

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525579	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2025
NAME OF PROVIDER OR SUPPLIER Little Chute Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 Garfield Ave Little Chute, WI 54140	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>(continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not ensure the appropriate care and treatment regarding dressing changes and lab work was provided for 2 residents (R) (R3 and R9) of 3 sampled residents. Staff did not complete R3's peripherally inserted central catheter (PICC) line dressing change as ordered. In addition, R3's weekly labs were not completed as ordered. Staff did not complete R9's PICC line dressing change as ordered. Findings include: The facility's Dressing Change for Vascular Access Devices policy, revised 10/2024, indicates: Purpose: To prevent local and systemic infection related to the intravenous (IV) catheter. A sterile dressing is maintained on all peripheral and central vascular access devices to protect the site, provide a microbial barrier, and to provide vascular access device securement. 3. Central venous access device and peripheral midline dressings are changed every 7 days and immediately if the integrity of the dressing is compromised, if moisture, drainage, or blood is present, or for further assessment if infection is suspected. Transparent semi-permeable membrane dressings are changed every 7 days and as needed (PRN). 4. Initial dressings after catheter placement will be changed PRN if saturated, and 24-48 hours post insertion of midlines, PICCS, or other central venous access devices if gauze is present under the dressing and/or there is blood/drainage under the dressing. Initial dressing with Biopatch/Guardiva at the site may be left in place for 7 days unless it is saturated or the dressing is otherwise compromised. 1. On 7/23/25, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] and had diagnoses including osteomyelitis of right tibia and fibula, infection of amputation stump and right lower extremity, and acquired absence of right leg below the knee. R3's Minimum Data Set (MDS) assessment, dated 5/22/25, had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated R3 had intact cognition. R3 had a Power of Attorney for Healthcare (POAHC). R3's medical record contained the following order:~ PICC dressing change: Change catheter site dressing with transparent dressing as needed and one time a day every Monday (initiated 5/15/25). R3's Medication Administration Record (MAR) and Treatment Administration Record (TAR) contained orders for a weekly PICC line dressing change. Staff documented PICC line dressing changes on 5/19/25 and 5/26/25. There was no documentation that dressing changes were completed on 6/9/25 and 6/16/25. R3's PICC line dressing was changed at the infectious disease clinic on 6/2/25. On 7/23/25 at 10:15 AM, Surveyor interviewed Infectious Disease Registered Nurse (IDRN)-F and confirmed R3's PICC line dressing was changed at R3's infectious disease appointment on 6/16/25. On 7/23/25 at 11:48 AM, Surveyor interviewed Director of Nursing (DON)-B who confirmed R3's PICC line dressing was changed by facility staff on 5/19/25 and 5/26/25 but was not changed by facility staff the week of 6/9/25 or 6/16/25. DON-B confirmed R3's PICC line dressing was changed by clinic staff on 6/2/25 and was due to be changed on 6/9/25. DON-B indicated PICC line dressings should be changed weekly or as needed and stated R3's PICC line was discontinued on 6/23/25. 2. R3's medical record contained the following laboratory orders:~ Hospital discharge order (start date 5/15/25): Weekly lab draw CBC w/ diff, Creatinine, ALT, CRP, ESR.~ Infectious disease order (start date 6/2/25): Continue weekly labs.~ Facility order (start date 5/20/25): Lab Draw: CBC w/ diff, Creatinine, ALT, CRP, ESR every day shift every Tuesday until 6/16/25. R3's medical record indicated labs were drawn on 5/19/25, 5/27/25, 6/3/25, and 6/10/25 and results were received. R3's medical record did not indicate labs were drawn the week of 6/16/25. On 7/23/25 at 11:48 AM, Surveyor interviewed DON-B who confirmed R3's labs were not drawn the week of 6/16/25 because the order staff entered was discontinued in error on 6/16/25. DON-B indicated the facility received an order from the infectious disease clinic on 6/2/25 to continue weekly labs with no end date. On 7/23/25 at 2:00 PM, Surveyor interviewed DON-B who indicated the facility does not have a policy for laboratory orders and drawing lab work. 2. On 7/23/25, Surveyor reviewed R9's medical record. R9 was admitted to the facility on [DATE] and had diagnoses including bacteremia and atrial fibrillation. R9's MDS assessment, dated 6/11/25, had a BIMS score of 14 out of 15 which indicated R9 had intact cognition. R9 was responsible for R9's healthcare decisions. R9's medical record contained the following order:~ Change PICC line dressing per sterile technique one time a day every 7 day(s) for PICC line maintenance (start date 6/17/25; discontinued 7/1/25). R9's MAR and TAR contained orders for a weekly PICC line dressing change on Mondays and as needed. There was no documentation that R9's PICC line dressing was changed on 6/18/25 or 6/25/25. On 7/23/25 at 12:27 PM, Surveyor interviewed DON-B who indicated R9's PICC line dressing was changed by Registered Nurse (RN)-D on</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interview and record review, the facility did not ensure adequate supervision was implemented for 1 resident (R) (R2) of 8 sampled residents. On 7/1/25, R8 reported to Registered Nurse (RN)-E that R2 rubbed R8's arm and made sexual statements to R8 including What size are your breasts? and Can I feel your breasts? The facility did not place R2 on supervision to prevent reoccurrence. On 7/13/25, RN-E witnessed R2 rubbing R1's arm. RN-E intervened and R1 indicated that R1 squeezed R2's breasts. R2 was placed on 1:1 supervision following the incident. Findings include: The facility's Abuse, Neglect and Exploitation policy, dated 7/15/22, indicates the facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves .B. Identifying, correcting, and intervening in situations in which abuse .is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff to meet the needs of the resident and assure that the staff assigned have knowledge of the individual resident's care needs and behavioral symptoms .D. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect .Possible indicators of abuse include but are not limited to .5. Verbal abuse of a resident overheard, or inappropriate verbal conducted overheard. On 7/23/25, Surveyor reviewed a facility-reported incident (FRI) that indicated RN-E observed R2 rubbing R1's arm on 7/13/25. RN-E observed the interaction from down the hall and immediately intervened and separated R1 and R2. RN-E interviewed R1 who stated R2 had hands on me like this and visually squeezed R1's breasts with R1's hands. R2 was placed on 1:1 supervision. From 7/23/25 to 7/24/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including schizophreniform disorder. R1's Minimum Data Set (MDS) assessment, dated 5/28/25, had a Brief Interview for Mental Status (BIMS) score of 8 out of 15 which indicated R1 had moderately impaired cognition. R1 had a Guardian for healthcare decisions. From 7/23/25 to 7/24/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including dementia with other behavioral disturbance, depression, and anxiety disorder. R2's MDS assessment, dated 4/22/25, had a BIMS score of 9 out of 15 which indicated R2 had moderately impaired cognition. R2 had a Guardian for healthcare decisions. A care plan, revised 8/7/24, indicated R2 was at risk for behavior symptoms related to depression/anxiety, impaired cognition with history of touching staff inappropriately during personal cares and had a history of making sexual comments to staff due to sexual dysfunction and advancing dementia. A care plan, revised 2/4/25, indicated R2 had a history of inappropriate verbal and physical behavior related to cognitive impairment and displayed the following behaviors: Asking female staff to get in bed with R2; Asking female staff to lift up their shirt; Physically touching female staffs' breasts, pubic region, and buttocks. The care plan also indicated R2 had a history of entering a female resident's room without permission and touched the resident's leg without permission. A progress note in R2's medical record, dated 7/1/25 and written by RN-E, stated R2 rubbed the back of R8's hand and stated, What size are your breasts? R8 stated to R2, You are very inappropriate. R2 then asked, Can I feel your breasts? R8 reported the incident to RN-E. From 7/23/25 to 7/24/25, Surveyor reviewed R8's medical record. R8 was admitted to the facility on [DATE] and had diagnoses including spinal stenosis, type 2 diabetes, congestive heart failure, and insomnia. R8's MDS assessment, dated 6/11/25, had a BIMS score of 15 out of 15 which indicated R8 had intact cognition. R8 was responsible for R8's healthcare decisions. On 7/23/25 at 11:21 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who stated the 7/1/25 note written by RN-E was inaccurate. NHA-A indicated R2 and R8 brushed past each other in their wheelchairs in the hallway. NHA-A indicated Assistant Director of Nursing (ADON)-C followed-up with RN-E on proper documentation and Director of Nursing (DON)-B followed-up with R8 who stated R2 never touched R8 and the statements R2 made occurred a long time ago, not on 7/1/25. On 7/23/25 at 11:51 AM, Surveyor interviewed R8 who stated R2 made inappropriate statements to R8 in the past, but not recently. R8 denied R2 touched R8 recently. R8 indicated R8 was not concerned with R2, denied any distress, and stated staff were usually with R2. On 7/23/25, Surveyor reviewed facility documentation that indicated DON-B followed-up with R8 on 7/2/25. R8 stated R2 did not touch R8 but did say that R8 had large breasts. R8 denied any mental or emotional distress regarding interactions with R2. R8 indicated to DON-B that R2 was old and did not know any better. On 7/23/25 at 2:46 PM, Surveyor interviewed NHA-A and DON-B. DON-B</p>		