

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525595	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/29/2024
NAME OF PROVIDER OR SUPPLIER  St Francis Home		STREET ADDRESS, CITY, STATE, ZIP CODE 33 Everett St Fond Du Lac, WI 54935	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40342</p> <p>Based on staff and resident interview and record review, the facility did not ensure an injury of unknown source involving potential abuse/neglect was reported to the State Agency (SA) in a timely manner for 1 Resident (R) (R1) of 4 sampled residents.</p> <p>On 6/30/24, R1 had a fall with major injury. The facility did not submit a 5-day investigation to the SA in a timely manner. In addition, the report submitted to the SA had incorrect information.</p> <p>Findings include:</p> <p>The facility's Abuse, Neglect, and Exploitation policy, with a revision date of January 2023, states it is the policy of the facility to take appropriate steps to prevent the occurrence of abuse and neglect .b. The Administrator, Director of Nursing (DON), or designee will notify the appropriate regulatory, investigative, or law enforcement agencies immediately, in accordance with state regulations .b. The results of all investigations are reported to the Administrator and to the appropriate state agency, as required by state law and/or within 5 working days of the alleged violation.</p> <p>1. On 7/29/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] with diagnoses including rheumatoid arthritis (a chronic progressive disease causing inflammation in the joints and resulting in painful deformity and immobility) and osteoarthritis (a painful joint disease that results from breakdown of joint cartilage and underlying bone). R1's Minimum Data Set (MDS) assessment, dated 7/11/24, stated R1's Brief Interview for Mental Status (BIMS) score was 14 out of 15 which indicated R1 had little to no cognitive impairment. R1's medical record indicated R1 was responsible for R1's healthcare decision.</p> <p>According to R1's medical record and a fall investigation, on 6/30/24 at approximately 8:35 AM, R1's right knee buckled behind R1's left leg when R1 pivot transferred from the toilet to a wheelchair. A Certified Nursing Assistant (CNA) assisted R1 to the floor. R1 complained of pain and was transferred to the emergency room (ER) and diagnosed with a mildly displaced fracture of the lateral aspect of the right distal femoral diaphysis (outside portion of the upper leg long bone at the lower end). The facility's 5-day investigation indicated R1's fall occurred on 6/30/24 at 12:00 PM. In addition, the 5-day investigation was due to the SA on 7/8/24. The facility did not submit the 5-day investigation until 7/9/24 at 1:00 PM.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/29/24 at 10:52 AM, Surveyor interviewed R1 who stated R1's fall occurred during morning cares in the bathroom when R1 got up on the morning of 6/30/24 with the assistance of a CNA. R1 reiterated the events of the fall which were consistent with the facility's investigation.</p> <p>On 7/29/24 at 2:09 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who verified the time of R1's fall was listed incorrectly on the facility's 5-day investigation. NHA-A also verified the facility submitted the 5-day investigation late.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40342</p> <p>Based on staff interview and record review, the facility did not ensure an environment free of accident hazards for 2 Residents (R) (R1 and R3) of 4 sampled residents.</p> <p>On 4/8/24 and 6/21/24, R1 experienced falls. The facility did not revise R1's care plan to help prevent future falls.</p> <p>On 4/5/24, R3 slapped R2 on the arm and told R2 to shut up. The facility did not revise R3's care plan to include measures to prevent R3 from further inappropriate interactions toward residents.</p> <p>Findings include:</p> <p>1. On 7/29/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] with diagnoses including rheumatoid arthritis (a chronic progressive disease causing inflammation in the joints and resulting in painful deformity and immobility) and osteoarthritis. R1's Minimum Data Set (MDS) assessment, dated 7/11/24, stated R1's Brief Interview for Mental Status (BIMS) score was 14 out of 15 which indicated R1 had little to no cognitive impairment. R1's medical record indicated R1 was responsible for R1's healthcare decision.</p> <p>R1's medical record, care plan, and fall investigations indicated the following:</p> <p>~ On 4/8/24: R1 experienced a fall while staff transferred R1 with a sit-to-stand mechanical lift and R1's feet slipped off the lift platform. An assessment indicated R1 had no injuries from the fall. R1's care plan was not revised to prevent future falls.</p> <p>~ On 6/21/24: R1 slid off a recliner and onto the floor after staff transferred R1 into the recliner and R1's feet got tangled up in the wheelchair pedals. An assessment indicated R1 had no injuries from the fall. R1's care plan did not contain a revision to prevent future falls.</p> <p>On 7/29/24 at 3:26 PM, Surveyor interviewed Director of Nursing (DON)-B who verified the facility did not revise R1's care plan following R1's falls on 4/8/24 and 6/21/24. DON-B stated DON-B expects staff to care plan revisions post-fall to help prevent future falls and injury.</p> <p>49563</p> <p>2. On 7/29/24, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] with diagnoses including chronic kidney disease (CKD), congestive heart failure (CHF), diabetes, and urinary tract infection (UTI). R3's MDS assessment, dated 6/24/24, stated R3's BIMS score was 2 out of 15 which indicated R3 had severe cognitive impairment. R3's Power of Attorney for Healthcare (POAHC) was activated on 11/28/22.</p> <p>R3's medical record, care plan, and altercation investigation indicated the following:</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>~ On 4/5/24, R3 was sitting next to R2 when R3 slapped R2's arm and told R2 to shut up. Staff separated the residents. Following the resident-to-resident altercation, the facility did not revise R3's care plan or implement interventions to prevent future inappropriate interactions with other residents.</p> <p>On 7/29/24 at 2:22 PM, Surveyor interviewed DON-B who verified the facility did not revise R3's care plan after the resident-to-resident altercation on 4/5/24. DON-B stated DON-B expects staff to revise residents' care plans post-altercation to keep residents safe.</p>		