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	05/21/2026

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on staff interview and record review, the facility did not ensure their abuse policy was implemented for 1 (Certified Nursing Assistant (CNA)-G) of 8 employees reviewed for caregiver background checks. The facility did not complete an out-of-state background check for CNA-G. Findings include: The facility's Abuse, Neglect and Exploitation policy, revised 7/15/22, indicates: .I. Screening: A. Potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. 1. Background, reference, and credentials checks shall be conducted on potential employees .Background checks, including re-checks, will be completed consistent with applicable state laws and regulation .2. Screenings may be conducted by the facility itself, a third-party agency or academic institution. 3. The facility will maintain documentation of proof that the screening occurred . On 5/21/26 Surveyor requested background check information, including Background Information Disclosure (BID) forms, Department of Justice (DOJ) and Governmental findings letters, references, and license information for 8 staff. Surveyor noted CNA-G was hired by the facility on 4/14/26. CNA-G's BID form indicated CNA-G lived outside of Wisconsin within the previous three years. Surveyor requested CNA-G's out-of-state background check. On 5/21/26 at 12:48 PM, Surveyor interviewed Guest Services Coordinator (GSC)-H who assisted with human resources and employee onboarding. GSC-H indicated an out-of-state background check was not completed for CNA-G prior to hire. GSC-H indicated GSC-H thought a previous HR staff had requested the out-of-state background check, however, GSC-H couldn't find it and indicated it had not been completed. GSC-H provided an out-of-state background check for CNA-G that was completed on 5/21/26. GSC-H indicated the out-of-state background check should have been completed prior CNA-G's hire. On 5/21/26 at 2:26 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated the facility should complete all background check and pre-employment screening prior to employment, including out-of-state background checks when applicable.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure weight monitoring was provided for 1 resident (R) (R12) of 2 sampled residents.R12 was not re-weighed for weight loss/gain greater than 5 pounds (lbs). R12's provider, Power of Attorney (POA), and the facility's Registered Dietician (RD) were not notified regarding R12's weight loss/gain greater than 5 lbs. In addition, R12's weight was not obtained with a consistent device.Findings include:The facility's Weight Monitoring policy, revised 12/21/22, indicates: Weight Assessment:.5. Team members will follow a consistent approach to weighing and using an appropriately calibrated and functioning scale. Since weight varies throughout the day, a consistent process and technique (e.g., weighing the resident wearing a similar type of clothing, at approximately the same time of day, using the same scale, either consistently wearing or not wearing orthotics or prostheses, and verifying scale accuracy) can help make weight comparison more reliable. 6. Any weight change of 5 pounds or more since the last weight assessment will be retaken for confirmation.10. Nursing staff will notify the individual or responsible party, physician, and Registered Dietitian (RDN) or designee of any individual with an unintended significant weight change.Between 5/19/26 and 5/21/26, Surveyor reviewed R12's medical record. R12 was admitted to the facility on [DATE] and had diagnoses including dysphagia, constipation, anxiety, major depression, and intracranial injury. R12's Minimum Data Set (MDS) assessment, dated 4/30/26, stated R12 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating intact cognition. R12 was protectively placed in the facility and had a legal Guardian. A care plan, dated 5/3/25, indicated R12 was at risk for nutritional status change related to obese body mass index (BMI) with continued increasing weight trend, impaired cognition from history of traumatic brain injury, need for therapeutic diet for calorie control, diagnosis of dysphagia, and poor dentition with need for mechanically-altered texture. The care plan also indicated R12 was at risk for obesity related to excessive calorie intake and physical inactivity as evidenced by BMI >30. The care plan indicated R12 would have no significant weight changes (>/= 5% in 30 days, >/= 7.5% in 90 days, or >/= 10% in 180 days) while allowing for beneficial loss. The care plan contained the following interventions: Review weights and notify RD, Medical Doctor (MD), and responsible party of significant weight change (dated 5/12/25) and diet education as able (dated 8/4/25).R12 had the following order:~ Weight needed; update MD if weight is 5 lb change since prior weight; one time a day starting on the 1st and ending on the 1st every month (dated 5/7/25)R12's medical record indicated the following:~ On 12/22/25, R12 weighed 256.5 lbs.~ On 1/1/26, R12 weighed 272.0 lbs (wheelchair scale). R12's weight was up 16 lbs. R12's medical record did not contain a progress note regarding R12's weight gain from 12/22/25 to 1/1/26. ~ A weight note, dated 1/14/26, indicated the provider was notified of R12's weight gain of 16 lbs from 12/22/25 to 1/1/26. The note indicated staff would obtain a re-weight on 1/15/26. ~ On 1/15/26, R12 weighed 268.0 lbs (wheelchair scale). ~ A Nutritional Assessment note, dated 1/15/26 and written by RD-E, indicated R12 had a consistent carbohydrate diet, mechanical-alternative texture with average meal intake of 76-100%. R12's BMI was 38.6 with gradual weight change present. R12's carbohydrate-controlled diet was appropriate to try to limit calories although R12's weight continued to increase. The note indicated RD-E would complete more diet education and have staff encourage R12 to limit snacks.~ On 2/5/26, R12 weighed 263.0 lbs (mechanical lift scale). R12's weight was down 5 lbs. ~ A provider note, dated 2/12/26, indicated the need for a dietary consult for diabetic diet education to address weight gain and snacking. An order was not obtained.~ On 3/1/26, R12 weighed 270.0 lbs (mechanical lift scale). R12's weight was up 7 lbs. R12's medical record did not contain a progress note regarding R12's weight gain from 2/5/26 to 3/1/26.~ A provider note, dated 3/3/26, indicated the need for a dietary consult for diabetic diet education to address ongoing weight gain. An order was not obtained.On 5/20/26 at 2:29 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-D who indicated nurses document weights in a (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's medical record. LPN-D indicated nursing staff obtain a re-weight if the resident's weight is greater than 5 lbs from the last weight and call the provider.On 5/20/26 at 3:22 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated nurses should re-weigh a resident using a consistent scale if there is a 5 lb weight differential. DON-B indicated if a resident has a 5 lb weight loss or gain from the previous weight, the nurse should update the provider. On 5/20/26 at 3:22 PM, Surveyor interviewed Unit Manager (UM)-C and reviewed the provider's documentation regarding R12's need for diet education. UM-C indicated nurses transcribe orders from provider notes. UM-C indicated the order for a dietary consult for diabetic diet education to address ongoing weight gain was not transcribed from the provider's notes on 2/12/26 and 3/3/26. On 5/21/26 at 10:42 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated RD-F and RD-E provided services to the facility prior to the newly assigned RD who started in March 2026.On 5/21/26 at 10:52 AM Surveyor interviewed RD-F who indicated RD-F was an as needed dietitian for the facility to fill in when the assigned dietitian was not available. RD-F indicated RD-F received email communication from the facility if there was an order requiring diet education. RD-F indicated RD-F did not receive communication from the facility regarding R12's order for diet education. On 5/21/26 at 11:00 AM, Surveyor interviewed RD-E who indicated RD-E provided services to the facility until March 2026. RD-E indicated staff notified RD-E of orders for dietary education via email or in weekly Interdisciplinary Team (IDT) meetings. RD-E did not recall an order for dietary education for R12 and stated RD-E did not provide R12 with dietary education. (Of note: RD-E's nutritional note on 1/15/26 indicated RD-E planned to provide education.) On 5/21/26 at 11:45 AM, Surveyor interviewed DON-B who indicated the provider was notified of R12's 1/1/26 weight gain on 1/15/26 and gave an order to limit snacks. DON-B confirmed an RD completed dietary assessments on 1/15/26 and 4/24/26. DON-B confirmed R12 did not have an active or discontinued order for dietary education as suggested in the provider's documentation on 2/12/26 and 3/3/26. DON-B indicated DON-B did not see RD-E's note regarding dietary education for R12.

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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 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, staff and resident interview, and record review, the facility did not provide the necessary respiratory care and services for 1 resident (R) (R1) of 1 sampled resident. R1's oxygen concentrator was not consistently set in accordance with a physician's order. In addition, R1's care plan did not indicate R1 had a diagnosis of chronic obstructive pulmonary disease (a progressive inflammatory lung disease that obstructs airflow from the lungs making it difficult to breathe). Findings include: The facility's Oxygen Concentrator policy, dated 6/3/22, indicates: .1. Staff responsible for the use and care of oxygen concentrators receive training on oxygen safety and the functionality of the device. 2. Oxygen is administered under orders of the attending physician, except in the case of an emergency .4. Use of the Concentrator: a. Orders for the rate of flow and route of administration of oxygen (mask, nasal cannula etc.) .k. Keep turned off when set up for use in the resident's room, but not actively in use . Between 5/19/26 and 5/21/26, Surveyor reviewed R1's medical record. R1 was readmitted to the facility on [DATE] and had diagnoses including COPD, congestive diastolic heart failure, atrial fibrillation, acute respiratory failure with hypoxia, and pleural effusions. R1's Minimum Data Set (MDS) assessment, dated 5/8/26, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. R1's plan of care indicated oxygen should be administered per physician orders. R1's plan of care did not indicate R1 had COPD. R1's Medication Administration Record (MAR) contained the following order: ~ Oxygen at 1-2 liters/minute via nasal cannula at rest and with activity to maintain oxygen saturation of 88-92% R1's medical record indicated R1 was hospitalized from [DATE] to 5/1/26 for acute hypoxic respiratory failure secondary to bilateral pleural effusions, COPD/asthma exacerbation, and new atrial fibrillation. On 5/19/26 at 9:28 AM, Surveyor observed an oxygen concentrator in R1's room. R1 was wearing a nasal cannula connected to the concentrator. The oxygen flow rate was set at 3.5 liters/minute. On 5/20/26 at 12:01 PM, Surveyor observed R1 in R1's room wearing a nasal cannula connected to an oxygen concentrator. The oxygen flow rate was set at 3.5 liters/minute. On 5/21/26 at 11:49 AM, Surveyor observed R1 in R1's room wearing a nasal cannula connected an oxygen concentrator. The oxygen flow rate was set at 3.5 liters/minute. Surveyor interviewed R1 who indicated R1 does not touch the oxygen concentrator. R1 indicated staff set the oxygen flow rate and R1 liked the current setting. On 5/21/26 at 12:58 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-D who indicated oxygen should be reflected on a resident's care plan, including the liters per minute of oxygen flow. LPN-D indicated a resident with orders for 1-2 liters of oxygen per minute should remain on 1-2 liters per minute unless they are in respiratory distress. LPN-D indicated if a resident has an oxygen saturation of less than 89%, the oxygen flow can be increased, however, the nurse should notify the physician of the change in flow rate right away. LPN-D indicated the facility has a 24-hour book to let staff know if a resident's oxygen flow rate has changed until a new order from the physician is obtained. LPN-D indicated R1 was not experiencing distress or low oxygen saturation. LPN-D checked R1's medical record and confirmed R1 had an order for 1-2 liters/minute which is how the concentrator should be set. LPN-D indicated increasing the oxygen flow rate for a resident with COPD can increase the resident's carbon dioxide level. On 5/21/26 at 1:07 PM, Surveyor noted R1's oxygen concentrator was running but R1 was not in the room. The oxygen flow rate was set at 3.5 liters/minute. On 5/21/26 at 1:45 PM, Surveyor and LPN-D entered R1's room. R1 was using a portable oxygen machine and was planning to leave the room. The portable oxygen machine was set correctly. Surveyor and LPN-D observed the oxygen concentrator and noted the machine was still on and the flow rate was set at 3.5 liters/minute. LPN-D indicated the flow rate should be set at 2 liters/minute and the machine should not be left on when not in use. LPN-D shut off the oxygen concentrator and again indicated the flow rate was set too high for R1 since R1 was not in distress. On 5/21/26 at 2:19 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated oxygen orders should be followed as written (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	by the physician. DON-B indicated R1's oxygen concentrator and portable oxygen machine should be correctly set. DON-B indicated staff should check settings for accuracy every time a resident uses oxygen. DON-B stated staff know residents adjust the settings themselves at times and, therefore, need to verify the flow rate with every use. When Surveyor indicated R1's oxygen flow rate was set at 3.5 liters/minute on three occasions instead of 1-2 liters/minute, DON-B indicated the increased rate could cause rebound for R1. DON-B indicated if the oxygen flow rate is too high for a resident with COPD, it can cause a negative effect and shut down the resident's lungs. DON-B indicated COPD should be reflected on a resident's care plan. On 5/21/26 at 2:26 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated a resident on oxygen therapy with a diagnosis of COPD should have a care plan to reflect that. NHA-A confirmed a resident should receive oxygen therapy as ordered by the physician.