Activities of Daily Living (ADL) assistance received the necessary services to maintain ability to practice good grooming and personal hygiene.R3 is scheduled for showers twice a week and did not receive showers on 7/26/25, 8/9/25, 8/13/25, 8/23/25, 8/27/25, 8/30/25, 9/6/25, 9/10/25, 9/17/25, 9/20/25, 10/4/25, 10/8/25, 10/11/25, and 10/15/25.Findings include:The facility's policy titled Activities of Daily Living (ADLs), Supporting, dated 3/6/22, last approved 5/22/25, documents the following:Residents will be provided with care, treatment and services as appropriate to maintain or improve their own ability to carry out activities of daily living (ADLs).Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care).R3 was admitted to the facility on [DATE]. R3's diagnoses include dysphagia (a language disorder caused by brain damage), cerebral infarction (death of brain tissue), Chronic Obstructive Pulmonary Disease (COPD) (long term lung disease), Congestive Heart Failure (CHF) (weakened heart muscle), and muscle weakness. R3's Quarterly Minimum Data Set (MDS) completed on 1/24/26, documents that R3 is independent with eating and rolling left to right. The MDS documents: R3 requires supervision with toileting hygiene, showering, bathing, dressing, transfers, and walking 10 feet using a walker; R3 is always continent of bowel and bladder; R3 was documented as having a Brief Interview for Mental Status (BIMS) score of 15, indicating that R3 is cognitively intact.R3's Annual MDS completed on 10/24/25, documents the following Care Area Assessment (CAA):Functional Abilities CAA: R3 requires supervision or touching assistance with transfers. R3 is continent of bowel and bladder. R3 is able to ambulate with a walker with supervision.R3's care plan, dated 10/18/24, documents:R3 has an ADL self-care performance deficit related to fatigue and impaired balance (created on 10/18/24, revised on 10/16/25).Interventions include:Transfer: stand and pivot transfer with two wheeled walker, contact guard assistance and one person (created on 10/18/24, revised on 2/2/26).Hygiene/Dressing: R3 requires upper body set up and lower body moderate assistance (created on 10/18/24, revised on 2/2/26).Bathing: R3 requires supervision or touching assistance by one staff to provide a bath as necessary (created on 10/18/24, revised on 1/28/26).On 2/16/26, at 9:29 AM, Surveyor interviewed R3 who stated R3 does not get a shower daily. R3 was unable to recall when R3's last shower was. On 2/17/26, at 9:52 AM, Surveyor observed R3 sitting in a recliner dressed in personal clothes. Surveyor observed R3's personal clothes to be soiled with food stains down the front of R3's shirt and pants.Surveyor reviewed R3's Electronic Medical Record (EMR) which documents R3 is to receive a shower twice weekly. Surveyor notes R3 did not receive showers on 7/26/25, 8/9/25, 8/13/25, 8/23/25, 8/27/25, 8/30/25, 9/6/25, 9/10/25, 9/17/25, 9/20/25, 10/4/25, 10/8/25, 10/11/25, and 10/15/25.On 2/18/26, at 8:20 AM, Surveyor interviewed Director of Nursing (DON)-B who stated the Certified Nursing Assistant (CNA) is to complete a shower sheet when a resident receives a shower. DON-B stated the CNA is to document any refusals on the shower sheet. Surveyor asked where the shower sheets are kept, and DON-B stated the facility keeps the handwritten shower sheets for approximately one month. Surveyor requested shower sheets for R3.On 2/18/26, at 10:49 AM, DON-B notified Surveyor the facility does not have shower sheets for R3. Surveyor notified DON-B of concerns with R3 not receiving a documented shower for the dates listed above. DON-B acknowledged these concerns. No additional information was (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provided.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure a resident received treatment and care in accordance with professional standards of practice for 1 (R1) of 2 residents reviewed for quality of care. R1 pulled out their catheter prior to a fall on 11/30/25. The catheter was reinserted and hematuria was noted. R1 was on an antiplatelet and an anticoagulant. There is lack of documentation that R1 was being monitored for bleeding due to being on blood thinning medications. R1 was sent to the hospital later for hematuria.Findings include:R1 was admitted to the facility on [DATE] with pertinent diagnoses that include Alzheimer's disease (a progressive, neurodegenerative brain disorder and the most common cause of dementia, characterized by memory loss, cognitive decline, and behavioral changes), delirium (an acute, fluctuating disturbance in attention, awareness, and cognition that develops rapidly (hours to days), often caused by underlying medical conditions, infections, or medication side effects), and chronic kidney disease stage 3B (kidneys are moderately damaged, filtering at 30-59% capacity).R1's Admission/Medicare 5 day Minimum Data Set (MDS) with an assessment reference date of 11/30/25, documents no Brief Interview for Mental Status (BIMS) being completed. R1 is coded as rarely/never understood and rarely/never understands others. The MDS documents that R1 was assessed to have behaviors of verbal behavioral symptoms directed toward others that occurred 1-3 days of the look back period. R1 was assessed to have other behavioral symptoms not directed towards others 1-3 days of the look back period. Per the MDS, R1 was taking both an anticoagulant and an antiplatelet.R1's physician order dated 11/27/25 documents Clopidogrel Bisulfate Oral Tablet 75 MG. Give 1 tablet by mouth in the morning for antiplatelet.R1's physician order dated 11/26/25 documents Warfarin Sodium Oral Tablet 5 MG. Give 1 tablet by mouth in the evening for anticoagulant.Surveyor noted there was no baseline care plan created for monitoring R1's use of an anticoagulant or antiplatelet. R1 had hematuria and was transferred to the hospital.Surveyor reviewed the Fall Protocol Checklist dated 11/30/25, with time of fall 23:30 (11:30pm). It is documented that R1 got up from bed, pulled out catheter, walk out the door and lost his balance and fell on his buttock outside his room door. R1's progress note, written by Registered Nurse (RN)-J dated 12/1/2025, at 12:44am, documents: 0030 (12:30am) Resident got up from bed, pulled off indwelling catheter, got out the room fell outside the door, staff found resident on the floor outside resident door, writer found resident with staff standing already with aggression towards staff. Writer able to calm down resident and assisted res. (resident) to bathroom per his request. Noted abrasion to left forearm and left lower back during head to toe assessment. Bleeding also noted from penis probably from trauma of dislodgement of catheter. Writer able to replaced catheter in 1 attempt, initial drainage of blood clots but thinning out after clots. C/o (complaints of) bladder pain, prn tylenol given.Surveyor noted a discrepancy regarding time of the fall. The Fall Protocol Checklist documents 11:30pm (11/30/25) and the progress note documents 12:30am (12/1/25).R1's medication administration note, dated 12/1/2025, at 8:43am, documents: Document Residents pain level. Resident is in pain from dislodged foley catheter. Resident has hematuria in foley line and bag. Foley is still in place but appears to be out partially. Patient is complaining of discomfort at his penis and has dried blood around site. [Name] Ambulance called for transport to hospital for further evaluation.R1's progress note, dated 12/1/2025, at 10:00am, documents: Resident was sent out to [hospital name] for complaint of hematuria. Resident has an indwelling foley catheter inserted. Resident was found with dried blood around his penis, groin, and right leg. Foley securement device had foley tubing secured but the point that is normally secured was further down, appears resident pulled on foley and dislodged catheter. Spoke with Unit Manager (UM)-I and reported he had (continued on next page)

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Chi Franciscan Villa	3601 S Chicago Ave South Milwaukee, WI 53172

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hematuria noted in foley yesterday (11/30) and was being monitored. Resident had blood throughout foley tubing and into foley bag. Spoke with NP (Nurse Practitioner) on the phone and was instructed to send resident out to hospital for further evaluation. [Name] Ambulance arrived around 09:45am. On 2/17/26, at 11:30am, Surveyor interviewed Registered Nurse (RN)-J regarding R1 pulling out catheter. Surveyor asked if R1 was having any bleeding around the catheter or in the urine before pulling out the catheter prior to R1's fall. Per RN-J there was no bleeding prior to R1 pulling out catheter. R1 did continue with hematuria after the catheter was reinserted.On 2/17/26, at 1:00pm, Surveyor interviewed Director of Nursing (DON)-B and asked how R1 was being monitored due to being on blood thinners. DON-B stated DON-B would review R1's medical record and let Surveyor know. On 2/17/26, at 2:15pm, DON-B stated that the facility has 14 days to set up a care plan. Surveyor asked due to the kind of medications R1 was on if there would be an expectation for monitoring and DON-B replied yes, they would expect monitoring. DON-B will provide the lab orders for PT/INR related to Warfarin. And would expect staff to monitor for bleeding and bruising due to the medications. On 2/18/26, at 8:55am, Surveyor interviewed Unit Manager (UM)-I and UM-I stated remembering the blood in R1's catheter. R1 was being monitored on the 24 hour board, UM-I will look for documentation and get back to Surveyor.Surveyor noted no documentation was provided by UM-I. Surveyor noted R1 was a new admit and would have been being monitored on 24 hour board for this.On 2/18/26, at 9:03am, Surveyor interviewed DON-B and Nursing Home Administrator (NHA)-A regarding the concern that R1 had a change of condition and there is a lack of documentation regarding assessments and monitoring between time of R1's fall and when R1 went out to the hospital.On 2/18/26, at 10:48am, Surveyor interviewed DON-B after the hospital records were provided and Surveyor stated there remains the concern that for approximately eight hours that R1 was in the facility after pulling out catheter and there is limited documentation of assessment and monitoring of the hematuria and R1 was then sent to the hospital for hematuria. No additional information was provided regarding the lack of assessments and monitoring.

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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 observations, interviews and record review the facility did not ensure that a resident receives care, consistent with professional standards of practice, to prevent pressure injuries and does not develop pressure injuries unless the individual's clinical condition demonstrates that they were unavoidable; and a resident with pressure injuries receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new injuries from developing for 1 of 2 (R4) residents reviewed for pressure injuries. R4 developed a facility acquired stage 3 pressure injury on her left buttock and an unstageable Deep Tissue Injury (DTI) on her right lateral ankle. Surveyors had observations of care plan interventions not in place and R4's feet were observed not to be offloaded during survey. Findings include:R4 admitted to the facility on [DATE] and has diagnoses that include anoxic brain damage, acute respiratory failure with hypoxia, tracheostomy and gastrostomy status, morbid obesity, congestive heart failure, major depressive disorder and anxiety.The facility did not provide a pressure injury policy and procedure. Surveyor was provided a form titled Pressure Injuries Overview dated last approved 5/22/25. The form only documented the general definitions and staging of pressure injuries.R4's Quarterly Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) documented a staff assessed score of 99, indicating that R4 is comatose. The MDS documents that R4 has impairment to both sides of R4's upper and lower extremities and is dependent on staff for her mobility needs of rolling left and right. Section M (Skin Conditions) documents that R4 is at risk for development of pressure injuries. R4's Pressure Injury CAA (Care Area Assessment) documents under the Care Plan Considerations section: Resident was admitted from hospital with dx (diagnosis): acute resp failure with hypoxia . She is at risk for skin impairment, preventive measures in place such as pressure reducing mattress and w/c cushion, weekly skin checks and prn (as needed). R4's CNA (Certified Nursing Assistant) Kardex dated 2/17/26 documents: Bed mobility - I require 2 staff members to reposition and turn in bed. Reposition every 2 hours as tolerated. I am totally dependent. I require bilateral heel boots to offload pressure to heels.R4's care plan documents: I have potential/actual impairment to skin integrity r/t (related to) bedbound, trach and PEG (Percutaneous Endoscopic Gastrostomy) tube placement.Approaches: I have an air mattress to assist with wound healing/prevention. Please make sure it is set to my weight for maximum benefits - initiated 1/16/25.I require bilateral heel boots to off load pressure to heels - created on 7/25/25, revised 2/13/26.R4 has a history of pressure injuries and is followed by [NAME] wound physician.R4's [NAME] wound physician notes dated 1/23/26 documents: Unstageable DTI of the right, lateral ankle undetermined thickness 0.6 x 0.5 x not measurable cm (centimeters). Unstageable DTI with intact skin. Purple/maroon discoloration. Duration >1 day. Approach: Close monitoring, off-loading.R4's [NAME] wound physician notes dated 1/30/26 documents: Stage 3 pressure wound of the left buttock full thickness 1.5 x 0.7 x 0.1 cm. Granulation tissue 100%. Light serous exudate. Duration >1 day; Unstageable DTI to right lateral ankle, 0.6 x 0.4 x Not Measurable cm. Intact skin, purple/maroon discoloration. On 2/13/26, [NAME] wound physician notes documented: Unstageable DTI of the right lateral ankle undetermined thickness 0.6 x 0.3 x not measurable cm. Intact with purple/maroon discoloration. Stage 3 pressure injury wound of the left buttock full thickness 0.9 x 0.7 x 0.1 cm. Granulation tissue 100%. Light sero-sanguinous exudate.Surveyor noted that the facility did not document a root cause for the development of R4's stage 3 left buttock pressure injury and noted that R4's care plan was not updated to include any interventions to address the potential root cause for the development of R4's left buttock pressure injury. On 2/16/26 at 9:20 AM, Surveyor observed R4 lying in bed on her back. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Surveyor observed R4 was not wearing pressure relieving boots and her feet were not offloaded. R4's feet were resting on a pillow with each foot lying on the lateral side on the pillow.On 2/16/26 at 12:00 PM, Surveyor observed R4 to be in the same position, on her back. R4 was not wearing pressure relieving boots and her feet were not offloaded. Each foot was resting on the lateral side directly on the pillow. On 2/17/26 at 7:19 AM, Surveyor observed R4 laying in bed, not wearing pressure relieving boots and R4's resting directly on the mattress and not offloaded. On 2/17/26 at 10:46 AM, Surveyor observed R4 laying in bed, not wearing pressure relieving boots and R4's resting directly on the mattress and not offloaded. On 2/17/26 at 11:00 AM, Surveyor observed R4 laying in bed, not wearing pressure relieving boots and R4's resting directly on the mattress and not offloaded. On 2/18/26 at 9:01 AM, Surveyor observed a pillow under R4's legs to float her heels. Surveyor noted the pillow was flattened, and although her heels were not resting on the mattress, both feet were resting on each lateral side on the pillow. R4 was not wearing pressure relieving boots.On 12/18/26 at 11:56 AM, Surveyor informed Nursing Home Administrator (NHA)-A and DON (Director of Nursing)-B about the above findings. Surveyor asked DON-B how the facility addressed the potential root cause of the development of R4's facility acquired stage 3 pressure injury. DON-B stated that the facility believes the root cause of R4's facility acquired stage 3 pressure injury was due to R4's incontinence product, as the edge of the incontinence product lies directly over the pressure injury. Surveyor informed DON-B that R4 is fully dependent on staff for repositioning and that R4's care plan did not include any interventions to address the development of R4's facility acquired stage 3 pressure injury. DON-B informed Surveyor that she would review and address it. DON-B informed Surveyor that DON-B would also review the heel boots that R4 is supposed to be wearing, as R4's family had brought in some heel boots for R4 to wear.No additional information was provided as to why R4 developed a DTI and a stage 3 pressure injury and why R4's interventions to prevent the development of pressure injuries were observed to not be in place.

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F 0689 Level of Harm - 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** Based on observation, interview and record review, the facility did not ensure 2 (R6 and R5) of 4 received adequate supervision and assistance devices to prevent and be free of accidents. R6 did not have a low bed in place and experienced a fall that resulted in sutures and a closed face fracture. R5 was not provided with supervision per R5's care plan to ensure safety while eating and to prevent choking. Findings include: 1.) R6 was admitted to the facility on [DATE] with diagnoses that include Alzheimer's Disease, Adult Failure to Thrive, Right Orbital Fracture and Cognitive Communication Deficit. R6's admission MDS dated [DATE] documents a BIMS (Brief Interview for Mental Status) score of 5, indicating R6 is severely cognitively impaired. Section E0900 Wandering documents wandering behavior occurred 1 to 3 days during the assessment period. Section GG (Functional Abilities and Goals) documents that R6 require supervision or touching assistance to sit to stand and requires partial/moderate assistance for chair to bed transfers. R6's Falls CAA (Care Area Assessment) dated 1/29/26 documents under the Care Plans Consideration section: Resident is at risk for falls r/t (related to) impaired mobility and cognition. She is receiving pt (physical therapy)/ot (occupational therapy)/sp (speech therapy) services. She currently requires partial to moderate assist with transfers. She is frequently incontinent of b/b (bowel and bladder), staff to check and change, provide peri care after each incontinence episode. Skin is intact, although she is at risk for impairments r/t (related to) incontinence. Preventive measures in place such as pressure reducing mattress and w/c (wheel chair) cushion, weekly skin checks and prn (as needed). Denies pain. Continues on anti anxiety, antidepressant medication r/t behaviors secondary to Alzheimer's. Staff to monitor for abnormal behaviors and s/s of depression. Proceed to care plans and update prn (as needed). R6's Falls Risk assessment dated [DATE] documents a score of 10, indicating that R6 is at risk for falls. R6's Falls care plan dated 1/27/26 documents the following interventions: Bed in lowest position. R6's nursing note dated 2/7/26 documents: Note Text: resident is being monitored for restless, combative behaviors and wandering into other resident rooms. Resident did display and combative behaviors while wandering. She is easily redirected and cooperative. resident walks in hallway to back to room. No c/o (complains of) pain or discomfort during shift. No concerns at this time. R6's nursing note dated 2/7/26 documents: Note Text: Patient is found walking down the hallway with her walker and blood on her head, right side of her face, nose and mouth. Writer and CNA [name] assisted this patient back to bed. Patients bed is noted to be above waist high in the air and blood on the floor next to her doorway and her glasses. Patient was just seen in her bed laying down with (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	her bed low to the ground approximately 20-30 minutes prior to her fall. Patient stated she had raised the bed up high and did not realize that she did this. Bed remote is noted to be next to patient on her side rail. Patient states her head does hurt but nothing else at this time and rates it a 2/10. Writer and CNA cleaned blood from patient and it is noted patient has about 1-1.5 inch laceration to her right eyebrow and a small laceration to her lower lip. Patient stated she did have her glasses on when she fell. Patient is alert and oriented per baseline and ROM (range of motion) WNL (within normal limits), no rotating or shortening noted. VSS (vital signs stable) at this time. Bell Ambulance called for transport of this patient to the ER (emergency room). R6's Fall Protocol Checklist dated 2/7/26 documents that R6 was seen around 20-30 minutes prior to the fall. The report documents that R6 appears to have rolled out of bed and that R6 had a bed at waist high level. Under the Summary Statement of Fall section it documents: Resident found walking in hallway with walker and blood on face/mouth. Previously 20 min/30 min resting in bed in lowest position. Resident stated she raised bed up high and didn't realize she did this. Bed remote found next to resident's side rail (enabler bar). Reported 2/10 head pain, laceration to right eyebrow and lower lip glasses on at time of the fall. Assessment completed. 911 called. Under the Witness Statement section it documents: I had helped resident to bed and her bed was in the lowest position. She later was walking in hallway with blood on her face. I assisted her back to her room and her bed was high. I didn't know R6' reaction to when I asked her how her bed got up so high. Nurse helped me assist back to room and stayed with resident until 911 arrived. R6's nursing note dated 2/8/26 documents: Narrative Text: 0317 Resident return from ER per stretcher, assisted back to bed by EMS (Emergency Medical Services). Res (resident) still sleeping quietly, respiration calm, non labored, skin warm and dry to touch, normal in color. New order of ABT (antibiotic) received from ER (emergency room) for acute bacterial infection of sinuses, Res. discharge diagnosis of closed fracture of right orbital floor, closed fracture of right maxillary sinus. Received also res. with 5 stitches to right eyebrow. Bruise to right periorbital, right cheek and upper lip. R6's hospital After Visit Summary dated 2/8/26 documents: Diagnoses- Closed Fracture of Right Orbital Floor, Facial Laceration-Sutures. R6's nursing note dated 2/8/26 documents: Late Entry: Note Text: IDT (interdisciplinary team) FALL REVIEW- 2/07/2026 The IDT met to review the fall that occurred on February 7, 2026. The resident has a documented medical history including Alzheimer's, adult failure to thrive, anxiety, mild cognitive impairment, diverticulitis, restlessness, agitation, muscle weakness, and cognitive communication deficit. Per the incident report, staff responded to the resident's need for assistance. Resident was found walking down the hall towards the nurses station. Resident was using her walker appropriately at this time and wearing proper footwear at the time of the fall. The resident was immediately assessed and obvious facial trauma was present. Ambulance was called and staff stayed beside with resident until she was transferred to the hospital. Resident reported facial pain rating of 2/10 during the time of the assessment. Resident was assisted back into her bed by nurse and CNA (Certified Nursing Assistant). Range of motion was within normal limits, and neuro checks were initiated as a precautionary measure. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The IDT determined that the resident likely attempted to use the bed control not understanding what she was doing and had the bed in the highest position, did not use call light and rolled out of bed. As a result, the facility has moved the resident's room closer to the nursing station for observation, bed in lowest position, and enabler bars to promote independence. The resident's primary care provider and family have been notified of the incident and the new interventions. Family is in agreement and has no questions at this time. The facility's self-report to the state agency submitted on 2/13/26 documents: Staff responded to the residents' need for assistance. The resident was found walking down the hall towards the nurses station. The resident was using her walker appropriately at this time and wearing proper footwear at the time of the fall. The resident was immediately assessed and obvious facial trauma was present. An ambulance was called and staff stayed beside the resident until she was transferred to the hospital.The IDT determined that the resident likely attempted to use the bed control not understanding what she was doing and had the bed in the highest position, did not use call light and rolled out of the bed. The result of the fall with injury was a closed right orbital fracture and closed right maxillary sinus fracture. Surveyor noted that the facility's self report and fall investigation did not address why R6 did not have adequate supervision to prevent R6's fall on 2/7/26, despite documentation stating that R6 was experiencing behaviors prior to her fall. Surveyor also noted that the facility's fall investigation documented that R6's fall interventions of a low bed was not in place at the time of R6's fall. On 2/17/26 at 12:23 PM, Surveyor informed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B of the above findings. Surveyor asked DON-B if R6 was provided with supervision prior to R6 falling. DON-B stated that she would provide additional information. On 2/17/26 at 9:47 AM, Surveyor spoke with LPN-L regarding the note she documented regarding R6's behaviors prior to R6's fall on 2/7/26. LPN-L informed Surveyor that R6 was experiencing behaviors including restlessness and getting out of bed frequently prior to R6's fall. LPN-L informed Surveyor that LPN-L was not present at the time of R6's fall. On 2/17/26 at 9:52 AM, Surveyor informed DON-B of the above findings. Surveyor informed DON-B of concerns that R6 was provided supervision prior to R6's fall on 2/7/26 despite experiencing R6 experiencing behaviors prior to R6's fall. Surveyor informed DON-B that R6's fall intervention of a low bed was not in place prior to R6's fall. No additional information was provided as to why R6 did not have fall interventions in place and supervision on 2/7/26 when R6 experienced a fall. 2.) The facility's policy titled Meal Supervision and Assistance dated 2/18/26 documents (in part): The resident will be prepared for a well-balanced meal in a calm environment, location of his/her preference and with adequate supervision and assistance to prevent accidents, provide adequate nutrition, and assure an enjoyable event. This includes: A. Identifying hazard(s) and risk(s). B. Evaluating and analyzing hazard(s) and risk(s). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	C. Implementing interventions to reduce hazard(s) and risk(s). D. Monitoring for effectiveness and modifying interventions when necessary. Risk refers to any external factor, facility characteristic (e.g. staffing or physical environment) or characteristics of an individual resident that influences the likelihood of an accident. Supervision/Adequate Supervision refers to an intervention and means of mitigating the risk of an accident. Facilities are obligated to provide adequate supervision to prevent accidents. This determination is based on the individual resident's assessed needs and identified hazards in the resident environment. Adequate supervision may vary from resident to resident and from time to time for the same resident. Compliance Guidelines: The facility will develop and implement an individualized care plan to address the residents needs and goals and to monitor the results of the planned interventions such as adequate supervision during mealtime. R5 was admitted to the facility on [DATE] and has diagnoses that include chronic respiratory failure, tracheostomy (trach) status, laryngeal hypoplasia, epilepsy, anxiety disorder, obesity, functional quadriplegia, Type 2 diabetes mellitus and dysphagia. R5's Speech Therapy Recommendations dated 11/4/25 document: Diet texture – mechanical soft. Dining assist – supervision. Swallowing guidelines – clear throat/cough when gurgly. Slow rate, small bites. PMSV (Passy Muir Speaking Valve) to be worn with all PO (by mouth) intake. R5's Care Plan documents: Alteration in nutrition/hydration r/t (related to) hx (history) pneumonia, DM (Diabetes Mellitus) II, obesity, quadriplegia, dysphagia as evidenced by needs for therapeutic diet, needs for mechanically altered diet, supervision with meals, swallowing recommendation – dated 1/6/26. Approaches – Swallowing recommendation: Oral care BID (twice daily); Passy Muir speaking valve must be worn during all PO (by mouth) intake. Needs supervision with meals. R5's Kardex dated 2/17/26 documents: Eating – I require partial to moderate assist with eating. Swallowing recommendation: Oral care BID; Passy Muir speaking valve must be worn during all PO intake. Needs supervision with meals. On 2/16/26 at 12:20 PM, Surveyor and Unit Manager-I entered R5's room to view supplies. Surveyor observed R5 had her lunch plate on her stomach/lap in bed, was eating independently and had consumed at least 50% of her meal. Unit Manager-I stated, We need to put the cap on you and proceeded to obtain a purple cap from the counter across from R5's bed and placed it on the end/opening of her trach. After viewing supplies with Unit Manager-I, she put a gown on and stated, I'm staying with her because she needs supervision when eating. On 2/17/26 at 12:10 PM, Surveyor observed R5 lying in bed with her head of bed elevated between 30-45 degrees. R5 appeared to be asleep, and her lunch tray was on the bedside table in front of her. Surveyor noted the purple PMSV valve was not on her trach and no other staff entered R5's room for another 27 minutes. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 2/17/26 at 12:37 PM, Surveyor observed 2 staff members gown and enter R5's room. Surveyor heard 1 staff member say she would sit with R5 while she eats. On 2/18/26 Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B were advised of the above findings. No additional information was provided.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that sufficient nursing staff was provided to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident potentially affecting 86 of 86 residents in the Facility. * The Facility had documented low staffing ratios in the month of October. Findings include: Due to a complaint received alleging October 2025 the facility was constantly understaffed Surveyor reviewed the PBJ (Payroll Based Journal) report for July 1 to September 30, 2025, and the facility triggered for one star staffing and excessively low weekend staffing. Surveyor reviewed PBJ report for October 1 to December 31, 2025, provided by the facility, and the facility again triggered for low weekend staffing. On 02/17/26, at 8:25 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-H and was told staffing is no different here than anywhere else, they are short because of the call ins. When asked about doing transfers with the mechanical lift CNA-H stated they have to get someone to help, and the nurses will step in. On 02/17/26, at 8:29 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-G and was told staffing is ok, it is the call ins that make shifts short. When asked if residents suffer when short CNA-G replied of course. On 02/17/26, at 8:34 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-E who stated that staffing is pretty good except for the call ins. If a CNA calls in the nurses have to help. On 02/17/26, at 8:42 AM, Surveyor interviewed Certified Medication Assistant (CMA)-F who stated that call ins are a problem, staff have to work as a team and help each other. They get behind but in the end get the work done. When asked about the impact on residents CMA-F responded they try their best to not affect residents. On 2/17/26, at 9:05 AM, Surveyor interviewed Scheduler-K who stated that on first shift they schedule 8 CNA, second shift 8 CNA, and third shift 5 CNA. For first shift there are 4 nurses/medication technicians, second shift is 5 and third shift is 2. Surveyor reviewed the October schedules and Daily Staffing postings. Of the 31 days in October, 21 days did not meet the number of CNA the facility deems appropriate for a shift. All four weekends were less than the number as well. Nurses and Certified Medication Assistants were short of the facility deemed numbers 6 times. Four of these were weekends the CNA numbers were also short. Surveyor noted that if a CNA relies on nurses for help and the nurses are short as well, this impacts resident care. On 2/17/26, at 9:10 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who stated that in (continued on next page)

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	October and November there were staffing challenges. They are now in a better spot as they have brought on four nurses and six CNA, it is the most staff they have had in 12-15 months. When asked how they met the resident needs in October and November NHA-A replied that nurse managers were here every weekend providing cares. On 2/18/26, at 10:48 AM, Surveyor informed Director of Nursing (DON)-B of concern related to low staffing, especially October per the review. The facility did not provide any additional information as to low staffing concerns. On 2/17/26, at 8:10 AM, Surveyor observed a call light activated (on) outside of R9's room. Surveyor noted the call light remained on for a period of 16 minutes until a staff member entered R9's room at 8:26 AM. Surveyor observed multiple staff members pass by R9's room [ROOM NUMBER] times, while R9's call light was activated. The light was then turned off at 8:26 AM, and the staff member left the room a short time later. On 2/17/26, at 9:54 AM, Surveyor observed a call light activated outside of R8's room. Surveyor observed Certified Nursing Assistant (CNA)-D go into R8's room and overheard R8 stating R8 needed to go to the bathroom. CNA-D told R8 to wait, stating she would be right back and turned off R8's call light. Surveyor observed R8 turn the call light on at 10:04 AM. Surveyor observed a staff member walk by R8's room and the staff member told R8 they would be right in. Surveyor observed a different staff member enter R8's room at 10:09 AM, the light was then turned off, and the staff member left the room a short time later. On 2/18/26, at 10:02 AM, Surveyor notified Nursing Home Administrator (NHA)-A of concern mentioned above. NHA-A acknowledged these concerns. No additional information was provided as to why there was a delay in the call lights being answered by staff and why there was sufficient staff observe to answer call lights in a timely manner.