STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525595	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Francis Home	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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and record review, the facility did not ensure food was stored and prepared in a safe and sanitary manner. This practice had the potential to affect 74 of 74 residents residing in the facility. The facility did not ensure time/temperature control foods were labeled appropriately with open and/or use-by dates. Findings include: On 3/30/26 at 9:22 AM, Food and Nutrition Services Director (FNSD)-C indicated the facility follows the Wisconsin Food Code as their standard of practice. The 2022 Wisconsin Food Code documents at 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking: (A) Except when packaging food using a reduced oxygen packaging method as specified under S 3-502.12, and except as specified in (E), (F), and (H) of this section, refrigerated, ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature and time combination of 5 degrees Celsius (C) (41 degrees Fahrenheit (F)) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1 .(2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety .(D) A date marking system that meets the criteria stated in (A) and (B) of this section may include: .(3) Marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (B) of this section .Disposition: (A) A food specified under 3-501.17 (A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3-501.17 (A) Except time that the product is frozen; (2) Is in a container or package that does not bear a date or day. The facility's undated Date Marking for Food Safety policy indicates: The facility adheres to a date marking system to ensure the safety of ready-to-eat, time/temperature control for safety food .1. Refrigerated, ready-to-eat, time/temperature control for safety food/perishable food shall be held at a temperature of 41 degrees Fahrenheit or less for a maximum of seven days. 2. The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded .4. The marking system shall consist of a color-coded label, the day/date of opening, and the day/date the item must be consumed or discarded .6. The head cook or designee shall be responsible for checking the refrigerator daily for food items that are expiring, and shall discard accordingly. 7. The dietary manager or designee shall spot check refrigerators weekly for compliance . During an initial tour of the kitchen with FNSD-C that began at 9:22 AM on 3/30/26, Surveyor observed the following food storage concerns: Dry Storage:~ Two plastic bins labeled salt 3/3 without use-by dates~ One plastic bin labeled baking cocoa 3/11 without a use-by date~ One bulk container labeled sugar 3/10 without a use-by date~ One bulk container labeled flood 3/10 without a use-by date~ One container labeled cracker crumbs 3/15/24 without a use-by date~ One package labeled instant cheese queso mix 11/5 without a use-by date Coolers:~ One container labeled breaded chicken 3/2 without a use-by date~ One rack of numerous pans of baked cookies and cinnamon rolls without use-by dates~ One pan with two packages labeled chicken thighs 2/20 without use-by dates~ One unlabeled package (waffles per FNSD-C) dated 3/30 (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	without a use-by date~ One package labeled Braunschweiger opened 3/24 without a use-by date~ One container labeled breaded chicken patty 3/2 without a use-by or pulled-from-freezer date ~ One container labeled sloppy joe 3/11 pull 3/28 without a use-by date~ One unlabeled container of yellow material labeled open 3/26 without a use-by date~ One pan labeled cherry cheesecake 3/29 dinner without a use-by date~ One container labeled pork chops 3/18, leave out AM Tues without a use-by date~ One container labeled pork 3/5, pulled 3/28 for 3/31 without a use-by date Freezers:~ One container labeled hot dogs 2/19 without a use-by date~ One container labeled beef 3/12 without a use-by date~ One container labeled smoth steak 3/14 without a use-by date~ One container labeled beef tips 3/28 without a use-by date~ One container labeled sl. beef 3/25 without a use-by date~ One container labeled beef stroganoff 3/25 without a use-by date~ One container labeled beef casserole 3/11 without a use-by date~ One container labeled salisbury steak 3/9 without a use-by date~ One container labeled lasagna sauce 3/5 without a use-by date~ One container labeled riblettes 3/29 without a use-by date~ One container labeled brat patties 3/16 without a use-by date~ One container labeled BBQ pork 3/8 without a use-by date~ One container labeled sausage patty 3/28 without a use-by date~ One container labeled pulled pork 3/23 without a use-by date~ One container labeled kielbasa 3/17 without a use-by date~ One container labeled hamloaf 3/19 without a use-by date~ One container labeled ham 3/24 without a use-by date~ One container labeled pork in peach sauce 1/12 without a use-by date~ One container labeled cod 2/3 from 1/27 without a use-by date~ One package labeled pork 2/26 without a use-by date~ One package labeled beef 2/15 without a use-by date~ One package labeled turkey 2/14 without a use-by date~ One package labeled quiche 3/6 without a use-by date~ One package labeled squash 3/28 without a use-by date~ One container labeled fish 3/24 3/28 without a use-by date~ One package labeled soft pot 3/19 without a use-by date~ One package labeled sweet pot 3/12 without a use-by date~ One package labeled tavern fish 3/22 without a use-by date~ One container labeled salmon 3/27 without a use-by date~ One container labeled fish 3/27 without a use-by date~ One container labeled turkey 3/29 without a use-by date~ One container labeled chx 3/23 without a use-by date Following the observations, Surveyor interviewed FNSD-C who indicated bulk food items such as flour and sugar don't have use-by dates because they are used up quickly. FNSD-C verified the items should contain use-by dates. FNSD-C was unsure of the use-by dates for the dry storage items. When asked about missing use-by dates for the salt and baking cocoa, FNSD-C indicated the items should have use-by dates. FNSD-C did not know the use-by date of the cracker crumbs and indicated they should be thrown out. FNSD-C also did not know the use-by dates for the cheese mix and various items in the cooler and freezer. When asked the use-by dates for several of the frozen items, FNSD-C was unsure and confirmed the items should have been labeled with use-by dates.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 2 of 8 employees reviewed for employee reference checks. This practice had the potential to affect more than 4 of the 74 residents residing in the facility.The facility did not complete reference checks for Certified Nursing Assistant (CNA)-F and CNA-G.Findings include:The facility's Abuse, Neglect and Exploitation policy, revised 2025, 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, contracted temporary staff, students affiliated with academic institutions, volunteers, and consultants. Background checks, including re-checks, will be completed consistent with applicable state laws and regulation. Responsibility for performance of compliance checks on contracted temporary staff will be established via contractual agreement. 2. Screenings may be conducted by the facility itself, a third-party agency, or an academic institution. 3. The facility will maintain documentation of proof that the screening occurred .On 4/1/26, Surveyor reviewed background check information, including Background Information Disclosure (BID) forms, Department of Justice (DOJ) letters, Governmental Findings letters, reference checks, and license information for 8 staff including, CNA-F and CNA-G.CNA-F's hiring information indicated CNA-F was hired by the facility on 1/26/26. CNA-F's background check information did not include any reference checks.CNA-G's hiring information indicated CNA-G was hired by the facility on 2/23/26. CNA-F's background check information did not include any reference checks.On 4/1/26 at 10:49 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A regarding reference checks for CNA-F and CNA-G. NHA-A indicated NHA-A requested everything on the list Surveyor requested from the facility's onboarding department. NHA-A indicted if reference checks were not included, the facility didn't have them. NHA-A confirmed reference checks should have been completed for CNA-F and CNA-G.

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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 the necessary care and services to monitor weight gain was provided 1 resident (R) (R5) of 2 sampled residents.R5's weight was not monitored as ordered. In addition, R5's physician was not notified as ordered when R5 gained 3 pounds or more in one day.Findings include:The facility's Weight Monitoring policy, revised 2025, indicates: .Weight can be a useful indicator of nutritional status. Significant unintended changes in weight (loss or gain).may indicate a nutritional problem.A weight monitoring schedule will be developed upon admission for all residents.If clinically indicated, monitor weight daily .The physician should be informed of a significant change in weight.Observations pertinent to the resident's weight status should be recorded in the medical record as appropriate.The facility's undated Assisted Nutrition and Hydration policy indicates: .Recognize, evaluate, and address the needs of.the resident at risk or already experiencing impaired nutrition and hydration.Maintain acceptable parameters of nutritional status and electrolyte balance.Offer sufficient fluid intake to maintain proper hydration and health.The facility's Notification of Changes policy, revised 2025, indicates: The purpose of this policy is to ensure the facility promptly .consults the resident's physician.The facility must consult with the resident's physician when there is a change requiring such notification.Circumstances that require a need to alter treatment may include: a. New treatment; b. Discontinuation of current treatment due to: .acute conditions, exacerbation of a chronic condition.From 3/30/26 to 4/1/26, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] and had diagnoses including end stage renal failure, dependence on renal dialysis, and congestive heart failure. R5's Minimum Data Set (MDS) assessment, dated 2/19/26, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R5 had intact cognition. R5 made R5's own healthcare decisions.Surveyor reviewed R5's Treatment Administration Record (TAR) and noted the following physician orders: ~ Weights daily, update provider if weight increases by 3 pounds (lbs) in one day or 5 lbs in one week (start date: 8/26/26; discontinue date: 2/23/26) ~ Weights after dialysis only one time a day every Monday, Wednesday, and Friday, update provider if weight increases by 3 lbs in one day or 5 lbs in one week (start date: 2/25/26; discontinue date: 4/1/26) (Of note: The order was discontinued after Surveyor asked about R5's weights.)R5's TAR contained missing documentation on the following dates:~ On 11/15/25, 11/20/25, and 11/28/25 (for daily weights, update physician if weight increases by 3 lbs in one day or 5 lbs in one week; start date: 8/28/25; discontinue date: 2/23/26).~ On 12/29/25 (nights), 1/13/26 (nights), 1/18/26 (nights), 3/22/26 (nights), 3/28/26 (nights), and 3/31/26 (nights) for fluid restriction of 1800 milliliters (ml) - 720 ml (AMs), 460 ml (PMs), 160 ml (nights) every shift for fluid restriction (start date: 8/26/25)On 3/31/26 at 1:29 PM, Surveyor interviewed Registered Dietician (RD)-H regarding physician updates and documented weights. RD-H indicated R5 is weighed at dialysis and the facility uses that weight which is documented in R5's medical record as dialysis. RD-H stated if R5 is weighed at the facility, the weight is documented as wheelchair. RD-H indicated nurses are responsible for documenting weights and updating the physician with any changes.On 3/31/26 at 1:48 PM, Surveyor interviewed Registered Nurse (RN)-I who indicated R5's weights are obtained from the dialysis binder and entered in R5's medical record. RN-I indicated nurses are responsible for updating the physician if R5 has a weight increase of 3 lbs in one day or 5 lbs in one week. RN-I indicated R5 had an order for daily weights until the end of February (2026). RN-I indicated R5's weight order was changed due to dialysis. Surveyor and RN-I reviewed R5's weights and noted the following:~ On 2/4/26, R5 weighed 201.9 lbs (dialysis)~ On 2/5/26, R5 weighed 208.4 lbs (dialysis; increase of 6.5 lbs in one day) ~ On 2/14/26, R5 weighed 206.8 lbs (wheelchair) ~ On 2/15/26, R5 weighed 212.2 lbs (wheelchair; increase of 5.4 lbs in one day)~ On 2/21/26, R5 weighed 205.0 lbs (wheelchair) ~ On 2/22/26, R5 weighed 208.8 lbs (wheelchair; increase of 3.8 lbs in one day)On 3/31/26 at 1:56 PM after reviewing R5's weights, RN-I (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confirmed the physician should have been updated regarding R5's weight increases of 3 lbs in one day.On 4/1/26 at 11:28 AM, Surveyor interviewed Director of Nursing (DON)-B and Registered Nurse Supervisor (RNS)-E who confirmed the physician should have been updated of R5's weight gains of 3 lbs in one day per the physician's order.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure fistula monitoring and pre-treatment dialysis forms were completed for 1 resident (R) (R5) of 1 sampled resident.R5's Treatment Administration Record (TAR) indicated R5's fistula wasn't consistently monitored. In addition, R5's pre-treatment dialysis forms were not consistently completed.Findings include:The facility's Dialysis policy, revised 2025, indicates: This facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan.to meet the special medical needs of the resident receiving hemodialysis .The facility will assure each resident receives care and services for the provision of hemodialysis consistent with professional standards of practice. This will include the ongoing assessment of the resident's condition and monitoring for complications before.dialysis treatments.ongoing assessment and oversight of the resident before, during, and after dialysis treatments .The licensed nurse will communicate to the dialysis facility via.written format, such as a dialysis communication form .The nurse will ensure the dialysis access site is checked before and after dialysis treatments and every shift for patency by auscultating for a bruit and palpating for a thrill. If absent, the nurse will immediately notify the attending physician, dialysis facility, and/or nephrologist.From 3/30/26 to 4/1/26, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] and had diagnoses including end stage renal failure, dependence on renal dialysis, and congestive heart failure. R5's Minimum Data Set (MDS) assessment, dated 2/19/26, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R5 had intact cognition. R5 made R5's own healthcare decisions. R5 received dialysis on Monday, Wednesday, and Friday.R5's TAR contained missing documentation for the following orders and dates:~ Dialysis evaluation form pre-treatment one time a day every Monday, Wednesday, and Friday. (R5's TAR indicated the order was not completed on 1/14/26 and 3/9/26.)~ Arteriovenous (AV) fistula - check bruit every shift. If bruit not auscultated, notify provider. (R5's TAR indicated the order was not completed on 11/16/25, 2/13/26, and 3/9/26.)~ AV fistula - check thrill every shift. If thrill not palpated, notify provider. (R5's TAR indicated the order was not completed on 11/16/25, 2/13/26, and 3/9/26.)~ Monitor AV site every shift for warmth, redness, tenderness, and edema, notify provider if present. (R5's TAR indicated the order was not completed on 11/16/25.)On 4/1/26 at 9:26 AM, Surveyor and Director of Nursing (DON)-B reviewed R5's TAR. DON-B was not aware of the missing documentation and stated DON-B would follow-up with Surveyor.On 4/1/26 at 11:19 AM, Surveyor interviewed DON-B and Registered Nurse Supervisor (RNS)-E. RNS-E indicated RNS-E could not find documentation in R5's progress notes that correlated to the missing entries on R5's TAR. RNS-E and DON-B confirmed the orders should have been completed and documented.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interview, and record review, the facility did not establish and maintain an infection prevention and control program designed to prevent the transmission of communicable disease and infection for 3 residents (R) (R1, R6, and R39) of 3 sampled residents. R1 was on enhanced barrier precautions (EBP) for an indwelling catheter and wounds. During care observations and medication administration, staff did not adhere to EBP. R6 was on EBP for an indwelling catheter. During care and therapy observations, staff did not adhere to EBP. R39 had an order for EBP due to an indwelling catheter; however, there was not an EBP sign outside R39's room. During a care observation, staff did not adhere to EBP. In addition, R39's care plan did not indicate R39 was on EBP. Findings include: The facility's Enhanced Barrier Precautions policy, dated January 2025, indicates: It is the policy of this facility to implement enhanced barrier precautions (EBP) for the prevention of transmission of multidrug-resistant organisms (MDROs). EBP refers to an infection control intervention designed to reduce the transmission of MDROs that employs targeted gown and gloves use during high-contact resident care activities .a. All staff receive training on EBP upon hire and at least annually and are expected to comply with all designated precautions. b. All staff receive training on high-risk activities and common organisms that require EBP. c. The facility will have discretion on how to communicate to staff which residents require the use of EBP prior to providing high-contact care activities .An order for EBP will be obtained for residents with any of the following: wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic [NAME] stasis ulcers) and/or indwelling medical devices (e.g. central lines, urinary catheters .) .4. High-contact resident care activities include: a. Dressing; b. Bathing; c. Transferring; d. Providing hygiene; e. Changing linens; f. Changing briefs or assisting with toileting; g. Device care or use: central lines, urinary catheters .; h. Wound care; any skin opening requiring a dressing . 1. Between 3/30/26 and 3/31/26, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including pneumonia, obstructive and reflux uropathy, and presence of other specified devices. R1 had an indwelling catheter and a colostomy. R1's Minimum Data Set (MDS) assessment, dated 3/11/26, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R1 had intact cognition. R1's medical record contained a physician order for EBP related to R1's indwelling catheter and wounds. A care plan, dated 3/24/26, indicated staff needed to wear a gown and gloves for all cares due to R1's indwelling catheter and wounds. On 3/30/26 at 12:23 PM, Surveyor observed a Centers for Disease Control and Prevention (CDC) EBP sign on the wall near the entrance to R1's room. The sign read: ENHANCED BARRIER PRECAUTIONS EVERYONE MUST: Clean hands, including before entering the room and when leaving the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following high-contact resident care activities. Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, Changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy, Wound Care: any skin opening requiring a dressing. Surveyor also observed a personal protective equipment (PPE) cart near R1's door that contained gowns and gloves. On 3/30/26 at 12:24 PM, Surveyor observed Certified Nursing Assistant (CNA)-J enter R1's room with paper towels and a urinal to empty R1's colostomy bag. CNA-J was not wearing a gown. At 12:31 PM, Surveyor observed CNA-J exit R1's room with the urinal. CNA-J emptied the urinal into the toilet and rinsed the urinal with water. On 3/30/26 at 12:35 PM, Surveyor interviewed CNA-J who verified R1 had a colostomy and an indwelling catheter. When asked if staff should wear PPE for high-contact cares and R1's EBP order, CNA-J indicated CNA-J did not need to wear PPE. On 3/30/26 at 1:18 PM, Surveyor observed CNA-J enter R1's room with a urinal to empty R1's catheter bag. CNA-J was wearing gloves but not a gown. At 1:23 PM, Surveyor observed CNA-J exit R1's room and empty the urinal into the toilet. CNA-J rinsed the urinal with water and put it back in R1's room. Surveyor interviewed CNA-J who confirmed CNA-J did not wear a gown. 2. During the AM medication pass on 3/30/26 at 10:20 AM, Surveyor observed Registered Nurse (RN)-D administer Lantus insulin to R1's abdomen per subdermal injection without wearing a gown. An EBP sign outside R1's room indicated all staff completing direct resident care must wear gloves and a gown. On 3/30/36 at 10:25 AM, Surveyor interviewed RN-D who verified R1 was on EBP and RN-D did not wear a gown when administering R1's insulin. RN-D verified administering insulin to a resident is direct resident care and confirmed RN-D should have worn a gown per the facility's EBP policy. On 4/1/26 at 9:28 AM, Surveyor interviewed Director of Nursing (DON)-B who verified RN-D should have worn a gown when administering an insulin injection per the facility's EBP policy. 3. Between 3/30/26 and 3/31/26, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] and had diagnoses including sepsis due to methicillin-resistant Staphylococcus aureus (MRSA), calculus in the bladder, and obstructive and reflux uropathy. R6 had an indwelling catheter. R6's MDS assessment, dated 3/12/26, had a BIMS score of 15 of out 15 which indicated R6 had intact cognition. R6's medical record contained a physician order for EBP related to R6's indwelling catheter. The order indicated an EBP sign should be posted outside R6's room. A care plan, dated 3/26/26, indicated staff should use EBP related to R6's indwelling catheter. On 3/30/26 at 12:23 PM, Surveyor observed a CDC EBP sign on the wall near the entrance to R6's room. The sign read: ENHANCED BARRIER PRECAUTIONS EVERYONE MUST: Clean hands, including before entering the room and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following high-contact resident care activities. Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, Changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy. Wound (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Care: any skin opening requiring a dressing. Surveyor also observed a PPE cart near R6's door that contained gowns and gloves. On 3/30/26 at 12:39 PM, Surveyor interviewed R6 who stated R6 had an indwelling catheter and had approximately ten urinary tract infections (UTIs). R6 stated R6 had to take over part of R6's catheter care, including cleaning the tubing and penis with alcohol wipes, because staff didn't do it right. R6 stated R6 was familiar with sterile protocol for catheter care and asked staff to use proper catheter and penis cleaning protocol to protect R6 from infection. R6 indicated staff didn't follow the appropriate technique and didn't wear gowns during cares. R6 stated staff used to wear gowns but stopped wearing them months ago. R6 stated DON-B removed the receptacle near R6's door where staff discarded used gowns and gloves. R6 stated even when staff wore gowns for catheter care, they did not wear them for transfers, bed changes, or other cares. On 3/30/26 at 1:05 PM, Occupational Therapist (OT)-K entered R6's room with a mechanical lift as Surveyor was leaving. OT-K was not wearing a gown or gloves. Surveyor observed OT-K exit R6's room at 1:37 PM. On 3/30/26 at 1:39 PM, Surveyor interviewed OT-K who indicated OT-K provided occupational therapy for R6 which included repetitive transfers with the mechanical lift to maintain R6's ability to stand. OT-K indicated OT-K did not wear any PPE, including a gown or gloves, because OT-K didn't touch R6's catheter. When Surveyor asked if OT-K was familiar with the facility's EBP policy, OT-K stated OT-K was and again stated OT-K didn't need to wear PPE if OT-K wasn't completing catheter care. 4. Between 3/30/26 and 3/31/26, Surveyor reviewed R39's medical record. R39 was admitted to the facility on [DATE] and had diagnoses including chronic kidney disease and diverticulum of bladder. R39 had an indwelling catheter. R39's MDS assessment, dated 11/20/25, had a BIMS score of 4 out of 15 which indicated R39 had severely impaired cognition. R39's medical record contained a physician order for EBP related to R39's indwelling catheter and wound care. R39's care plan indicated R39 was at risk for infection and complications of an indwelling catheter. The care plan did not indicate R39 was on EBP. On 3/30/26 at 1:57 PM, Surveyor observed R39 in the four seasons room. R39's catheter bag was inside a dignity bag that hung under R39's wheelchair. On 3/30/26 at 2:13 PM and 3/31/26 at 12:51 PM, Surveyor noted there was not an EBP sign outside R39's room. On 4/1/26 at 8:35 AM, Surveyor observed CNA-J complete catheter care for R39 without wearing a gown. CNA-J emptied R39's catheter bag into a urinal. Surveyor notified DON-B who accompanied Surveyor back to R39's room to observe CNA-J complete catheter care. DON-B informed CNA-J that a gown is required during direct care for residents with catheters who are on EBP. Surveyor noted an EBP sign was not posted outside or inside R39's room. On 4/1/26 at 9:19 AM, Surveyor interviewed DON-B who indicated a resident on EBP should have a sign near the entrance to their room indicating they are on EBP. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525595	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Francis Home	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/1/26 at 9:55 AM, Surveyor interviewed Registered Nurse Supervisor (RNS)-E who indicated EBP should be indicated on the care plan of a resident who is on EBP. On 4/1/26 at 11:52 AM, Surveyor noted there was not an EBP sign posted outside R39's room. On 4/1/26 at 11:55 AM, Surveyor interviewed DON-B regarding an EBP sign for R39. DON-B confirmed there was not an EBP sign posted outside R39's room. When Surveyor asked how staff know R39 is on EBP without a sign and or indication on R39's care plan, DON-B indicated staff should know because R39 has a catheter.