

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

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 07/29/2026
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)		
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 adequate supervision and interventions were in place to prevent falls for 2 residents (R) (R1 and R3) of 3 sampled residents from a total sample of 11 residents. R1 sustained multiple falls with injury (including a broken nose and patella fracture) and without injury while on 1:1 supervision and 30-minute checks. Check sheets contained gaps in completion and were missing entries for days which coincided with some of R1's falls. In addition, R1's medical record did not consistently indicate when they were on 1:1 supervision, 15-minute checks, or 30-minute checks. (This example is being cited at a level G.) R3 was left in bed connected to a Hoyer lift without staff in the room to provide supervision. Findings include: The facility's Fall Prevention and Management Guidelines policy, revised 7/18/24, indicates: .Suggested interventions for residents determined to be at higher risk for falls may include: .b. Provide additional interventions as directed by the resident's assessment and based on input from the resident or family members, including but not limited to: .ii. Increased frequency of rounds; iii. Increased supervision, if indicated .The plan of care will be revised as needed and should be communicated to the staff, resident, and resident's family/responsible party. The facility's Safe Lifting and Movement of Residents Policy, revised 11/28/22, indicates: .3. Staff responsible for direct resident care will receive education on transfers including the use of gait belts and mechanical lifts before providing direct care. Staff will be observed for competency in using mechanical lifts and performing manual transfers (one and two-person assist transfers) . 1. R1 was admitted to the facility on [DATE] after a 46-day hospital stay related to recurrent falls and failure to function at home. R1 had diagnoses including Alzheimer's disease with early onset, dementia, fracture of nasal bones, encounter for palliative care, laceration without foreign body of other part of head, repeated falls, anxiety disorder, and right fracture of the patella. An admission Minimum Data Set (MDS) assessment, dated 12/14/25, stated R1 had a Brief Interview for Mental Status (BIMS) score of 5 out of 15, indicating severely impaired cognition. The assessment also indicated R1 had multiple falls, including one with a major injury. R1 had an activated Power of Attorney for Healthcare (POAHC). R1 was transferred to the hospital after a fall on 2/12/26 and did not return to the facility. R1 remained in the hospital for over 90 days before their family found another facility for them. (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A hospital Discharge summary, dated [DATE], indicated R1 was admitted to the hospital on [DATE] for recurrent falls and failure to function at home. R1 had diagnoses including Alzheimer's dementia, spinal stenosis, multilevel degenerative changes of the spine, osteoarthritis of the spine, and peripheral neuropathy which were likely causes or contributing factors of the falls. Physical Therapy staff indicated R1 would likely require stand-by-assistance. R1's hospital course was complicated due to their impulsiveness. R1 did not always cooperative with staff and experienced several falls. R1's dementia with agitation also contributed to their severe fall risk because they did not request assistance when ambulating. An activities of daily living (ADL) self-care and functional deficit care plan (initiated 12/8/25) indicated R1 had impaired balance, cognition deficit, and impaired vision. The care plan contained an intervention (dated 1/15/26 to 1/20/26) for 1:1 supervision at all times. A behavior care plan (initiated 1/8/26) contained an intervention (dated 1/20/26 to 2/4/26) for 1:1 supervision at all times. A potential for falls due to impulsive behavior, restlessness, unsteady gait, poor trunk control, impaired cognition, impaired safety awareness, medication side effects, and shuffles feet when walking care plan (initiated 12/8/26) indicated R1 self-transferred, attempted to ambulate without assistance, and did not use the call light for assistance. The care plan indicated R1 would not allow staff to assist them off the floor due to a previous fall involving a full-body lift. R1 often refused assistance from staff, however, staff stood by R1 for safety due to them self-transferring off the floor per their choice. R1 often refused to wear gripper socks. Risks versus benefits education was completed. The care plan indicated R1 could lock their wheelchair without prompting, however, forgot to do so at times due to impulsivity. A physician's discharge summary indicated R1's falls were likely due to a combination of peripheral neuropathy, osteoarthritis of the spine, spinal stenosis, and Alzheimer's dementia. The care plan contained the following interventions: ~ Assist to/from destination when seen attempting to self-transfer (initiated 1/7/26) ~ Bed at transfer height (initiated 1/6/26) ~ Check on and ask if R1 needs to use the restroom prior to meals (initiated 12/16/25); Check on R1 approximately every 2 hours and assist to bathroom when awake, if sleeping do not wake up (initiated 2/2/26) (At this point in time, the care plan indicated R1 was on 1:1 supervision.) ~ Dycem added to the top and below the wheelchair cushion (initiated 12/19/25); Ensure Dycem is on recliner chair (initiated 12/20/25) ~ Encourage to wear gripper socks at all times (initiated 12/8/25); Non-skid clothing encouraged and slippery clothing removed (initiated 12/18/25) ~ Encourage to transfer and change positions slowly (initiated 12/8/25); Monitor orthostatic blood pressure (initiated 1/12/26) (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	~ Engage in an activity by the nurses' station before supper (initiated 1/12/26) ~ Ensure room is tidy, organized, and clutter free (initiated 12/28/25) ~ Ensure walker is next to R1 when in bed and recliner (initiated 2/11/26); Have commonly used articles within easy reach (initiated 12/9/25); Reacher in room (initiated 1/26/26) ~ If awake, offer to get R1 up for the day around 6:00 AM (initiated 2/2/26); Night shift to encourage toileting and ADLs to get ready for the day if awake between 5:30-6:30 AM (initiated 2/7/26) ~ Offer to go to bed around 8:00-8:30 (PM) (initiated 1/12/26); If still awake in wheelchair after 8:00 PM, offer an activity for R1 to engage in by the nurses' station (initiated 1/12/26) ~ Keep pudding and apple sauce in room (initiated 2/2/26); Offer snacks between meals (initiated 2/2/26) ~ Medication regimen review completed by Hospice (initiated 12/9/25) ~ Nightlight in room and bathroom (initiated 1/28/26); Nightlight was added to bathroom (initiated 2/2/26) ~ Offer to stay outside of room when awake and active, watch movies by the nurses' station, join activities, or visit with family (initiated 12/16/25) ~ Offer toileting and transfer into recliner after supper (initiated 1/12/26); Offer toileting beginning of night shift (initiated 12/23/25); Place urinal in room and demonstrate its use. Provide cueing and reminders as necessary (initiated 2/11/26) ~ Bed moved to other side of room, close to bathroom (initiated 12/10/25) ~ Room near nurses' station (initiated 12/8/25) ~ Sign in room: Lock your wheelchair (initiated 1/8/26) ~ Stay within eyesight when they are using the restroom (initiated 12/16/25) ~ When spouse not at facility, encourage R1 to be at nurses' station from 2:30 PM until supper time. Offer snacks and activity to keep entertained (initiated 2/2/26; revised 2/16/26). R1's medical record contained the following risk versus benefits statements: ~ 1/9/26 - R1 should wear grippy socks or appropriate footwear for transfers, ambulation, and when up in wheelchair. POAHC states they try to have R1 wear grippy socks or footwear which they will often remove themselves. Interventions: Ensure R1 has appropriate footwear/grippy socks during care times. If R1 is barefoot, encourage to put grippy socks or footwear on. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	~ 12/23/26 - Broda scoot. POAHC states Broda scoot limits R1's ability to move and declined for R1 to be in Broda scoot when POAHC is at the facility. (Child) also involved in discussion and is asking POAHC to reconsider the recommendation. Interventions to minimize risk of not following recommendations/orders: R1 is encouraged to be in common areas when awake and in wheelchair; Dycem to chair. ~ 1/19/26 - Commode over toilet for easier, safer transfers on and off the toilet. R1 will sometimes allow it and at other times will not use the restroom unless it is moved. POAHC aware of preferences. ~ 1/21/26 - Use Hoyer lift to get off of floor after a fall. R1 refuses to do this. POAHC is aware and stated to let R1 do things their way. ~ 1/30/26 - R1 is a one assist for transfers and uses a wheelchair for locomotion. POAHC is aware that R1 self-transfers without calling for help and states that is the way they have always been. Frequent checks; Dycem in wheelchair and recliner; Wheelchair in locked position next to bed; Side rails; Grippy socks. ~ 2/11/26 - Recommend for R1's recliner to be moved closer to the bathroom. R1 has had many falls where they self-transferred from the recliner to the bathroom. Nursing Home Administrator (NHA)-A spoke with R1 and their POAHC about fall prevention. The Interdisciplinary Team (IDT) suggested to move the recliner to the opposite side of the room closer to the bathroom to shorten the distance R1 has to walk from the recliner to the bathroom. POAHC does not want the recliner moved at this time and will talk to R1 about re-arranging the room before the recliner is moved. Surveyor reviewed R1's falls and noted the following: R1 fell on [DATE] at 10:45 AM and 12/9/25 at 2:00 AM and 5:30 PM. On 12/10/25 at 3:00 AM, R1 fell. A Fall Risk Management report indicated R1's nose appeared to be broken. R1 stated they hit their nose on the floor and was sent to the emergency room (ER) for evaluation. (A hospital visit summary, dated 12/10/25, confirmed a mildly displaced nasal fracture.) On 7/28/26 at 9:09 AM, Surveyor interviewed NHA-A who stated 30-minute checks were initiated after R1's fall on 12/10/25. The facility implemented 30-minute check sheets where staff initialed every 30-minutes and documented where R1 was and what they were doing. (R1's care plan was not updated to indicate they were placed on 30-minute checks.) R1 continued to fall. Surveyor compared sign-out sheets and Fall Risk Management reports to determine when R1 was last seen. Surveyor noted R1's 30-minute check sheets contained many blanks and missing days. R1 fell on [DATE] at 2:30 PM, 12/17/25 at 9:30 PM, 12/18/25 at 2:45 PM, 12/19/25 at 10:30 AM, 12/20/25 at 3:40 PM, and 12/21/25 at 10:45 PM. Fall documentation and Fall Risk Management reports indicated the 30-minute check sheets were signed out or R1 was last seen within 30 minutes of the falls. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 12/22/25 at 8:00 AM, R1 had an unwitnessed fall without injury. The 30-minute check sheet was not signed out. A Fall Risk Management report did not indicate the last time R1 was seen. R1 fell on [DATE] at 7:15 AM, 12/25/25 at 9:15 PM, 12/26/25 at 11:55 PM, and 12/27/25 at 3:54 PM. Fall documentation and Fall Risk Management reports indicated the 30-minute check sheets were signed out or R1 was last seen within 30-minutes of the falls. R1 fell on [DATE] at 4:25 PM, 12/30/25 at 8:30 PM, and 1/1/26 at 10:00 PM. The 30-minute check sheets were not signed out at the time of the falls. Fall Risk Management reports did not indicate the last time R1 was seen. On 1/3/26 at 7:00 AM, R1 had an unwitnessed fall. Fall documentation and a Fall Risk Management report indicated the 30-minute check sheet was signed out or R1 was last seen within 30-minutes of the fall. On 1/4/26 11:30 PM, R1 had an unwitnessed fall and was found sitting on the toilet. A Fall Risk Management report indicated R1 was sleeping in bed prior to being found in the bathroom without a wheelchair. R1 had a gash on their forehead that was 3 centimeters (cm) long x 0.25 cm wide with an unknown depth. R1 received 3 stitches at the hospital. A Falls Risk Management report did not indicate the last time R1 was seen. A 30-minute check sheet was not signed out. The facility completed a chart review of R1's falls and noted 30-minute check sheets were missing. The facility provided staff education that included reminders of various interventions, to monitor every 30 minutes (fill out the 30-minute check sheet), and monitor if R1's call light is on. The education was signed by staff on 1/7/26. A Hospice note written by Hospice Registered Nurse (HRN)-G on 1/7/26 indicated staff continued with 30-minute checks. R1 fell on 1/8/26 at 10:00 AM, 1/10/26 at 5:30 PM, and 1/12/26 at 8:15 AM. Fall documentation and Fall Risk Management reports indicated the 30-minute check sheets were signed out or R1 was last seen within 30 minutes of the fall. On 1/13/26 at 6:45 PM, R1 had an unwitnessed fall in the courtyard. The door alarm went off and staff responded. A Fall Risk Management report indicated R1 was last seen approximately 4 minutes prior to the fall. R1 was wearing appropriate footwear and clothing. A progress note indicated R1 had been wandering into residents' rooms and was difficult to redirect. R1 was placed on a 1:1 supervision after the fall and their care plan was updated. (The facility continued to use the same 30-minute check sign-out sheet previously used to document 1:1 supervision.) R1 fell during 1:1 supervision on 1/17/26 at 7:28 PM and 1/25/26 at 5:45 PM. On 1/28/26 at 11:45 PM, R1 had an unwitnessed fall. A Fall Risk Management report indicated the writer and Certified Nursing Assistant (CNA)-K heard a loud bang at the nurses' station and found R1 on the floor on their left side. A skin assessment revealed several skin tears, including one on the left (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	1/13/26 until 2/4/26. R1 was on 30-minute checks from 2/5/26 until they transferred to the hospital on 2/12/26. (R1's care plan was not updated.) R1 had falls on 2/5/26 at 6:30 AM and 4:20 PM, 2/6/26 at 5:50 AM and 3:15 PM, 2/8/26 at 6:30 AM and 6:35 AM, and 2/10/26 at 8:00 AM and 2:00 PM. R1 had a third fall on 2/10/26 at 7:00 PM that was unwitnessed. R1 attempted to self-transfer to their wheelchair and was found on the floor leaning on the wheelchair. R1 had an abrasion on the left knee and reported pain from the stupid questions. A fall report indicated R1 was last seen in the wheelchair at 6:00 PM (1 hour prior). R1's 30-minute check sheet was blank between 3:00 PM and 9:30 PM. R1 fell on 2/11/26 at 5:00 AM and 9:20 PM. A Fall Risk Assessment on 2/11/26 indicated to increase check frequency which was not updated on R1's care plan or addressed in a Fall Risk Management report. R1 was on 30-minute checks and staff continued to document on the 30-minute check sheet. R1 fell on 2/12/26 at 7:25 AM and 1:00 PM. Following the second fall, R1 was transferred to the ER and did not return to the facility. An X-ray revealed a right patella fracture. An ER note, dated 2/12/26, indicated R1 arrived after increased falls. X-rays of the knees revealed a right non-displaced patella fracture. R1 did not plan to return to the facility and needed placement at another facility. A Hospice note on 2/12/26 indicated R1's spouse and family were overwhelmed and upset with the facility and felt R1's care needs were not adequately met due to numerous falls. On 7/27/26 at 3:47 PM, Surveyor interviewed LPN-H who stated the facility did all they could to keep R1 safe and always had a 1:1 staff available. LPN-H was not aware of a time when R1 was not on 1:1 supervision but should have been. LPN-H stated before the facility officially put R1 on 1:1 supervision, LPN-H sat with R1 because they fell so much. LPN-H stated R1 was fast and impulsive and had behavior toward staff at times. (Surveyor interviewed LPN-H prior to knowing they were the nurse on duty when R1 fell on 1/28/26 when documentation showed R1 was not on 1:1 supervision per their care plan.) On 7/28/26 at 8:45 AM, Surveyor interviewed Hospice Social Worker (HSW)-I who stated R1 was impulsive, challenging, and had poor safety awareness. HSW-I stated the facility eventually implemented 1:1 supervision, however, it took a while to implement after numerous falls. HSW-I did not feel the facility had enough staff to keep R1 safe. HSW-I was not aware of a time when 1:1 supervision was not provided but should have been. On 7/28/26 at 12:17 PM, Surveyor interviewed Ombudsman (OMB)-L who was doing a routine visit at the facility. OMB-L spoke with R1's POAHC who stated the family felt the facility was neglectful and did not provide proper supervision for R1 who had gotten out a door and had multiple falls that resulted in bruises, lacerations, a broken nose, and/or a fractured patella. On 7/28/26 at 2:46 PM, Surveyor interviewed HRN-G who stated the facility put interventions in place after R1's falls. HRN-G stated R1 had frequent checks or 1:1 supervision at different times throughout their stay. HRN-G confirmed 1:1 supervision was discontinued because R1's spouse thought it upset them. HRN-G was not aware of any instances when the 1:1 staff was not present but should have (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 0689 Level of Harm - Actual harm Residents Affected - Few	On 7/28/26 at 11:53 AM, Surveyor interviewed CNA-F who stated they don't like to leave residents unsupervised in a sling attached to a Hoyer lift to look for a second staff unless the resident is well-minded. (R3 had severely impaired cognition.) On 7/28/26 at 11:41 AM, Surveyor interviewed CNA-R who indicated stated Hoyer lift transfers are completed with two staff. CNA-R stated they would not leave a resident unsupervised in order to find assistance. CNA-R stated a Hoyer lift should not be in a resident's room without staff present. On 7/28/26 at 3:45 PM, Surveyor interviewed NHA-A who confirmed HSW-E notified Unit Manager (UM)-D that R3 was left unsupervised and attached to a Hoyer lift. NHA-A stated by the time UM-D got to the room, R3 had been transferred into their chair. When CNA-F was asked about the incident, CNA-F verified they left R3 in bed in a sling attached to the Hoyer lift and left the room to find assistance. NHA-A stated it is not the facility's standard of practice to leave a resident alone and attached to a Hoyer lift, however, if staff are in the middle of preparation and a resident is in bed, it is understandable since the facility instructs staff that two people are required for a Hoyer transfer. NHA-A stated the last staff education regarding transfers was completed on 2/2/26.		

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 07/29/2026
NAME OF PROVIDER OR SUPPLIER Little Chute Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 Garfield Ave Little Chute, WI 54140	
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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not have an effective process for labeling items and did not ensure missing laundry was returned or replaced for 3 residents (R) (R4, R10, and R11) of 3 sampled residents. Power of Attorney for Healthcare (POAHC)-N reported R4 was missing pants and shirts. POAHC-N replaced the items when the facility could not find the items and did not provide follow-up communication. R10 informed Laundry Staff (LS)-M they were missing a nightgown. The nightgown had not been found or replaced. R11 was missing underwear and t-shirts which had not been found or replaced. Findings include: The facility's Grievance Policy, revised 7/2022, indicates: When a complaint/grievance report is initiated: . The original form will be forwarded to the department head for which the grievance pertains. (Laundry Supervisor for missing clothing issues). Surveyor requested a policy regarding resident belongings. A policy was not provided. On 7/28/26 at 8:00 AM, Surveyor interviewed LS-M who stated an overwhelming amount of unmarked items end up in laundry and they do not know what happens to them. LS-M stated when residents tell them they are missing something, they put a note on the laundry room wall and look for the item. LS-M stated the facility use labels for marking which do not always stay on and residents report missing items daily. LS-M was not sure who was in charge of labeling residents' clothing but thought it was Social Worker (SW)-Q or nursing staff who were present during the admission. LS-M stated they receive a bag of items with a note to label on occasion. LS-M stated personal laundry is mixed together and sent to the laundry room in a cart. LS-M stated the process could be improved so residents are not missing so many items. Surveyor observed 14 notes with missing items on the laundry room wall. LS-M also showed Surveyor 2 racks and 2 boxes full of unclaimed items from the past 2 weeks. LS-M stated there was also a hanging rack of unlabeled items. On 7/28/26 at 2:11 PM, Surveyor interviewed POAHC-N who stated R4 needed more pants and shirts since they were admitted and POAHC-N brought more that day. R4 had approximately 8 of each when admitted and most were missing. POAHC-N thought the missing items were marked and was not sure what happened to them. (R4 was admitted to the facility on [DATE] and had an activated POAHC.) On 7/29/26 at 11:33 AM, Surveyor interviewed R10 who stated they were missing a nightgown and thought the marker had come off or faded in the laundry. R10 stated LS-M was aware of the nightgown. (A Quarterly Minimum Data Set (MDS) assessment, dated 5/15/26, stated R10 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition.) On 7/29/26 at 11:40 AM, Surveyor interviewed R11 who stated they were missing a lot of items and received other residents' items which they returned. R11 stated they started with a 6-pack of underwear and were down to 3 pair. R11 stated they were also missing t-shirts. (R11 was admitted to the facility on [DATE]. An admission MDS assessment, dated 5/10/26, stated R11 had a BIMS score of 15 out of 15, indicating intact cognition.) On 7/28/26 at 3:39 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-O who stated housekeeping staff or hospitality aids typically label residents' items. If they are not present, nursing staff put the items in a bag and attach a label. CNA-O stated CNAs and nursing staff used to label clothing, however, they no longer had access to laundry labels. On 7/28/26 at 3:41 PM, Surveyor interviewed CNA-P who stated laundry staff label residents' clothing. On 7/29/26 at 11:13 AM, Surveyor interviewed SW-Q who stated clothing is labeled by families and laundry staff. For new residents, housekeeping or laundry staff sort the clothes and bring them to the laundry area to be labeled. SW-Q removed fabric labels from their drawer that were used to label items. SW-Q stated they had not received any concerns (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	about missing items. On 7/29/26 at 11:20 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who was not aware of the missing items and had not received a laundry grievance in a while. NHA-A stated if a resident/family wants the facility to do their laundry, the facility should label the items. NHA-A stated if housekeeping staff are in the building, they are given the items. If a resident is admitted after housekeeping staff leave for the day, nursing staff know to label the bag and let the Housekeeping Supervisor know in the morning. NHA-A stated if they need more labels, housekeeping staff tell them and they order more.		

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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, interview, and record review, the facility did not ensure the care plan was followed for 1 resident (R) (R3) of 3 sampled residents.R3 had an order and a care plan intervention for pressure relieving boots to bilateral feet at all times. R3 was observed in bed without pressure relieving boots. Findings include:The facility's Comprehensive Care Plan policy, revised 9/2022, indicates: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident .that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs identified in the comprehensive assessment. R3 was admitted to the facility on [DATE], received Hospice services, and had diagnoses including alcohol induced dementia and Wernicke's encephalopathy. A Minimum Data Set (MDS) assessment, dated 5/13/26, stated R3 had a Brief Interview for Mental Status (BIMS) score of 0 out of 15, indicating severe cognitive impairment. R3's medical record and care plan contained an order/intervention for pressure relieving boots to bilateral feet at all times every shift (dated 12/20/25). On 7/27/26 at 9:48 AM, Surveyor observed R3 in bed without pressure relieving boots. A sign on the wall in the room indicated pressure relieving boots should be on at all times when in bed. On 7/27/26 at 10:13 AM, Surveyor interviewed Registered Nurse (RN)-C who verified R3 did not have pressure relieving boots on and put the boots on them. On 7/28/26 at 9:37 AM, Surveyor interviewed Unit Manager (UM)-D who confirmed R3 should have pressure relieving boots on at all times.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not provide the necessary respiratory care and services for 1 resident (R) (R3) of 1 resident. R3 had an order for oxygen to prevent low oxygen saturation levels. R3 was observed in bed without oxygen. In addition, R3's care plan did not indicate they received oxygen. Findings include: The facility's Comprehensive Care Plan policy, revised 9/2022, indicates: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident .that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in their comprehensive assessment. R3 was admitted to the facility on [DATE], received Hospice services, and had diagnoses including alcohol-induced dementia and Wernicke's encephalopathy. A Minimum Data Set (MDS) assessment, dated 5/13/26, stated R3 had a Brief Interview for Mental Status (BIMS) score of 0 out of 15, indicating severe cognitive impairment. R3's medical record contained the following order: ~ Ensure 2 liters of oxygen is on while resting in bed two times daily for hypoxia. Please apply 2 L of oxygen to maintain oxygen (O2) saturation (level) above 90% (dated 7/6/26). (R3's care plan did not include goals or interventions for the use of oxygen.) On 7/27/26 at 9:48 AM, Surveyor observed R3 in bed without oxygen. On 7/27/26 at 10:13 AM, Surveyor interviewed Registered Nurse (RN)-C who verified R3 was not receiving oxygen and stated they would check their care plan to see if oxygen was required. RN-C reviewed R3's orders and verified oxygen should be used when in bed at 2 liters via nasal cannula. On 7/28/26 at 9:37 AM, Surveyor interviewed Unit Manager (UM)-D who stated R3 should wear oxygen anytime they are in bed for a nap. NM-D stated R3's care plan should also reflect the use of oxygen.		