STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525579	A. Building B. Wing	01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Little Chute Health Services	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)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety 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 staff interview and record review, the facility did not provide care and services to maintain the highest practicable physical well-being when they did not recognize and appropriately respond to a change in condition for 1 resident (R) (R1) of 6 sampled residents. On 12/23/25, R1 was admitted to the facility following a C3-C4 laminectomy (major spinal surgery in which part of the vertebra is removed). R1 was alert and oriented upon admission. From 12/24/25 to 12/29/25, R1 experienced a change in condition including decreased cognition, an oxygen saturation level of 79% which required continuous supplemental oxygen, an episode of hypoglycemia (low blood sugar) that required 2 doses of glucose gel, and abnormal vital signs. During a care conference on 12/29/25, R1's family reported concerns to staff regarding R1's overall condition. On 12/30/25, R1 was unresponsive when a Registered Nurse (RN) attempted to administer medication. The RN did not assess R1, alert medical staff, or check R1's blood sugar. R1's family called Emergency Medical Services (EMS) who transported R1 to the hospital and noted R1's blood sugar was 42. R1 was admitted to the hospital and diagnosed with severe hypoglycemia with coma requiring emergent intravenous (IV) glucose administration, sepsis secondary to acute cystitis, depressed Glasgow Coma Scale (GCS) (a tool used in the assessment of those with acute brain injury and impaired consciousness) with decreased responsiveness, and acute kidney injury. The facility's failure to recognize and appropriately respond to a change in condition for a resident who experienced decreased cognition, a need for supplemental oxygen, low blood sugar, and abnormal vital signs for a period of days following surgery led to a finding of immediate jeopardy that began on 12/30/25. Nursing Home Administrator (NHA)-A was notified of the immediate jeopardy on 1/15/26 at 4:00 PM. The immediate jeopardy was removed on 1/16/26; however, the deficient practice continues at a scope/severity level D (potential for harm/isolated) as the facility continues to implement its action plan. Findings include: The facility's Change in Condition of the Resident policy, dated 9/2022, indicates: When a resident presents with a possible change of condition .or noted changes in mental or physical functioning: 1. Assess the resident's need for immediate care/medical attention. Provide emergency care as needed. 2. Assess/evaluate the resident. This assessment/evaluation could include, but is not limited to the following: a. vital signs, oxygen saturation, blood glucose level .f. Alteration in level of consciousness, ability to respond .3. Notify resident's physician: a. Immediate notification for any symptom .i. Acute or sudden onset . Aspiration, as defined by the Mayo Clinic, is the unintentional entry of foreign matter into the airways and lungs, which can lead to various pulmonary disorders. It is particularly concerning for older patients, those with neurological disorders, and those with a history of head and neck cancer or structural abnormalities. Chronic aspiration can lead to recurrent pneumonia, bronchiectasis, and malnutrition .Silent aspiration, often unrecognized without objective evaluation, contributes substantially to disease burden. Effective management requires a multidisciplinary approach to preserve quality of life and prevent life- threatening complications. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	From 1/14/26 to 1/15/26, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including C3-C4 laminectomy, cervical spondylosis, diabetes, hypertension, hypothyroidism, atrial fibrillation, and congestive heart failure. R1's Minimum Data Set (MDS) assessment, dated 12/29/25, indicated R1 had moderately impaired cognition. R1was responsible for R1's medical decisions. A progress note, dated 12/23/25 at 9:16 PM, indicated R1 was alert and oriented x 4 (person, place, time, and situation) and able to make R1's needs known. R1 had a Foley catheter that was patent of clear amber urine. R1's lung sounds were clear on room air with no shortness of breath. Progress notes, dated 12/24/25 at 11:45 AM and 1:27 PM, indicated R1 was drowsy and hard of hearing. R1 and R1's family voiced concerns regarding pain management, diet, and bed positioning/repositioning. R1's diet was downgraded to pureed per R1's choice. A progress note, dated 12/25/25 at 2:45 AM, indicated R1's oxygen saturation level was 79%. R1's oxygen saturation level rose to 84% after deep breathing. An on-call Advance Practice Nurse Prescriber (APNP) was notified and gave an order to start 2-5 liters of oxygen. R1 was placed on 2 liters of oxygen. A progress note, dated 12/25/25 at 2:34 PM, indicated R1 slept throughout the shift. R1's medication was crushed because R1 had difficulty swallowing. A progress note, dated 12/26/25 at 6:25 PM, indicated R1 was alert and oriented x 2 (which indicated a decrease in cognition from 12/23/25) and spent a lot of time sleeping. Progress notes, dated 12/27/25 at 8:32 AM and 12:34 PM, indicated R1's blood sugar was 45 and two doses of 40% glucose gel were administered. R1 was alert and oriented x 2-3 and had involuntary jolting arm movements consistent with hypoglycemia. An on-call APNP was notified. An order was given to decrease the frequency of R1's Vicodin from every 4 hours to every 8 hours and update if no improvement in mental status. A progress note, dated 12/27/25 at 2:48 PM, indicated a change in condition evaluation noted R1 had abnormal vital signs (low/high blood pressure, heart rate, respiratory rate, weight change), food and/or fluid intake (decreased or unable to eat and/or drink adequate amounts), and other changes in condition, including talks/communicates less, tired, weak, confused, and/or drowsy. A progress note, dated 12/28/25 at 12:43 PM, indicated R1 had a slight cough. A progress note, dated 12/28/25 at 9:01 PM, indicated an on-call APNP was notified that R1 had a low blood pressure of 94/52. An order was given to hold R1's hydralazine dose (a medication to treat high blood pressure). A progress note, dated 12/29/25 at 1:57 AM, indicated R1 remained on 2 liters of oxygen via nasal cannula and had an oxygen saturation level of 93%. R1's blood sugar was monitored throughout the night due to poor eating. R1 received sips of orange juice throughout the night and had a productive cough with mucus. On 12/29/25, R1's family attended a care conference and shared concerns about R1's eating, confusion, and overall medical condition with Director of Nursing (DON)-B. A progress note, dated 12/30/25, indicated R1's family member called EMS to have R1 sent to the emergency room (ER) due to not eating/drinking for several days. On 1/14/26 at 8:57 AM, Surveyor interviewed Family Member (FM)-P who stated when RN-C entered R1's room on 12/30/25 at 8:10 AM, R1's blood pressure was 102/53. RN-C tried to administer R1's medications in pudding; however, R1 was totally out of it and did not drink or open R1's eyes. FM-P stated RN-C left the room and did not return. FM-P also stated there was no output from R1's catheter. FM-P approached the nurses' station at 9:30 AM and notified RN-C that FM-P was extremely concerned and going to call 911. RN-C stated, I understand. An ambulance arrived at approximately 10:00 AM and EMS asked about R1's blood sugar level. DON- B stated the facility did not know. FM-P stated EMS checked R1's blood sugar in the ambulance which was 42 (According to www.diabetes.org,uk, a blood sugar level below 54 milligrams/deciliter (mg/dL) is a cause for immediate action.) On 1/14/26, Surveyor reviewed an emergency room report, dated 12/31/25, that indicated R1 required critical care and was diagnosed with severe hypoglycemia with coma requiring emergent IV (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	glucose administration, sepsis secondary to acute cystitis, depressed GCS with decreased responsiveness, and acute kidney injury. On 1/14/26 at 1:35 PM, Surveyor interviewed RN-C who stated RN-C was not familiar with R1 and had only known R1 for approximately 3 hours on 12/30/25. RN-C indicated blood sugars are usually obtained between 7:00-9:00 AM and are usually taken before meals. RN-C stated R1's blood sugar order was in the Treatment Administration Record (TAR) instead of the Medication Administration Record (MAR) and indicated orders in the TAR are completed by Certified Nursing Assistants (CNAs). RN-C stated RN-C obtained R1's vital signs at 8:10 AM. RN-C noted R1's blood pressure was low and was going to hold R1's blood pressure medication. RN-C attempted to administer R1's medications but was unable to arouse R1. RN-C verified that FM-P informed RN-C that R1 was not eating or drinking and was concerned. RN-C verified R1's medications were held the day before because R1 was not swallowing and staff were swabbing R1's mouth to provide fluids. On 1/14/26 at 3:51 PM and 1/15/26 at 12:21 PM, Surveyor interviewed DON-B who stated staff should look at both the MAR and TAR for orders. DON-B indicated RN-C should have initiated a change in condition and responded to R1's medical condition promptly. DON-B indicated the response time should be immediate. DON-B verified FM-P reported concerns about R1's condition at a care conference on 12/29/25 and stated staff were reviewing R1's condition. DON-B confirmed a change in condition should have been initiated a few days earlier for R1. The failure to recognize a change in condition for a resident who declined over a period of days following surgery and required hospitalization for critical care created a reasonable likelihood for serious harm and thus leading to a finding of immediate jeopardy. The facility removed the jeopardy on 1/16/26, however, the deficient practice continues at a scope/severity level D (potential for harm/isolated) as the facility continues to implement the following action plan: 1. Reviewed current residents with like diagnoses to ensure appropriate monitoring/interventions were in place.2. Reviewed the last fourteen days of residents' progress notes and vital signs completed on 1/15/26 to identify residents with a potential change in condition that required provider notification, care plan changes, or additional monitoring.3. Educated licensed nurses on the need to promptly recognize, assess/evaluate, and report a change in condition. Education included the importance of implementing appropriate follow-up monitoring. 4. Educated CNAs on recognizing and reporting changes in condition to a licensed nurse.5. Initiated audits to ensure monitoring protocols are in place for new admissions with diabetes.6. Initiated audits of nursing documentation to ensure changes in condition are promptly identified, pertinent and accurate medical information is communicated to the physician, and appropriate monitoring interventions are implemented.

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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 observation, staff interview, and record review, the facility did not provide the necessary care and services to prevent the development of avoidable pressure injuries and/or promote healing for 2 residents (R) (R1 and R2) of 5 sampled residents. R1 was admitted to the facility on [DATE] without any pressure injuries. A Braden Scale assessment completed upon admission indicated R1 was at high risk for the development of pressure injuries. R1 was admitted to the hospital on [DATE] with a bilateral sacral pressure injury with serosanguineous (a fluid mixture of serous fluid (clear plasma) and blood, appearing as thin, watery, pinkish or light red indicating mild capillary bleeding) drainage, a right posterior thigh pressure injury, and a right heel pressure injury. The facility was unaware of the pressure injuries. A skin integrity care plan for R1 was not initiated until 1/5/26 (which was six days after R1 was admitted to the hospital.) This example is being cited at a level G (actual harm/isolated). R2 was admitted to the facility on [DATE] with a stage 4 sacral pressure injury and had an order for an alternating air mattress to be set at 250 pounds alternating. On 1/14/26, R2's air mattress was set at 350 pounds alternating. On 1/15/26, R2's air mattress was set at 350 pounds static (not alternating). In addition, R2's most recent weight was 156 pounds which indicated the air mattress should have been set at 200 pounds per manufacturer's guidelines. Findings include: According to the National Pressure Injury Advisory Panel: Deep tissue pressure injury remains one of the most serious forms of pressure injury. The pressure is exerted at the muscle-bone interface but due to the resiliency of the skin, the color change is not immediate, in contrast to a bruise. The process leading to deep tissue pressure injury precedes the visible signs of purple or maroon skin tears. Within another week, the wound bed is often necrotic. The lag between the pressure event and the change in color of the skin makes the root cause analysis complex. It is important to be aware that 48 hours prior to the patient's skin being deep red, maroon, or purple, he/she may not have been in your facility. The facility's Pressure Injuries and Non Pressure Injuries policy, dated 7/2022, indicates: This center will complete a comprehensive assessment to identify risk factors for the development of pressure injuries and put in place measures intended to achieve the goal of prevention of pressure injuries in our residents. For those residents admitted with, or who subsequently develop a pressure injury or impaired skin integrity, they will receive care, treatment, and services that seek to promote healing, prevent infection, and prevent further development of pressure injuries/impaired skin integrity .Care Planning: A comprehensive skin integrity care plan is based on resident history, skin assessments, Braden Scale scoring, nutritional assessments, resident and family interviews, and staff observations. Consider the areas of risk, as well as the overall risk assessment score of the Braden Scale. Communicate identified risk factors and interventions to direct care staff. 1. Develop interventions based on subsets of the Braden Scale .A stage 4 pressure injury includes full thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone in the ulcer, slough (yellow, white, or gray dead tissue, fibrin, proteins, and white blood cells that form in the wound bed acting as a barrier that slows or prevents healing) or eschar (dark, hard scab of dead tissue that forms over a deep wound acting as a protective barrier but also potentially hindering healing by trapping bacteria) .For residents admitted with a pressure injury, they will (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	receive care, treatment, and services that seek to promote healing, prevent infection, and prevent further development of pressure injuries. 1. From 1/14/26 to 1/15/26, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including C3-C4 laminectomy, cervical spondylosis, diabetes, and congestive heart failure. R1's Minimum Data Set (MDS) assessment, dated 12/29/25, indicated R1 had moderately impaired cognition. R1was responsible for R1's medical decisions. On 1/14/26, Surveyor reviewed R1's progress notes, care plan, and Treatment Administration Record (TAR) which indicated the following: ~ Hospital transfer orders, dated 12/23/25, did not contain any wounds aside from R1's C3-C4 cervical surgery site. ~ A note, dated 12/23/25 at 9:05 PM, indicated an admission assessment was completed with no wounds. ~ A note, dated 12/23/25 at 5:08 PM, indicated a Braden Scale Assessment was completed with a score of 15 which indicated R1 was at high risk for the development of pressure injuries. Documented wounds included: cervical surgical incision, left hand (back) bruising, left antecubital bruising, and bilateral wrist bruising. ~ A care plan, initiated 12/23/25, did not contain a focus area or interventions to prevent alteration in skin integrity. (Of note: A skin integrity care plan was initiated on 1/5/26 which was 6 days after R1 was admitted to the hospital.) ~ Nursing documentation from 12/23/25 to 12/30/25 did not contain skin integrity information or skin assessments other than the Braden Scale assessment completed upon admission. ~ A note, dated 12/24/25 at 9:13 PM, indicated R1 had been in bed since arriving at the facility. ~ R1's TAR contained daily documentation of diabetic foot checks at bedtime. Hospital wound care notes, including an initial assessment of R1's wounds (dated 12/30/25 at 11:00 AM) and complete wound assessments (dated 12/31/25 at 5:05 PM) indicated: ~ R1 had a bilateral sacral pressure injury classified as a deep tissue injury that measured 11 centimeters (cm) (length) x 9 cm (width) x 0.l cm (depth) with a small amount of serosanguineous drainage. ~ R1 had a right posterior thigh pressure injury classified as a deep tissue injury that measured 9.3 cm x 10.5 cm with no drainage. ~ R1 had a right heel pressure injury classified as a deep tissue injury that measured 2.7 cm x 3.6 cm with no drainage. On 1/15/26 at 8:39 AM, Surveyor interviewed Registered Nurse (RN)-F who stated RN-F obtains vital signs and does a head-to-toe assessment during the admission process. RN-F stated R1 had bilateral hand edema. RN-F stated RN-F would have assessed R1's coccyx if there were any wounds documented on (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	the Braden Scale assessment. RN-F did not recall if R1 had a specialty mattress upon admission or if one was added later. On 1/15/26 at 4:19 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-D who stated LPN-D does not complete skin assessments because they are done on the AM shift when residents are changed. LPN-D stated R1 had many bruises due to intravenous (IV) therapy in the hospital. On 1/15/26 at 8:27 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-E who stated R1 had a bowel movement on 12/26/25 and there was a dressing on R1's coccyx. CNA-E did not know who applied the dressing and stated the dressing was clean and not removed during cares. CNA-E indicated staff offered to reposition R1 every two hours; however, R1 occasionally refused. CNA-E did not recall if R1 had a specialty mattress. On 1/15/26 at 12:09 PM, Surveyor interviewed LPN-G who stated LPN-G assisted with repositioning R1 but did not recall if R1 had any skin injuries. LPN-G stated staff applied zinc to R1's coccyx. On 1/14/26 at 12:03 PM and 1/15/26 at 12:41 AM, Surveyor interviewed Advanced Practice Nurse Prescriber (APNP)-H who completed R1's admission assessment on 12/24/25 but did not recall if R1 had any wounds. APNP-H reviewed hospital wound photos and documentation and stated R1's coccyx wound appeared to be older than 24 hours, however, the thigh and heel wounds were questionable. On 1/15/26 at 11:42 AM, Surveyor interviewed Director of Nursing (DON)-B who stated nursing staff completed a Braden Scale assessment for R1 upon admission and noted no wounds other than a surgical incision. DON-B was not aware that staff applied a dressing to R1's coccyx and was not aware that a skin integrity care plan focus area was added on 1/5/26. DON-B indicated if R1's skin was fragile, anything could develop in a short period of time. 2. On 1/15/26, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including quadriplegia, dysphagia, expressive aphasia, anxiety, and a stage 4 sacral pressure injury. R2's MDS assessment, dated 11/13/25, indicated R2's Brief Interview for Mental (BIMS) score was not assessed. R2 was R2's own decision maker. Per staff interview, R2 could appropriately answer yes/no questions and used a communication application on a tablet. A care plan, dated 11/10/25, indicated R2 was admitted with a stage 4 pressure injury on the sacrum. The care plan contained interventions for a pressure redistribution cushion on chair and an air mattress set to 250 pounds alternating on the bed. R2's TAR contained an order to check the function and setting of the air mattress every shift: 250 pounds alternating. A wound assessment, dated 1/13/26, indicated R2 had a stage 4 pressure injury on the coccyx that measured at 1.2 cm x 1 cm x 0.3 cm. On 1/14/26 at 10:07 AM, Surveyor observed R2 in bed. R2's air mattress was set at 350 pounds alternating. On 1/15/26 at 8:46 AM, Surveyor observed R2 in bed. R2's air mattress was set at 350 pounds static (versus alternating as care planned). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 1/15/26, Surveyor reviewed R2's TAR for 1/14/26 and 1/15/26 and noted staff documented that R2's air mattress was set appropriately at 250 pounds on the 1/14/26 AM, PM, and night (NOC) shifts and the 1/15/26 AM shift. On 1/15/26, Surveyor reviewed the manufacturer's guidance regarding air mattress settings. The manual stated the number was to be set as close as possible to the resident's current weight to ensure proper pressure relief. R2's most recent weight was 156 pounds on 1/10/26. According to ProCare Medical Equipment: When an air mattress is set too firmly, it loses its ability to provide the pressure redistribution therapy it was designed for. The cells become firmer than a standard mattress and all pressure reduction qualities go by the wayside .This is avoidable with appropriate settings. On 1/15/26 at 9:02 AM, Surveyor interviewed LPN-I regarding R2's air mattress setting and order. RN-I stated staff check R2's air mattress setting each shift and document it in the TAR. If the setting is incorrect, staff correct it and notify DON-B and/or the wound nurse. On 1/15/26 at 11:11 AM, Surveyor interviewed DON-B regarding R2's pressure injury and air mattress setting. DON-B verified R2's air mattress was set too high and should be at set at approximately 200 pounds based on R2's most recent weight. DON-B also verified R2's air mattress was not set to alternating on 1/15/26. DON-B stated R2's order and care plan were updated on 1/15/26 and DON-B would update the wound nurse and provide education to staff on checking air mattress settings appropriately.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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, staff and resident interview, and record review, the facility did not ensure adequate supervision, positioning, and assistive devices were provided during a meal for 1 resident (R) (R2) of 3 sampled residents.R2 had a history of aspiration. R2's care plan indicated R2 required 1:1 supervision for meals. The care plan contained interventions to encourage R2 to take small bites and clear mouth before the next bite, to seal R2's lips around the cup opening until R2 swallowed, and to be seated upright during meals and have a neck pillow in place for proper positioning. R2 was hospitalized from [DATE] to 12/22/25 for sepsis caused by urinary tract infection (UTI) and aspiration. On 1/15/26, Surveyor heard R2 coughing and observed R2 eating alone in R2's room with the curtain drawn and the head of the bed at 45 degrees. Staff were not in R2's room or in the hallway outside the room providing supervision. There was a large amount of food on R2's dignity cover and juice spilling out the right side of R2's mouth. The facility's failure to provide adequate supervision, positioning, and an assistive device during meal time for a resident at risk of aspiration led to a finding of immediate jeopardy that began on 1/15/26. Nursing Home Administrator (NHA)-A was notified of the immediate jeopardy on 1/15/26 at 4:00 PM. The immediate jeopardy was removed on 1/16/26; however, the deficient practice continues at a scope/severity level D (potential for harm/isolated) as the facility continues to implement its action plan.Findings include:The facility's Dining Experience policy, revised 7/27/25, indicates: Individuals will be positioned comfortably for the meal in a way that will assist with independent eating (i.e., promote safe swallowing) and that positioning and assistance must be appropriate for individual needs. Individuals should eat in an upright position and be positioned properly. Beds will be at the appropriate height and position for those eating in bed (as close to 90 degrees as possible). Staff will provide cueing, prompting, or assistance as needed to prevent a decline in eating ability. On 1/15/26, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including quadriplegia, dysphagia, expressive aphasia, and anxiety. R2's most recent Minimum Data Set (MDS) assessment, dated 11/13/25, indicated R2's Brief Interview for Mental Status (BIMS) score was not assessed. R2 was R2's own decision maker. Per staff interview, R2 was able to appropriately answer yes/no questions and used a communication application on a tablet.A progress note, dated 11/23/25, indicated R2 coughed and had food coming out of R2's mouth during lunch. The head of R2's bed was elevated to sitting. Staff assisted R2 with finishing the meal and provided cues to take small bites and clear R2's mouth. There were no further episodes or signs/symptoms of aspiration.R2's comprehensive care plan, revised 11/26/25, indicated R2 was at risk for nutritional status change related to dysphagia with need for mechanically-altered texture and thickened liquids. The care plan contained a goal that R2 would not exhibit chewing or swallowing problems as evidenced by no signs or symptoms of aspiration, choking, or complaints of difficulty eating. The care plan contained interventions including 1:1 supervision for all meals, encourage small bites and clear mouth before next bite, encourage (R2) to seal lips around cup opening until swallow is completed (11/7/25), insert neck pillow for proper neck positioning for all meals (11/14/25); and position (R2) upright in wheelchair for meals (11/26/25). A progress note, dated 12/13/25 at 10:04 PM, indicated R2 refused supper and did not drink much. When asked if R2 was okay, R2 said R2 did not know and R2's lungs felt funny. An assessment indicated R2's lung sounds were mostly clear with crackles.A progress note, dated 12/14/25 at 5:15 AM, indicated R2 vomited during the night shift. The on-call physician ordered Zofran (an antiemetic), light and bland meals for 12/14/25, and to monitor R2 for nausea/emesis.A progress note, dated 12/14/25 at 5:56 PM, indicated R2's vital (continued on next page)

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	525579	A. Building B. Wing	01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Little Chute Health Services	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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	signs changed during the shift. R2's oxygen saturation level was 89% on room air, respirations were 24, and pulse was 123. R2's lung sounds included rhonchi (low-pitched, rattling, snoring-like sounds heard during breathing caused by mucus or secretions in the larger airways and often indicative of bronchitis or pneumonia). R2 was transferred to the hospital.A progress note, dated 12/22/25 at 11:34 PM, indicated R2 was on new admission follow-up and required honey-thick liquids and full assistance with feeding.On 1/15/26, Surveyor reviewed R2's hospital paperwork for R1's 12/14/25 to12/22/25 stay. An Occupational Therapy (OT) evaluation, dated 12/14/25, indicated R2's swallowing precautions included upright positioning, one sip or bite at a time, alternate liquids and solids, and 1:1 supervision during meals. A computed tomography (CT) scan (a non-invasive imaging procedure that uses X-rays to create detailed cross-sectional images of the body) completed on 12/14/25 revealed focal infiltrate (localized areas in tissue with abnormal density that indicate the collection of pus, fluid, or abnormal cells and commonly signal infection/inflammation) or atelectasis (the collapse of part or all of a lung that prevents normal gas exchange and is often caused by airway blockage) in the dependent portion of the right lung. An initial physician exam, dated 12/14/25, indicated R2 was admitted with acute onset of hypoxemia (low oxygen saturation) and a low-grade fever after an episode of vomiting. Imaging revealed right lower lobe infiltrate typical of aspiration. R2 was treated with levofloxacin (an antibiotic). R2 was also treated for septic shock (a life-threatening, advanced stage of sepsis where infection causes severe, persistent low blood pressure and cellular dysfunction, resulting in over 40% mortality) in the Intensive Care Unit (ICU) from 12/15/25 to 12/17/25. R2 discharged back to the facility on [DATE] with an additional seven day course of oral antibiotics.On 1/14/26 at 11:45 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-M who wrote the 11/23/25 progress note and observed R2 coughing during lunch. LPN-M recalled the coughing episode and stated the information was reported at a morning meeting on 11/24/25. LPN-M was not sure if anything was done after that and verified LPN-M did not notify the physician. LPN-M stated R2 required direct supervision during meals because R2 ate quickly and needed reminders to slow down, alternate sips, and take breaths. LPN-M stated R2 also needed to be seated as close to 90 degrees as possible during and for a while after meals. LPN-M indicated R2 required constant supervision when eating in R2's room. On 1/14/26 at 11:55 AM, Surveyor interviewed Advanced Practice Nurse Prescriber (APNP)-H regarding R2's coughing episode on 11/23/25. APNP-H did not recall being notified. APNP-H stated APNP-H would want to be notified and would want to ensure staff assessed R2's respiratory status (vital signs, lung sounds, etc.) at least each shift. A Speech Therapy (ST) progress note, dated 12/11/25, indicated R2 required prompting to improve oral containment and bolus management. Safety precautions were emphasized with staff, including upright posture. A ST evaluation, dated 12/31/25, indicated R2's precautions included pureed texture and honey-thick liquids. It was recommended that R2 eat in a wheelchair with total supervision and be upright for meals. ST recommendations for swallowing strategies included positioning R2 upright during meals and upright posture for at least 30 minutes after meals.A ST progress note, dated 12/11/25, indicated R2 required prompting to improve oral containment and bolus management. Safety precautions were emphasized with staff, including upright posture. A ST treatment note, dated 1/13/26, indicated R2 was on a pureed diet with honey-thick liquids. It was recommended that R2 eat in a wheelchair with total supervision and be upright for meals.A ST encounter note, dated 1/14/26, indicated Speech Therapist (ST)-L reviewed R2's Videofluoroscopic Swallow Study (VFSS) (a real-time X-ray procedure conducted by a speech-language pathologist and radiologist to evaluate oral, pharyngeal, and esophageal swallowing functions) done on 12/16/25 which indicated R2's airway was invaded by nectar-thick liquids during 1 of 2 opportunities. R2 also presented with poor posture (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and an inability to sense penetration/aspiration. On 1/15/26 at 8:40 AM, Surveyor was walking towards R2's room and overheard several deep, congested coughs from R2 before R2's airway was cleared. Surveyor observed R2 in bed eating breakfast. The head of the bed was at 45 degrees and R2 did not have a neck pillow in place. R2's dignity cover contained multiple bites of food and there was juice spilling out the right side of R2's mouth. There were no staff in the room or in the hallway. When Surveyor asked if staff had been in the room to assist or check on R2 since breakfast began, R2 shook R2's head no. When Surveyor asked if staff usually sat in R2's room to provide supervision and/or assistance during meals, R2 shook R2's head no. On 1/15/26 at 9:01 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-J and CNA-K who were assigned to R2's wing. Both staff indicated they assist R2 with meal set-up and look in R2's room every 15 to 20 minutes. Both staff stated they would notify the nurse immediately if R2 was coughing.On 1/15/26 at 9:23 AM, Surveyor interviewed Registered Nurse (RN)-C who verified R2 should be directly supervised when eating which is indicated on R2's Kardex (an abbreviated care plan used by nursing staff). RN-C stated R2 typically eats in R2's room.On 1/15/26 at 9:39 AM, Surveyor interviewed ST-L regarding R2's positioning and supervision during meals. ST-L stated R2 should be seated as close to 90 degrees as possible during meals and at least 30 minutes afterward to reduce the risk of aspiration. ST-L stated while R2 may be more appropriate for general supervision during meals with additional adaptive equipment, R2's care plan stated total supervision. On 1/15/26 at 10:14 AM, Surveyor interviewed Director of Nursing (DON)-B regarding R2's supervision and positioning during meals as well as follow-up for R2's coughing episode on 11/23/25. DON-B verified staff should be with R2 when R2 is eating in R2's room and should watch for signs/symptoms of aspiration. Regarding follow-up for R2's coughing episode on 11/23/25, DON-B indicated the Interdisciplinary Team (IDT) discussed the incident on 11/24/25 and updated R2's care plan with an intervention to get R2 up/out of bed and in a chair or dining room for meals. On 1/15/26 at 12:22 PM, Surveyor observed ST-L in R2's room providing supervision and cueing during the lunch meal. Surveyor observed R2 sitting at 90 degrees in a chair with a neck pillow in place. ST-L confirmed that R2 eats better and maintains best positioning when provided cues during a meal.The facility's failure to provide proper supervision, positioning, and an assistive device during meal time for a resident with a history of aspiration created a reasonable likelihood for serious harm which led to a finding of immediate jeopardy. The facility removed the jeopardy on 1/16/26, however, the deficient practice continues at scope/severity level D (potential for harm/isolated) as the facility continues to implement the following action plan: Reviewed R2's care plan, dietary orders, and ST recommendations and made appropriate updates/revisions.Reviewed current residents to identify those who require supervision, assistance, cueing, or monitoring during meals due to aspiration risk.Educated staff on R2's care plan and supervised meals and snacks for residents at risk for choking or aspiration. Nursing staff were also instructed to verify diet orders and supervision levels prior to serving meals, document the supervision provided, and promptly report swallowing concerns and condition changes.Observed meal service to ensure compliance with general supervision recommendations.Initiated record review and observation audits to ensure ST recommendations are documented in residents' care plans and are being followed by staff.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure physician visits were completed timely for 1 resident (R) (R6) of 3 sampled residents. R6 was admitted to the facility on [DATE]. R6 was not seen by a physician at least once every 30 days for the first 90 days after admission.Findings include:The facility's Physician Visits and Physician Delegation policy, revised 7/27/25, indicates: .2. The physician should: a. See resident within 30 days of initial admission to the facility. b. The resident must be seen at least once every 30 calendar days for the first 90 calendar days after admission .On 1/20/26, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] and had diagnoses including vascular dementia, hemiplegia, cerebral infarction, and diabetes. R6's Minimum Data Set (MDS) assessment, dated 12/30/25, had a Brief Interview for Mental Status (BIMS) score of 6 out of 15 which indicated R6 had severe cognitive impairment.Surveyor reviewed R6's physician visits after admission and noted R6 was not seen by a physician within 30 days of admission (including a 10 day grace period) and every 30 days after for the first 90 days. Surveyor noted R6's initial visit was completed by an Advance Practice Nurse Prescriber (APNP) on 2/20/25. R6 was seen by a physician on 4/8/25 and 6/10/25. On 1/20/26 at 1:35 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who confirmed R6 was not seen by a physician for the initial visit and was missing a physician visit in May of 2025.