STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525617	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Paul Elder Services, Inc	316 East 14th Street Kaukauna, WI 54130

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48794 Based on staff interview and record review, the facility did not accurately code Minimum Data Set (MDS) 3.0 assessments for 2 residents (R) (R59 and R214) of 27 sampled residents. R59's MDS assessment, dated 3/14/25, inaccurately indicated R59 had an unhealed stage 3 pressure injury. R214 had a physician order for tramadol (an opioid medication used to treat moderate to severe pain). R214's MDS assessments, dated 3/9/25 and 3/25/25, did not indicate R214 received opioid medication. Findings include: 1. From 3/31/25 to 4/2/25, Surveyor reviewed R59's medical record. R59 was admitted to the facility on [DATE] and had a diagnosis of pulmonary embolism. R59's Admission MDS assessment, dated 3/14/25, indicated R59 had an unhealed stage 3 pressure injury. On 4/2/25 at 11:55 AM, Surveyor interviewed Clinical Nurse Coordinator (CNC)-O who confirmed CNC-O completed R59's Admission MDS assessment. CNC-O stated R59's hospital discharge paperwork indicated R59 had a pressure injury. CNC-O stated upon assessment of the pressure injury, staff determined the pressure injury was resolved. CNC-O acknowledged R59's Admission MDS assessment was coded inaccurately. 2. From 3/31/25 to 4/2/25, Surveyor reviewed R214's medical record. R214 was admitted to the facility on [DATE] and had a diagnosis of fracture of the left humerus. R214 had the following physician orders for opioid medication: ~ Hydrocodone-acetaminophen (Vicodin) 5-325 milligrams (mg). Give 1 tablet by mouth every 6 hours as needed. (Start date: 2/28/25; End date: 3/4/25) ~ Tramadol 50 mg. Give 1 tablet by mouth every 6 hours as needed. (Start date: 3/4/25; End date: 3/5/25) (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~ Tramadol 50 mg. Give 1 tablet by mouth every 4 hours as needed. (Start date: 3/5/25; No end date) R214's Discharge-Return Anticipated MDS assessment, dated 3/9/25 and R214's Admission MDS assessment, dated 3/25/25, did not indicate R214 received opioid medication. On 4/2/25 at 12:00 PM, Surveyor interviewed Director of Nursing (DON)-B who confirmed R214 was prescribed opioid medication and had taken the medication during the MDS assessment period. DON-B confirmed R214's MDS assessments should have been coded to indicate R214 received opioid medication.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49010 Based on observation, staff and resident interview, and record review, the facility did not ensure the appropriate care and treatment was provided for 1 resident (R) (R11) of 27 sampled residents. R11 had a wound on the left great toe. Staff did not complete a wound assessment or provide appropriate care for the wound. In addition, R11 was not provided compression stockings as ordered and was not placed on enhanced barrier precautions (EBP) when the wound was discovered. Findings include: The facility's Pressure Injury Prevention and Management policy, revised 10/2024, indicates: .The goal is that all residents receive prompt assessment and treatment for all skin conditions .C. Ongoing Assessment for Risk of Wound Development: 1. Certified Nursing Assistants (CNAs) observe skin with all cares and report any concerns to the charge nurse. 2. Any patient/resident living with diabetes will have foot checks every evening by the CNAs or designee. 3. Charge nurses are to conduct thorough skin observations on a weekly basis . The facility's Use of Personal Protective Equipment (PPE) and Standard and Transmission-Based Precautions and Enhanced Barrier Precautions policy, revised 8/30/22, indicates: .7. Enhanced Barrier Precautions (EBP) are designed to prevent the spread of novel and targeted multidrug-resistant organisms (MDROs) to those who are at risk or susceptible .A susceptible and at-risk resident is anyone who: 1. Has a wound or skin opening that requires a dressing regardless of any known MDRO colonization status of that resident .B. High-contact activities that require EBP to be used to protect susceptible or at risk residents: 1. dressing. 2. bathing/showering .8. wound care .Gloves and gown are worn during high-contact activities with those residents who are susceptible or at risk of infection . From 3/31/25 to 4/2/25, Surveyor reviewed R11's medical record. R11 was admitted to the facility on [DATE] and had diagnoses including type 2 diabetes mellitus with diabetic chronic kidney disease and polyneuropathy, age-related bilateral nuclear cataracts, hemiplegia and hemiparesis following cerebrovascular disease, and abnormalities of gait and mobility. R11's Minimum Data Set (MDS) assessment, dated 3/19/25, had a Brief Interview for Mental Status (BIMS) score of 7 out of 15 which indicated R11 had severely impaired cognition. On 3/31/25 at 1:25 PM, Surveyor interviewed R11 who indicated R11 had an open sore on the left great toe. R11 stated R11 reported the wound to an unidentified female staff earlier that day and a staff applied ointment and a bandage. R11 indicated R11 was worried about the wound because R11 had toe ulcers in the past and almost lost two toes. Surveyor noted there was not an EBP sign on or near R11's door. R11's care plan contained an intervention to check R11's body for breaks in skin and treat promptly as ordered by the physician (initiated 9/20/24). R11's care plan did not include interventions for the toe wound or EBP. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R11's medical record did not contain progress notes regarding the wound, wound assessments, or orders for wound care or EBP. In addition, there was no documentation that staff applied ointment and a bandage to R11's left great toe on 3/31/25. R11's Medication Administration Record (MAR) and Treatment Administration Record (TAR) contained orders for compression stockings 15-20 millimeters of mercury (mmHg) on in AM and off in PM. On 4/1/25 at 8:00 AM and 11:19 AM, Surveyor noted there was not an EBP sign on or near R11's room. On 4/1/25 at 11:31 AM, Surveyor interviewed Clinical Services Coordinator (CSC)-R and Infection Preventionist (IP)-K who indicated EBP should be initiated for any resident with an indwelling medical device or wound. IP-K indicated EBP should be implemented as soon as the reason for EBP is discovered. IP-K indicated EBP should be added to the resident's care plan and CNA pocket notes and an EBP sign should be posted at the resident's room entrance. IP-K indicated IP-K had walked the hall at approximately 10:00 or 10:30 AM and posted any missing signs for residents who should be on EBP. On 4/1/25 at 1:20 PM, Surveyor interviewed Wound Care Nurse (WCN)-Q who indicated WCN-Q had not seen R11 because R11 was not on WCN-Q's list of residents with wounds. WCN-Q indicated if staff discover a wound on a resident, they should complete a new wound note by completing a skin incident report. WCN-Q indicated the incident report is sent to the supervisor and the Director of Nursing (DON) who email the wound team. WCN-Q indicated WCN-Q assesses residents noted to have wounds or skin concern. WCN-Q reiterated WCN-Q did not have any new wounds to see other than a resident who was not R11. WNC-Q confirmed residents with wounds should be placed on EBP. On 4/1/25 at 2:05 PM, Surveyor interviewed R11 who indicated no one looked at R11's toe that day which still contained a bandage from the day before. On 4/2/25 at 7:38 AM, Surveyor noted there was not an EBP sign on or near R11's door. On 4/2/25 at 7:43 AM, Surveyor interviewed R11 who indicated R11 received a shower that morning. R11 indicated no one checked on R11's toe wound since the bandage and ointment were applied on 3/31/25. R11 indicated the staff who gave R11 a shower did not remove the bandage. R11 indicated R11 still had a wet bandage on the toe and no one had assessed the wound. R11 indicated R11 did not have much feeling in R11's toes so the wound did not hurt. R11 was concerned due to previous injuries from R11's shoes. R11 indicated R11's wounds did not heal well. R11 indicated R11 had not seen the wound since the bandage was applied. On 4/2/25 at 7:49 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-P who was not aware of R11's toe wound. LPN-P reviewed R11's medical record and indicated R11 did not have any wounds. Surveyor informed LPN-P that R11 had a toe wound with ointment and a bandage applied on 3/31/25 that was not assessed during R11's shower that morning. R11 walked down the hall at that time and confirmed what Surveyor had stated. When LPN-P asked R11 if a family member applied the bandage, R11 stated twice that a staff applied the bandage. LPN-P asked to see the wound and removed R11's shoe, sock, and bandage. Surveyor noted R11 was not wearing compression stockings. LPN-P and Surveyor observed an open wound on the front underside of R11's great toe. The skin surrounding the wound was moist and white. LPN-P cleaned the wound and applied a new dressing. LPN-P indicated LPN-P would notify the wound care team to assess the wound and determine treatment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/2/25, Surveyor reviewed R11's TAR and noted LPN-P initialed at 7:29 AM that LPN-P put compression stockings on R11. Surveyor reviewed CNA task charting and noted CNA staff initialed nightly that they completed daily diabetic foot checks, including 3/31/25 and 4/1/25. No new skin issues were noted on the CNA task foot checks. On 4/2/25 at 10:02 AM, Surveyor noted an EBP sign at the entrance to R11's room. On 4/2/25 Surveyor noted R11's care plan had been updated with new orders initiated on 4/2/25 that indicated R11 had an open wound on the toe and staff should use EBP during cares. On 4/2/25 at 10:04 AM, Surveyor interviewed LPN-P who reviewed R11's MAR and TAR and confirmed LPN-P initialed that R11's compression stockings were applied. LPN-P indicated LPN-P should not have initialed the task without applying compression stockings. LPN-P indicated a supervisor posted the EBP sign due to R11's toe wound. On 4/2/25 at 12:52 PM, Surveyor interviewed Infection Preventionist (IP)-K who indicated R11's wound should have been assessed and documented on 3/31/25 when R11 reported the wound to staff. IP-K indicated R11 should have been on EBP since the day the wound was discovered. IP-K indicated it was not acceptable for staff to leave the bandage on in the shower and not inform the nurse that wound care needed to be completed. IP-K indicated there was a concern that R11's daily diabetic foot checks were not being done or accurately documented. IP-K indicated it is not acceptable for staff to document that R11's compression stocking were applied if they were not. IP-K agreed if staff followed the facility's protocol, addressed R11's wound, accurately completed diabetic foot checks, showers, and wound care, and ensured compression stockings were applied, R11 would have received appropriate care days before Surveyor alerted staff of R11's toe wound. On 4/2/25 at 1:15 PM, Surveyor interviewed DON-B who indicated a resident with a wound should be on EBP that is enacted immediately. DON-B indicated R11's wound should have been addressed on 3/31/25 when R11 reported the wound to staff. DON-B indicated R11 should have been placed on EBP and staff should have notified the wound care nurse to initiate a wound care plan. DON-B indicated R11's wound could be precarious because R11 was diabetic. DON-B indicated it is not acceptable for staff to document that tasks are completed when they have not been completed.

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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** 51043 Based on staff interview and record review, the facility did not provide the necessary respiratory care and services for 3 residents (R) (R25, R29, and R13) of 3 sampled residents. R25 and R29's plans of care did not indicate R25 and R29 received oxygen therapy and did not contain orders to change R25 and R29's oxygen tubing. R13's plan of care did not indicate R13 received oxygen therapy. Findings include: The facility's Oxygen Storage, Transportation, and Administration policy, dated 2/21/24, indicates: Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration . The National Library of Medicine, Nursing Fundamentals (2021) indicates: .Goals, expected outcomes, and nursing interventions are documented in the patient's nursing care plan so that nurses, as well as other health professionals, have access to it for continuity of care . Found at https://www.ncbi.nlm.nih.gov/books/NBK591807/ 1. From 4/1/25 to 4/2/25, Surveyor reviewed R25's medical record. R25 was admitted to the facility on [DATE] and had diagnoses including COVID-19, pulmonary fibrosis, sleep apnea with use of continuous positive airway pressure (CPAP) machine at night, and insomnia. R25's Minimum Data Set (MDS) assessment, dated 3/13/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R25 was not cognitively impaired. R25's plan of care did not indicate R25 received oxygen therapy. R25 did not have an order to change R25's oxygen tubing. Neither R25's Medication Administration Record (MAR) or Treatment Administration Record (TAR) indicated R25's oxygen tubing was changed or scheduled to be changed. On 4/2/25 at 11:23 AM, Surveyor interviewed Director of Nursing (DON)-B and Nursing Home Administrator (NHA)-A who indicated oxygen therapy should be identified on R25's care plan. DON-B indicated R25 should have an order to change R25's oxygen tubing. 50988 2. From 3/31/25 to 4/2/25, Surveyor reviewed R29's medical record. R29 was admitted to the facility on [DATE] and had diagnoses including Lewy body dementia, acute respiratory failure, and dependence on supplemental oxygen. R29's MDS assessment, dated 3/3/25, had a BIMS assessment completed by staff and indicated R29 was unable to answer questions. R29's medical record did not contain a care plan for oxygen therapy. In addition, R29's medical record did not contain an order to change R29's oxygen tubing. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/1/25 at 1:00 PM, Surveyor interviewed DON-B who indicated an order to change oxygen tubing should be in place for all residents who use oxygen. DON-B verified R29 did not have an order to change R29's oxygen tubing. DON-B also indicated residents who receive supplemental oxygen should have a care plan for oxygen therapy. DON-B verified R29 did not have a care plan for oxygen use. On 4/2/25, Surveyor noted R29's medical record contained an order to change oxygen tubing every Friday with a start date of 4/1/25. R29's medical record also contained a care plan for oxygen therapy with an initiation date of 4/1/25. On 4/2/25 at 8:43 AM, Surveyor interviewed Registered Nurse (RN)-N who indicated residents on oxygen should have their oxygen tubing changed when soiled or every 30 days which should be documented on the resident's MAR. RN-N verified the order to change R29's oxygen tubing was not initiated until 4/1/25. 48794 3. From 3/31/25 to 4/2/25, Surveyor reviewed R13's medical record. R13 was admitted to the facility on [DATE] and had diagnoses including cerebral infarction, palliative care, congestive heart failure and supplemental oxygen. R13's MDS assessment, dated 3/18/25, had a BIMS score of 7 out of 15 which indicated R13 had severely impaired cognition. R13's care plan did not indicate R13 received oxygen therapy. On 4/2/25 at 11:23 AM, Surveyor interviewed DON-B and NHA-A who indicated oxygen therapy should be identified on R13's care plan.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47248 Based on observation, staff interview, and record review, the facility did not ensure food was stored and prepared in a sanitary manner. This practice had the potential to affect more than 4 of the 98 residents residing in the facility. Food items were not labeled with received, opened, or use-by dates. Staff did not the ensure the temperature of the activity freezer was monitored to ensure resident food was stored safely. Cook (CK)-F and CK-E did not wait two minutes to temp microwave reheated food to ensure the food was heated evenly. Findings include: During a continuous kitchen observation that began at 11:30 AM on 4/1/25, Director of Dining (DD)-D indicated the facility follows the Wisconsin Food Code. Undated Items in Refrigerators/Freezers: The Wisconsin Food Code indicates at 3-501.17 Ready-to-Eat, Potentially Hazardous Food (Time/Temperature Control for Safety Food), Date Marking: .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 Celsius (C) (41 Fahrenheit (F)) or less for a maximum of 7 days. The day of preparation shall be counted as day 1 .ready to eat time and temperature controlled food shall be clearly marked at the time the original container is opened in a food establishment and, if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded based on the temperature and time combinations . During an initial kitchen tour with Executive [NAME] (EC)-C that began at 8:18 AM on 3/31/25, Surveyor observed the dry storage area and noted multiple bottles of Simply Thick brand Thick & Easy clear drinks. The bottles contained a labeling sticker that indicated the date the drink was obtained by the facility, a line for staff to write the opened date, a line below the opened date for the expiration date, and line below the expiration date/use-by date that indicated the product should be thrown away seven days after opening. EC-C indicated stickers are affixed to the bottles when they arrive and are used to ensure staff label the bottles with the opened and use-by dates to ensure all clear drinks are discarded after seven days. On 3/31/25 beginning at 9:15 AM, Surveyor toured the facility's neighborhoods and noted the following: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	~ The Poppy Place dining room refrigerator contained an undated Celsius drink and an undated container of queso cheese dip for resident consumption. The Poppy Place dining room freezer contained undated containers of chicken soup and beef vegetable soup. ~ The Birch Place dining room refrigerator contained an open container of Simply Thick brand Thick & Easy lemon-flavored juice with no open or use-by dates, an open bottle of Mountain Dew with no open or use-by dates, and a can of Bubbler with no use-by date. On 4/1/25 at 8:20 AM, Surveyor observed the Primrose Place dining room refrigerator and noted an open and undated container of Simply Thick brand Thick & Easy with an affixed label. Surveyor observed Certified Nursing Assistant (CNA)-G serve the open and undated Thick & Easy drink to a resident during meal service. During a continuous kitchen observation that began at 11:31 AM on 4/1/25, Surveyor interviewed EC-C who indicated the dining room refrigerators and freezers contain food items for resident use. EC-C verified the food and drink items observed by Surveyor were not labeled or dated in accordance with the facility's policy. Freezer Temperatures: The Wisconsin Food Code indicates: .1. Temperature control: Perishable food items must be stored at appropriate temperatures to prevent spoilage and reduce the risk of foodborne illnesses. Refrigerators should be set below 41 F (5 C) and freezers at or below 0 F (-18 C). During a continuous kitchen observation that began at 11:31 AM on 4/1/25, Surveyor interviewed EC-C who indicated Activity Director (AD)-H was responsible for the refrigerator and freezer in the activity room and the temperature monitoring logs. On 4/1/25 at 1:18 PM, Surveyor toured the activity room and observed the refrigerator and freezer with AD-H. Surveyor observed containers of soup and ice cream in the freezer that AD-H confirmed were for resident consumption. Surveyor noted the refrigerator/freezer temperature log indicated the freezer temperature was above 0 degrees F on multiple dates. Surveyor interviewed AD-H who indicated AD-H did not know who was responsible for monitoring refrigerator/freezer temperatures. AD-H indicated AD-H collects and files the temperature logs and was unsure what the freezer temperature should be. Surveyor requested the facility's January, February, and March 2025 temperature logs. On 4/1/25 at 1:30 PM, Surveyor reviewed the activity room refrigerator/freezer temperature logs and noted the following: ~ In January of 2025, the freezer had a temperature above 0 degrees (with a highest recorded temperature of 20 degrees F) on 30 of 31 documented days. ~ In February of 2025, the freezer had a temperature above 0 degrees (with a highest recorded temperature of 28 degrees F) on 24 of 28 documented days. ~ In March of 2025, the freezer had a temperature above 0 degrees (with a highest recorded temperature of 24 degrees F) on 30 of 31 documented days. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Microwave: The Wisconsin Food Code indicates at 3-403.11 Reheating for Hot Holding: .(B) Except as specified under (C) of this section, potentially hazardous food (time/temperature control for safety food) reheated in a microwave oven for hot holding shall be reheated so that all parts of the food reach a temperature of at least 74 C (165 F) and the food is rotated or stirred, covered, and allowed to stand covered for 2 minutes after reheating . During a continuous kitchen observation that began at 11:31 AM on 4/1/25, Surveyor observed CK-F heat an uncovered container of spaghetti in the microwave for one minute. CK-F stirred and temped the spaghetti (which did not reach 165 degrees F) and heated the spaghetti for another minute. CK-F temped the spaghetti again (which did not reach 165 degrees F) and heated the spaghetti for another minute. CK-E then stirred and temped the spaghetti which was 165 degrees F. CK-E indicated the food was up to temperature and put the spaghetti on a tray for service. CK-E did not wait two minutes to ensure the covered spaghetti maintained a temperature of 165 degrees F. Surveyor then observed CK-E heat a bowl of green beans in the microwave for one minute and temp the beans which did not reach 165 degrees F. CK-E heated the beans in the microwave for another minute and temped the beans without stirring them. Surveyor noted the temperature was 167 degrees F. CK-E then put the beans on a tray for service. Surveyor also observed CK-E heat a container of covered soup in the microwave for one minute and temp the soup which reached 170 degrees F. CK-E then handed the soup to staff to serve to a resident. CK-E did not wait two minutes to ensure the covered soup maintained a temperature of 165 degrees F. On 4/1/25 at 2:10 PM, Surveyor interviewed EC-C and DD-D who confirmed staff did not microwave food during lunch service in accordance the Wisconsin Food Code. EC-C and DD-D indicated it was an unusual process for the cooks because the food is usually cooked in the microwave and held for service and a temperature is obtained when the food is served. EC-C and DD-D indicated due to new admissions that day and one resident ordering soup for a meal, staff did not follow the usual process for having all food cooked prior to service.

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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** 51043 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 2 residents (R) (R25 and R16) of 27 sampled residents. R25 was on airborne precautions (used to prevent the spread of germs through the air). Following the provision of care on 4/1/25, Certified Nursing Assistant (CNA)-L and CNA-M removed their N95 masks (used to filter out viruses in the air) prior to leaving R25's room. R16 had a catheter and was on enhanced barrier precautions (EBP). On 4/1/25, CNA-I and CNA-J did not wear gowns during high-contact resident cares. Findings include: The facility's Use of Personal Protective Equipment and Standard and Transmission Based Precautions and Enhanced Barrier Precautions policy, revised 8/30/22, indicates: .Airborne precautions are used for patients known or suspected to be infected with microorganisms that spread over long distances while suspended in the air .Personal protective equipment (PPE) use - a surgical mask and face shield or N95 .7. Enhanced Barrier Precautions (EBP) are designed to prevent the spread of novel and targeted multidrug-resistant organisms (MDROs) to those who are at risk or susceptible .A susceptible and at-risk resident is anyone who: 1. Has a wound or skin opening that requires a dressing regardless of any known MDRO colonization status of that resident .B. High-contact activities that require EBP to be used to protect susceptible or at risk residents: 1. dressing. 2. bathing/showering .8. wound care .Gloves and gown are worn during high-contact activities with those residents who are susceptible or at risk of infection . 1. On 4/1/25, Surveyor reviewed R25's medical record. R25 was admitted to the facility on [DATE] and had diagnoses including COVID-19, bilateral hip osteoarthritis, pulmonary fibrosis, insomnia, and muscle weakness. R25's Minimum Data Set (MDS) assessment, dated 3/13/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R25 was not cognitively impaired. On 4/1/25 at 12:17 PM, Surveyor observed an airborne precautions sign on R25's door and a PPE cart that contained N95 masks, gowns, goggles and gloves outside R25's room. The airborne precautions sign indicated an N95 mask should be applied prior to entering R25's room and should be removed after exiting the room. Surveyor observed recommendations on top of the PPE cart that indicated staff should wear a gown, gloves, goggles, and an N95 mask when entering R25's room. Surveyor observed CNA-L and CNA-M complete hand hygiene and don gowns, goggles, and gloves prior to entering R25's room. On 4/1/25 at 12:33 PM, Surveyor observed CNA-L and CNA-M exit R25's room without any PPE, including N95 masks. On 4/1/25 at 12:33 PM, Surveyor interviewed CNA-L who indicated the N95 mask was the last thing CNA-L removed before leaving R25's room. CNA-L verified the airborne precautions sign on R25's door indicated CNA-L should not remove the mask prior to exiting R25's room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525617	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Paul Elder Services, Inc	316 East 14th Street Kaukauna, WI 54130

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 4/1/25 at 12:35 PM, Surveyor interviewed CNA-M who indicated the N95 mask was the last thing CNA-M removed prior to exiting R25's room. CNA-M verified the airborne precautions sign on R25's door indicated CNA-M should not remove the mask prior to exiting R25's room. On 4/1/25 at 12:53 PM, Surveyor interviewed Infection Preventionist (IP)-K who indicated CNA-L and CNA-M should have removed their N95 masks after exiting R25's room. On 4/2/25 at 10:04 AM, Surveyor interviewed Director of Nursing (DON)-B and Nursing Home Administrator (NHA)-A who both indicated staff should remove N95 masks after exiting the room of a resident who is on airborne precautions. 50988 2. From 3/31/25 to 4/2/25, Surveyor reviewed R16's medical record. R16 was admitted to the facility on [DATE] and had diagnoses including supranuclear palsy, Parkinson's disease, and obstructive uropathy. R16's MDS assessment, dated 4/25/23, had a BIMS score of 15 out of 15 which indicated R16 was not cognitively impaired. On 4/1/25 at 9:10 AM, Surveyor observed an EBP sign posted outside R16's room and observed CNA-I and CNA-J transfer R16 to bed via sit-to-stand lift. Surveyor noted CNA-I and CNA-J did not wear gowns during the transfer as required for high-contact resident care. CNA-I then emptied urine from R16's catheter drainage bag into a urinal. CNA-I and CNA-J then completed peri-care for R16 who was incontinent of stool, changed R16's brief, and repositioned R16 without wearing gowns. On 4/1/25 at 9:27 AM, Surveyor interviewed CNA-I and CNA-J who acknowledged CNA-I and CNA-J should have worn gowns when completing peri-care, emptying R16's catheter bag, and transferring R16 to bed. CNA-I and CNA-J verified R16 was on EBP and had an EBP sign outside R16's room. On 4/1/25 at 2:57 PM, Surveyor interviewed DON-B who confirmed staff should wear gowns and gloves during high-contact cares for a resident on EBP. DON-B confirmed peri-care, emptying a catheter bag, and transferring a resident were considered high-contact resident cares.