STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525599	A. Building B. Wing	10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Joseph Residence	107 E Beckert Rd New London, WI 54961

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 - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not maintain an infection prevention and control program designed to prevent the transmission of communicable disease and infection for 4 residents (R) (R57, R18, R40, and R3) of 16 sampled residents.Certified Nursing Assistant in Training (CNAT)-D entered the dining room and placed a ice pack from R57's room on R57's knee. R57 was on enhanced barrier precautions (EBP). Without completing hand hygiene, CNAT-D then passed lunch trays and put clothing protectors on R18, R40, and R57.R18 was on EBP. CNA-E did not don a gown or gloves prior to transferring R18 from recliner to wheelchair.R3 was on EBP. CNA-E emptied R3's catheter bag and removed personal protective equipment (PPE). CNA-E then removed garbage from a can, opened the door, and exited the room without completing hand hygiene. Findings include: The facility's Handwashing - Hand Hygiene policy, dated 5/1/24, indicates: .1. All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors .Indications for Hand Hygiene: 1. Hand hygiene is indicated: a. Immediately before touching a resident; .d. After touching a resident; e. After touching a residents' environment .Applying and Removing Gloves: .4. Hold the removed glove in the gloved hand and remove the other glove by rolling it down the hand and folding it into the first glove. 5. Perform hand hygiene. According to the Association for Professionals in Infection Control and Epidemiology (APIC) website retrieved 10/2/25: Proper hand hygiene is the number one way to prevent the spread of infection. Everyone - healthcare professionals, patients, residents, families, and volunteers - should clean their hands thoroughly and at appropriate times to prevent the spread of disease. The facility's Enhanced Barrier Precautions policy, dated 4/26/25, indicates: EBP is used to prevent the spread of multidrug-resistant organisms (MDROs) to residents while performing direct high-contact care for residents with wounds regardless of a diagnosis of MDRO colonization. Personal protective equipment (PPE) such as gloves and a gown are applied prior to complete high-contact resident cares such as transferring. 1. On 9/29/25 at 12:06 PM, Surveyor observed lunch in the rehab dining room. Surveyor observed CNAT-D walk toward R57 with an ice pack and secure the ice pack on the pant leg of R57's left knee. (R57's medical record indicated R57 was on EBP due to a surgical incision on R57's knee.) Without completing hand hygiene, CNAT-D removed a lunch tray from the serving line and delivered it to a table where R57, R18, and R40 were seated. CNAT-D put a plate of food, beverages, a napkin, and silverware from the tray in front of R18. CNAT-D took the tray back to the serving line, removed another tray, and put a plate of food, beverages, a napkin, and silverware in front of R40. CNAT-D took (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the tray back to the serving line, retrieved 3 clothing protectors, and put the clothing protectors on R57, R18, and R40. CNAT-D removed another tray from the serving line and put a plate of food, beverages, a napkin, and silverware in front of R57. CNAT-D then took the tray back to the serving line. CNAT-D did not complete hand hygiene during the observation. At 12:10 PM, Surveyor interviewed CNAT-D who verified CNAT-D did not complete hand hygiene after putting an ice pack from R57's room on R57's left knee and before delivering lunch and putting clothing protectors on R57, R18, and R40. CNAT-D stated CNAT-D should have completed hand hygiene between interactions. On 10/1/25 at 12:52 PM, Surveyor interviewed Director of Nursing (DON)-B who was aware of the observation and verified CNAT-D should have completed hand hygiene. DON-B indicated the facility was working on staff education. 2. From 9/29/25 to 10/1/25, Surveyor reviewed R18's medical record. R18 had diagnoses including diabetes, localized edema, laceration of head, asthma, and cellulitis of the left lower limb. A Minimum Data Set (MDS) assessment completed 9/18/25 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R18 was not cognitively impaired. A care plan, dated 9/23/25, indicated R18 should be on appropriate isolation precautions due to a risk for infection. The facility's September 2025 resident infection surveillance log indicated R18 had cellulitis of the left lower extremity and was on EBP. On 9/29/25 at 1:24 PM, Surveyor observed an EBP sign inside the entrance of R18's room. After R18 activated the call light, CNA-E entered the room and R18 requested to be transferred from recliner to wheelchair. CNA-E moved a wheelchair in front of R18, assisted R18 with the transfer, and wheeled R18 out of the room. CNA-E did not don PPE prior to the transfer. On 9/29/25 at 1:25 PM, Surveyor interviewed CNA-E who was not sure if R18 was on EBP. CNA-E then read the precautions sign in R18's room and indicated CNA-E should have worn a gown and gloves during the transfer. On 9/29/25 at 1:28 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-I who verified R18 was on EBP and CNA-E should have worn a gown and gloves to transfer R18. On 10/1/25 at 9:29 AM, Surveyor interviewed DON-B who verified R18 was on EBP and confirmed CNA-E should have worn a gown and gloves during the transfer. 3. From 9/29/25 to 10/1/25, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] and had diagnoses including breast cancer, lung cancer, and femur fracture. An MDS assessment completed 9/12/25 had a BIMS score of 14 out of 15 which indicated R3 was not cognitively impaired. A care plan, revised 9/16/25, indicated R3 had an indwelling catheter. The care plan contained an intervention, revised 8/26/25, that indicated R3 was on EBP. On 9/30/25 at 1:26 PM, Surveyor observed CNA-E empty R3's catheter drainage bag. After CNA-E (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	emptied the bag, CNA-E walked into the bathroom and removed CNA-E's gown and gloves. CNA-E then bagged the garbage, opened the door, and walked into the hallway. CNA-E did not complete hand hygiene after removing PPE prior to or after exiting the room. When Surveyor interviewed CNA-E and asked about hand hygiene, CNA-E indicated CNA-E was going to look for hand sanitizer in the hallway. When asked if there was hand sanitizer in R3's room, CNA-E re-entered the room, noted there was a hand sanitizer dispenser on the wall, and completed hand hygiene. On 9/30/25 at 2:04 PM, Surveyor interviewed DON-B who confirmed CNA-E should have completed hand hygiene after removing PPE and exiting R3's room.

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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 ensure appropriate respiratory care and services were provided for 2 residents (R) (R18 and R28) of 2 sampled residents. R18 had a continuous positive airway ressure (CPAP) machine. R18 did not have an order to use the CPAP machine or orders to clean the face mask or tubing. R28 used a nebulizer machine. R28's nebulizer tubing was not changed according to the facility's policy. In addition, R28's medical record did not contain orders to change the nebulizer tubing or clean the face mask and other parts of the nebulizer. Findings include: The facility's CPAP/BiPAP (bilevel positive airway pressure) policy, dated 12/1/24, indicates to set the CPAP mode as prescribed, connect supplemental oxygen to the flow rate as prescribed, monitor oxygen saturation of the resident, and clean masks, nasal pillows, and tubing daily. The facility's Administering Medications Through a Small Volume (Handheld) Nebulizer document, dated 1/1/25, indicates: The purpose of this procedure is to safely and aseptically administer aerosolized particles of medication into the resident's airway .Equipment and Supplies: .4. Nebulizer kit, including nebulizer, medication cut, T-piece, mouthpiece (or facemask), and tubing .Steps in the Procedure: .27. Rinse/clean the nebulizer equipment according to facility protocol .30. Change equipment and tubing every seven days, or according to facility protocol. 1.From 9/29/25 to 10/1/25, Surveyor reviewed R18's medical record. R18 had diagnoses including obstructive sleep apnea (OSA), diabetes, and asthma. A Minimum Data Set (MDS) assessment completed 9/18/25 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R18 was not cognitively impaired. A hospital Discharge summary, dated [DATE], indicated R18 had OSA and to continue using home device and settings. The discharge summary contained an order for oxygen 1 liter bled into sleep machine with all sleep. R18's plan of care, dated 9/23/25, did not indicate R18 used a CPAP machine. R18's Medication Administration Record (MAR) and Treatment Administration Record (TAR) did not contain a physician order for the CPAP machine or indicate what settings to use. R18's MAR and TAR also did not contain orders to clean the CPAP and supplies or to monitor R18's oxygen saturation aside from a weekly vital signs order. On 9/29/25 at 10:24 AM and 1:46 PM, Surveyor observed a CPAP machine half-filled with water and a mask and tubing on R18's nightstand. Surveyor also observed a half-full gallon of spring water on R18's bed. Surveyor interviewed R18 who was not sure if staff are supposed to clean the CPAP machine and supplies. R18 indicated staff fill the machine with water provided by the facility. R18 indicated R18 used the CPAP machine at night and staff had not cleaned the mask or tubing. On 9/30/25 at 11:13 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-F who indicated CNA-F only fills the machine with water and helps apply the mask if R18 requests. On 9/30/25 at 12:43 PM, Surveyor interviewed Registered Nurse (RN)-G who verified R18's medical record did not contain an order for CPAP use. RN-G was not sure if an order was needed to use the (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CPAP machine. On 9/30/25 at 12:44 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-H who indicated LPN-H offered R18 use of the CPAP machine but did not recall documenting the use. LPN-H verified R18's medical record did not contain an order for CPAP use and indicated LPN-H would get an order from the physician. LPN-H stated R18's medical record indicated R18 used the CPAP machine inconsistently at home. LPN-H indicated LPN-H would add orders for cleaning the CPAP machine/parts when LPN-H entered R18's CPAP orders on the TAR. On 9/30/25 at 12:48 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated the facility should have orders for CPAP use and cleaning. DON-B indicated when R18 was initially admitted on [DATE], R18 indicated R18 was not going to use the CPAP machine and did not bring the machine. When R18 was readmitted following a brief hospitalization, DON-B reviewed R18's hospital admission orders from 9/23/25 and noted an order for CPAP use. DON-B indicated the CPAP order should have been transcribed in R18's TAR. DON-B indicated nurses should clean the mask and tubing daily 2. From 9/29/25 to 10/1/25, Surveyor reviewed R28's medical record. R28 was admitted to the facility in October of 2024 and had a diagnosis of chronic obstructive pulmonary disease (COPD). R28's medical record contained an order for ipratropium-albuterol solution 0.5-2.5 milligrams (mg)/3 milliliters (ml) (used to relax and open the airways to improve breathing in people with COPD), inhale orally every 8 hours as needed for COPD via nebulizer (start date 5/19/25.) Surveyor reviewed R28's MAR for 9/19/25 to 10/1/225 and noted the nebulizer treatment was administered on 9/25/25, 9/26/25, 9/27/25, and 10/1/25. On 9/29/25 at 11:46 AM, Surveyor observed a nebulizer machine with tubing attached on R28's night stand. The tubing contained a piece of tape that was dated 9/19. Surveyor also observed an oxygen concentrator with tubing attached to a nasal canula that R28 was using. The tubing contained a piece of tape that was dated 9/27. On 10/1/25 at 9:43 AM, Surveyor interviewed LPN-C who verified R28's medical record did not contain orders to change the nebulizer tubing or clean the mask. LPN-C stated an order to change oxygen tubing is usually combined with a nebulizer tubing order and the night shift nurse changes both sets of tubing weekly at the same time. LPN-C stated the mask and parts should be disconnected, rinsed with water, and left to dry after every use and the tubing should be dated when changed. On 10/1/25 at 9:46 AM, Surveyor and LPN-C observed R28's nebulizer and oxygen tubing. LPN-C verified the nebulizer tubing was dated 9/19 and the oxygen tubing was dated 9/27. The nebulizer mask and connector appeared to be drying on paper towel on R28's dresser from the last administration in the early morning of 10/1/25. On 10/1/25 at 10:57 AM, Surveyor interviewed DON-B who stated the facility usually combines orders to change oxygen and nebulizer tubing and indicated the order should be on a resident's TAR. DON-B verified R28's TAR did not contain an order to change nebulizer or oxygen tubing. On 10/1/25, Surveyor noted R28's medical record was updated on 10/1/25 with an order to change nebulizer tubing and mask/pipe weekly every night shift every Saturday (start date 10/4/25 at 10:30 PM.)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure the coordination of Hospice services for 1 resident (R) (R3) of 1 sampled resident.R3 received Hospice services. R3's medical record did not contain a current Hospice care plan and Certified Nursing Assistant (CNA) visit notes were not accessible. In addition, the facility did not coordinate or document bed baths and offer range of motion (ROM) exercises per R3's request.Findings include:The facility's contract with Hospice Company (HC)-J, dated 5/1/21, indicates: Services to be provided by Hospice: .2. Hospice will develop .a plan of care for the management and palliation of the resident's terminal illness .The plan of care will be updated as often as the patient's condition requires, but no less frequently than every 15 days. Part III: Services to be provided by Facility: .2. Facility will provide room and board services to Hospice patients who are residents of the facility, including but not limited to .personal care, and such other residential care services that are customarily provided by the facility to its residents. The facility acknowledges and agrees that it is the facility's responsibility to continue to furnish 24-hour room and board care meeting the personal care and nursing needs that would have been provided by the primary caregiver at home at the same level of care provided before Hospice care was selected and that the facility will provide all of the room and board services which the facility normally would have provided in the absence of the Hospice program. The facility further acknowledges and agrees that it is the facility's responsibility to meet the Hospice patient's personal care and nursing needs in coordination with the Hospice representative to ensure the level of care provided is appropriate based on the individual Hospice patient's needs. From 9/29/25 to 10/1/25, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] and had diagnoses including breast cancer, lung cancer, and femur fracture. A Mimimum Data Set (MDS) assessment completed 9/12/25 had a Brief Interview for Mental Status Score (BIMS) score of 14 out of 15 which indicated R3 had intact cognition. R3 made R3's own medical decisions. A care plan, initiated 3/20/25, related to comfort care/end of life indicated R3 received Hospice services from HC-J. A hospice care plan in R3's medical record was dated 6/25/25 through 9/2/25. R3's current Hospice care plan was not in R3's medical record.On 9/29/25 at 10:51 AM, Surveyor interviewed R3 who cofirmed R3 received Hospice services but indicated R3 didn't always receive scheduled baths. R3 also indicated R3 requested to have daily lower extremity ROM exercises which were not always provided. In a subsequent interview on 10/1/25 at 9:00 AM, R3 clarified that R3 wanted a full bed bath for bathing because R3 did not want to get out of bed. R3 indicated only Hospice staff offered bed baths and sometimes ROM exercises were completed by Hospice or facility staff. Surveyor reviewed R3's bathing records from July 2025 to the present which included facility bathing records and Hospice notes. R3's facility bathing records indicated bed baths were provided on Monday and Wednesday AM by Hospice. The bathing records indicated R3 received a bed bath on 7/2/25, 7/9/25 and 7/16/25. Not applicable was documented for 8/6/25, 8/20/25, and 8/27/25. Total dependence was documented for 7/23/25, 7/30/25, 9/17/25, and 9/24/25. There was no charting for 8/13/25, 9/3/25, and 9/10/25. HC-J bed bath records contained Certified Nursing Assistant (CNA) notes that documented bed baths on the same days the facility documented bed bathsSurveyor reviewed HC-J nursing notes in R3's medical record but did not see any CNA notes.A Hospice progress note, dated 7/28/25 at 11:02 AM, indicated it was discussed and written in R3's notebook that a named staff will do ROM exercises with R3 during every visit.A Hospice progress note, dated 9/3/25 at 3:58 PM, indicated R3's bilateral lower extremities had edema. Family was concerned that R3 did not receive ROM exercises because R3 could not remember. The writer informed R3 and R3's family that the Hospice CNA usually provides ROM exercises with cares when the CNA visits.On 10/1/25 at 9:21 AM, Surveyor interviewed Restorative Aid (RA)-K who worked as a CNA on the weekend. RA-K indicated R3's family told the (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurse that R3 was supposed to receive ROM. The nurse asked if RA-K worked with R3. RA-K indicated R3 was not and had not been on RA-K's restorative list. R3's care plan did not indicate R3 wanted to receive daily ROM exercises.On 10/1/25 at 9:51 AM, Surveyor interviewed Director of Nursing (DON)-B who confirmed R3's medical record did not contain an updated Hospice care plan or CNA Hospice notes. DON-B indicated HC-J removed the physical binders and switched to a computer charting system. DON-B indicated the facility was not provided with the notes. DON-B indicated facility staff should offer a bed bath once weekly and Hospice staff should offer the second bed bath. DON-B indicated CNA staff documented NA for bathing when R3 refused and informed staff they need to document refused instead. When Surveyor indicated facility staff documented bed baths on the same days Hospice staff documented, DON-B was not sure which staff provided the bed bath. DON-B confirmed improvement was needed for offering and documenting bed baths. DON-B stated DON-B would follow-up with R3 and Hospice staff regarding ROM and indicated if staff provide ROM it should be in R3's care plan.