STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525660	A. Building B. Wing	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Dominic Villa	2375 Sinsinawa Rd Hazel Green, WI 53811

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 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 1 of 9 reviewed for bedrailsBased on interview and record review, the facility did not ensure other alternatives were tried prior to installing/utilizing bed rails, failed to accurately assess the risk of possible entrapment, failed to identify and recognize the use of an air mattress with bed rails increases the risk for entrapment, failed to re-assess and obtain an updated consent after the installation of an air mattress with bed rails, and care plan the need and use of bed rails for 1 of 9 residents (R11) reviewed for bed rails.R11 did not have alternatives attempted prior to the facility installing and utilizing bed rails.R11's bed rail assessment was not completed accurately.R11's bed rail assessment and consent form were not updated after the installation of an air mattress.R11's comprehensive care plan was not updated with the need and use of bed rails.R11 became entrapped in the bed rail resulting in multiple abrasions, bruises, and redness on R11's inner upper arm, neck, under jaw, face and torso.The facility failed to ensure other alternatives were tried prior to installing/utilizing bed rails, failed to accurately assess the risk of possible entrapment, failed to identify and recognize the use of an air mattress with bed rails increases the risk for entrapment, failed to re-assess and obtain an updated consent after the installation of an air mattress with bed rails, and care plan the need and use of bed rails. This created a finding of immediate jeopardy that began on 11/16/25 when R11 became entrapped in the bed rail. NHA A (Nursing Home Administrator) and DON B (Director of Nursing) were notified of the immediate jeopardy on 12/11/25 at 2:00 PM. The immediate jeopardy was removed on 12/11/25. However, the deficient practice continues at a scope/severity of D (Potential for harm/Isolated) as the facility continues to implement its action plan.This is evidenced by:On 12/11/25 at 12:10 PM, Surveyor requested the facility's policy on bed rails. DON B indicated the facility does not have a policy for bed rails.According to the Food and Drug Administration (FDA), The FDA recommends the following actions to prevent deaths and injuries from entrapment and falls from adult portable bed rails: When installing and using bed rails: Confirm that the age, size, and weight of the person using the bed rails are appropriate for the bed rails used. Install bed rails using the manufacturer's instructions to ensure a proper fit. Check bed rails regularly to make sure they are still installed correctly as rails may shift or loosen over time. Potential Zones of Entrapment. This guidance describes seven zones in the hospital bed system where there is a potential for patient entrapment. Entrapment may occur in flat or articulated bed positions, with the rails fully raised or in intermediate positions. The seven areas in the bed system where there is a potential for entrapment are . Zone 1: Within the Rail.https://www.fda.gov/medical-devices/adult-portable-bed-rail-safety/recommendations-consumers-and-car to the Food and Drug Administration (FDA), Recommendations for consumers and caregivers about adult portable bed rails, dated 2/27/2023, indicates the following: Some people are at a high-risk for entrapment, falls or other injury from adult portable bed rails. High-risk people include those with pre-existing conditions such as confusion, restlessness, lack of muscle control, or a combination of these factors. Additionally, people who are cognitively impaired from the use of medication or from a (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	medical condition, such as Alzheimer's or dementia, Parkinson's disease, Multiple Sclerosis (MS), balance disorders, stroke, or low blood pressure (hypotension), are at a higher risk of entrapment and injury. Consider other alternatives when bed rails are not appropriate. Alternatives include roll guards, foam bumpers, lowering the bed as near to the floor as possible, using concave mattresses that can help reduce rolling off the bed, or a bed trapeze to help reposition while in bed and to get in and out of bed.Adult portable bed rails should not be used as a substitute for proper monitoring, especially for people at high risk for entrapment and falls.If your loved one is in a long-term care facility, make sure that a comprehensive assessment and care plan is in place before using bed rails (see information under Recommendations for Health Care Providers).The FDA recommends the following actions to prevent deaths and injuries from entrapment and falls from adult portable bed rails:Before you install bed rails:Check whether the adult portable bed rails you are using comply with ASTM F3186-17: Standard Specification for Adult Portable Bed Rails and Related Products. This FDA-recognized international consensus standard establishes performance criteria for adult portable bed rails including resistance to entrapment.Be aware that not all bed rails, mattresses, and bed frames are interchangeable, and not all bed rails fit all size beds.Check with the manufacturers to make sure the bed rails, mattress, and bed frame are compatible, since most bed rails and mattresses are purchased separately from the bed frame.Rails should be selected and placed to discourage climbing over rails to get in and out of bed, which could lead to falls.When installing and using bed rails:Confirm that the age, size, and weight of the person using the bed rails are appropriate for the bed rails used.Install bed rails using the manufacturer's instructions to ensure a proper fit.Ensure that the safety strap or bed rail retention system is permanently attached to the rail and secured to the bed frame according to the manufacturer's instructions.Regularly inspect the mattress and bed rails for gaps and areas of possible entrapment. Regardless of mattress width, length, and depth, the bed frame, bed rail and mattress should leave no gap wide enough to entrap a patient's head or body.Use caution when using bed rails with a soft mattress as this may increase risk of entrapment between the mattress and bed rail.Be aware that gaps can be created by movement or compression of the mattress which may be caused by patient weight, patient movement or bed position, or by using a specialty mattress, such as an air mattress, mattress pad or waterbed.Check bed rails regularly to make sure they are still installed correctly as rails may shift or loosen over time.R11 admitted to the facility on [DATE] with diagnoses including atrial fibrillation (a heart arrhythmia causing the upper chambers to quiver chaotically instead of beating effectively), stage 3 chronic kidney disease, metabolic encephalopathy (a brain dysfunction caused by a chemical imbalance from an underlying illness, like kidney failure), history of falling, and macular degeneration (an eye disease that blurs central vision).R11's admission record printed on 12/11/25 indicates R11's height is 63 inches (5 feet 3 inches). R11's weight on 12/1/25 was 123.4 pounds.R11's BIMS (Brief Interview for Mental Status) on 8/7/25 has a score of 2, indicating severe cognitive impairment. R11's BIMS on 11/7/25 has a score of 99, indicating R11 was unable to complete the assessment due to cognitive impairment.R11's Side Rail Assessment & Risk Screen dated 8/1/25 includes:Does the resident have an alteration in safety awareness due to cognitive deficit? No.Does the resident use the half side rail or bed bar for positioning, turning or support? No.Based on this assessment, is the use of half side rail or bed bar indicated? No.What kind of adaptive equipment? Side rail or Grab bar. Grab bar was selected.Are any of the following hazards applicable? Resident could attempt to climb over, around, between, or through the rails, or over the foot board. Resident or part of his/her body could be caught between rails, the openings of the rails, or between the bed rails and mattress. No was selected.Of note, the assessment indicates R11 does not have a cognitive deficit and does not use the side rail or bed bar for position, turning, or support. R11's assessment indicates a side rail or grab bar is not indicated. R11's assessment indicates a grab bar for adaptive equipment. R11's assessment indicates R11 could not be caught between the rails or the openings of the rails.R11's assessment states informed consent shall be obtained after alternatives are attempted and what medical need the bed rails would be addressing and what (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	this shift, this nurse called, via walkie, to resident's room. Resident in bed with padded side rails up. Left arm was wedged under side rail bar with head wedged through side rail bars. Resident was turned on left side with feet hanging over bed. Staff already in room and sliding resident back onto bed. Head and arm able to be wedged back through side rail and resident was repositioned back safely to supine position. Multiple abrasions, bruises, redness noted over multiple areas including, lower left leg, inner upper left arm, neck, under jaw, face, left side of torso. Side rails are in use with consent from family who are aware of risks of injury and entrapment to resident. Hospice notified and informed this nurse they would be here today to assess. DON (Director of Nursing) notified. Pastoral team notified. Resident not able to describe incident. PRN Tylenol given due to painad (Pain assessment in Advanced Dementia, observational tool for rating pain) 8/10.On 12/10/25 at 1:54 PM, Surveyor interviewed LPN C regarding R11's entrapment. LPN C indicated R11 had padded 1/2 bed rails on her bed. LPN C indicated on 11/16/25, he was called to R11's room by staff through the walkie. LPN C stated when he entered R11's room, her arm and head were through the bed rail. LPN C indicated R11's left arm was through the lower portion of the bed rail and her head was through the upper portion of the bed rail. LPN C indicated he had to push down on the middle part of the rail and lift up on the top part of the rail to unwedge R11's head to get her head back through the bed rail. LPN C indicated he did not know how she was able to get her head through the rail. LPN C indicated R11 had significant bruising and some abrasions from the incident. LPN C indicated R11's responsible party had signed a consent form for the bed rails. LPN C indicated he contacted R11's provider and the director of nursing. LPN C indicated he did not complete an incident report, as it was not a fall. On 11/16/25 R11's Risk management report states in part: .Incident description: At 1700 (5:00PM) this shift, this nurse called, via walkie, to residents room. Resident in bed with padded side rails up. Left arm was wedged under side rail bar with head wedged through side rail bars. Resident was turned on left side with feet hanging over bed. Resident Description: Resident unable to give description. was this incident witnessed: N (no). Immediate actions taken: .Resident taken to hospital? N. Injuries observed at time of incident: Injury type.injury location. 16) left antecubital.42)left lower leg (front).64) other (describe). (of note no description given and no injury type selected for any of the 3 locations).predisposing physiological factors.confused.incontinent.impaired member.weakness/fainted.Predisposing situation factors. side rails up. Notes: 11/16/2025 Resident and resident family requested use of siderails due to the thought of it assisting her maintaining some independence with bed mobility. Education provided to residents POA/Care team of the negative outcomes and risk of keeping side rails on bed. Family agreed to these risks prior to this incidence [sic] and signed a risk benefit form to continue to use. At this time this writer has requested the side rails to be removed from residents bed. Fall matt was placed at bedside to be proactive with any falls. On 12/10/25 at 1:31 PM, Surveyor interviewed Maintenance J (MNT) regarding side rails. MNT J indicated he cannot add or remove side rails unless approved by the ADON (assistant Director of Nursing) or DON (Director of nursing). MNT J indicated for an air mattress they put in a work order, and MNT J tries to get it done at meal time. MNT J indicated they have 2 (two) different types of safety rails, clip rail that folds up and down, 12-inch rail that has 2 bolts. MNT J indicated the ADON/DON will tell him which one to put on. MNT J indicated they do not have a tool for it (measuring), we can't have a big gap between the head. There are no gaps, because they could get wedged between side rails and bed. MNT indicated he has never come across a gap and they're all the same width even with air mattresses. MNT j indicated he has never come across a gap even with air mattress, not on the sides or top and bottom. MNT J indicated he installs the mattress and pump, but the nurses set the settings. MNT J indicated R11's side rails were removed on 11/17/25. On 12/10/25 at 2:21 PM, Surveyor interviewed DON B. DON B indicated they assess side rails quarterly with care conferences. DON B indicated R11 was due, her care conference was yesterday (12/9) but she expired before then. DON B indicated they added side rails after assessment because she was assisting with turning and repositioning. DON B indicated R11's family wanted the side rails even if (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	she was unable to use them. On 10/1 discussed as IDT (interdisciplinary team) why resident needed side rails, resident needed them for bed mobility, alternative not attempted due to resident's condition. DON B indicated no therapy due to being hospice. DON B indicated no trapeze due to R11's trunk control. On 12/11/25 at 7:41 AM, Surveyor interviewed DON B again. DON B indicated R11 rolled out of bed the day of admission and that fall was reviewed with no concerns. DON B indicated that R11's mattress was changed to a convertible mattress with tubes inside and a foamy border. DON B indicated there was no difference in risk vs benefits with the change of R11's mattress. DON B indicated audits were completed on side rails in June and December was the next planned audit to be reviewed with care conference. DON B indicated the bed rails are compatible with the bed. DON B indicated after R11 became entrapped in the bed rails, the facility removed the bed rails and placed a floor mat next to R11's bed due to terminal restlessness.The facility failed to ensure other alternatives were tried prior to installing/utilizing bed rails, failed to accurately assess the risk of possible entrapment, failed to identify and recognize the use of an air mattress with bed rails increases the risk for entrapment, failed to re-assess and obtain an updated consent after the installation of an air mattress with bed rails, and care plan the need and use of bed rails. This created a reasonable likelihood for serious harm, thus leading to a finding of immediate jeopardy. The facility removed the jeopardy on 12/11/25 when the facility completed the following: All residents with siderails will have a side rail assessment completed and a measurement evaluation completed. All consents and risk vs benefits have been reviewed and validated. All residents with siderails have care plans for entrapment risk. Any future siderail or mattress changes will be authorized by the NHA/DON who will ensure alternative modalities, proper documentation, assessments and consents are in place. On 12/11/25, standard operating procedures will include review of alterative modalities trailed, side rail assessment, maintenance measurements evaluation, consent and risk vs benefit document, care plan for risk of entrapment. On 12/11/25, a sweep of all residents with siderails completed with assessment, maintenance measurement evaluation, consent risk vs benefit and care plan for risk of entrapment completed. On 12/11/25, education to all staff before the start of their next shift includes a picture showing area that may cause risk to resident for injury of entrapment, the risk of using siderails with an air mattress as an increase risk for entrapment, residents with cognitive impairment having an increased risk for entrapment, when to alert nursing staff when changes to residents bed mobility and bed mattress change, proper measurement following FDA and CMS guidelines for siderails. On 12/11/25, education to licensed nursing staff before the start of their next shift on updated side rail assessment to ensure accuracy in completion. On 12/11/25, all residents with siderails have completed care plans including risk for entrapment. On 12/11/25, all staff educated before the start of their shift on alternative modalities that can be trialed prior to side rails being placed. On 12/11/25, All risk benefits and consents for side rails will be completed when a new mattress/ air alternating mattress is applied. On 12/11/25, Updated side rail assessment form, initiating maintenance measurement form and ensuring risk for entrapment care plans are completed. On 12/12/25, DON or NHA will conduct audits for changes in mattresses/additions and side rail additions or removals daily at stand-up for 14 days, weekly for 4 weeks and monthly for 3 months. DON or NHA will conduct audits of 5 resident siderails and air mattresses for compliance weekly for 4 weeks and monthly for 3 months.

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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, interview, and record review, the facility did not store, prepare, distribute, and serve food in accordance with professional standards for food service safety. This has the potential to affect all 59 residents.Visible dust was observed over a food preparation area. Food was improperly dated. Example 1On 12/9/25 at 11:01 AM, Surveyor observed, with DM E (Dietary Manager), the main kitchen's hood vents with visible clumps of dust on them and hanging off. Directly underneath the hood vents is a stove top and griddle where two pots of food were observed cooking. DM E was asked if he felt the hood vents were clean to which he replied, No, I can see some dust bunnies up there. Example 2 On 12/9/25 at 10:40 AM, Surveyor observed the following food items and corresponding dates:*Cocoa in a container dated 8/8 with no use by or expiration date.*Cheerios in a container, dated 11/25 with no use by or expiration date.*Modified bread mix in a container, dated 6/20, use by 7/20.*Three containers of pasta, one marked 10/25, use by 11/25, another marked 10/10, use by 11/10, and a third with no opened, use by or expiration dates. At this time, DM E indicated that those food items were marked that way as he felt they would be used by the stated use by date. Additionally, DM E indicated that the cocoa should have a use by/expiration date

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not provide behavioral health services to ensure the highest practicable mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care for 1 of 15 residents (R6) reviewed. R6 admitted to the facility with a history of post-traumatic stress disorder (PTSD). The facility failed to include PTSD on R6's comprehensive plan of care, nor were staff aware of any of R6's PTSD triggers. This is evidenced by: The National Institutes for Health states, in part: .PTSD can develop after exposure to a potentially traumatic event that is beyond a typical stressor. Events that may lead to PTSD include, but are not limited to, violent personal assaults, natural or human-caused disasters, accidents, combat, and other forms of violence. Exposure to events like these is common. People who experience PTSD may have persistent, frightening thoughts and memories of the event(s), experience sleep problems, feel detached or numb, or may be easily startled. In severe forms, PTSD can significantly impair a person's ability to function at work, at home, and socially. The State Operations Manual, Appendix PP states, in part: Providing behavioral health care and services is an integral part of the person-centered environment. This involves an interdisciplinary approach to care, with qualified staff that demonstrate the competencies and skills necessary to provide appropriate services to the resident. Individualized approaches to care (including direct care and activities) are provided as part of a supportive physical, mental, and psychosocial environment, and are directed toward understanding, preventing, relieving, and/or accommodating a resident's distress or loss of abilities. In addition to the facility-wide approaches that address residents' emotional and psychosocial well-being, facilities are expected to ensure that residents' individualized behavioral health needs are met. Behavioral health care and services could include: Ensuring that the necessary care and services are person-centered and reflect the resident's goals for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety; Ensuring that direct care staff interact and communicate in a manner that promotes mental and psychosocial well-being. The facility policy, entitled, Comprehensive Person Centered Care Plan, dated 7/9/19 with most recent review date of 5/8/25, states, in part: Policy: The Comprehensive Person Centered Care Plan will reflect the individual's needs and preferences to facilitate care. Procedure: . B. Within 21 consecutive days after admission, and in correlation with the Minimum Data Set (MDS), a comprehensive assessment will be completed and a written care plan will be developed based on the individual's history, preferences, and assessments from appropriate disciplines and the physician's evaluation and orders. The facility policy, entitled, Trauma Informed Care, dated 8/28/19 with most recent review date of 2/21/24, states, in part: Policy: Entity will establish a trauma-informed approach that will recognize signs and symptoms of trauma in individuals. Entity will treat all individuals with dignity and respect and will promote a culture of trauma-informed care. Procedure: A. Individuals: i. Upon admission individuals will be screened for trauma exposure and/or related symptoms. v. Care plan will be established collaboratively with the Individual with trauma-informed care in mind. B. Employees: i. Will be educated on Trauma Informed Care upon hire and as needed. ii. Will be assessed on their acquired knowledge of Trauma Informed Care. R6 was admitted to the facility on [DATE], with diagnosis that include, in part: Type 2 Diabetes Mellitus, Unspecified Dementia with Anxiety, Bipolar Disorder, unspecified, Obsessive-Compulsive Disorder, unspecified, Post-Traumatic Stress Disorder, unspecified, Insomnia, unspecified, Fibromyalgia, Suicidal Ideations, Personal History of Suicidal Behavior, and Anxiety Disorder, unspecified. R6's most recent Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/8/25 states in part, R6 has a Brief Interview for Mental Status (BIMS) of 15 out of 15, indicating that R6 is cognitively intact. Section I of R6's an active diagnosis of Post-Traumatic Stress Disorder. R6's Trauma Informed Care Screening, dated (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/21/23, states, in part: A. What have been the most difficult time(s) in your life? States relocating to the US from [NAME]. States she has ran an adult family home with her husband for the developmentally disabled. States their house manager began carving swastikas into her vehicle and raped her in the driveway. Stated her mother-in-law forced her to change her name to [NAME] as she did not want her friends/neighbors to know her son had married a [NAME]. B. Have you ever been through anything life threatening or traumatic? Yes.C. Do you ever experience disturbing memories, thoughts, dreams or other side effects (such as heart pounding, trouble breathing, or sweating) related to this (these) difficult experiences? Yes. R6's Psych admission Evaluation Note from Southwest IP (Inpatient) provided by the facility, dated 8/31/23 (prior to R6's admission to the facility), states, in part: Patient born in [NAME]. Reported history of two rapes., and included the diagnosis of Post-Traumatic Stress Disorder. R6's Behavioral Health Note, dated 11/2/25, states, in part: pertinent mental health problems: anxiety disorder, PTSD (Post Traumatic Stress Syndrome) and depression. Of note: At the time of Survey, R6's Comprehensive Care Plan did not include anything about PTSD or R6's triggers, despite R6 having a diagnosis of PTSD prior to admission, PTSD being indicated on the facility's trauma informed care assessment, PTSD being included on her facility diagnosis list, PTSD indicated on her MDS, and PTSD being listed as an active problem on a recent behavioral health note that was included in R6's medical record and provided to surveyor by the facility. On 12/10/25 at 8:58 AM, Surveyor interviewed R6, who stated that she grew up in [NAME] during a war zone and a British officer shot her and shot and killed the horse she was riding on. R6 pointed to a scar on her interior forearm and indicated that scar was from the bullet. R6 stated that her ulnar nerve was damaged during the surgery that was performed to remove the bullet from her arm. R6 stated, I've seen things that you can't unsee. R6 indicated that the facility staff were not aware of her PTSD or her triggers. R6 stated that food was a trigger for her because her hands were starting to cripple because of the damage done to her ulnar nerve, and can only use special adaptive silverware and even with that it is difficult for her to eat without spilling on herself. R6 stated she just cannot eat in front of other people and staff try to make her, and then she becomes a weeping, screaming mess, really putting on a show. R6 indicated that the staff don't do anything for her PTSD. On 12/10/25 at 12:55 PM, Surveyor interviewed MT F (Med Tech). Med Tech F indicated that R6 never ate in dining room. Surveyor asked MT F if she knew why R6 never ate in the dining room. MT F stated that she had no idea, she just knew that R6 prefers to eat in her room, and when they try to get her to eat in the dining room, R6 becomes very anxious and upset about it. Surveyor asked MT F how she would know if a resident were a trauma survivor and what she would need to do differently for that resident. MT F stated she would watch the resident, their routine and see if something specific triggers them, such as if they seem anxious about who is coming into their room or anxious about certain situations. MT F indicated she would also watch to see if the resident had bouts of crying or self-isolation. Surveyor asked MT F if she was aware that R6 had a diagnosis of PTSD. MT F stated she wasn't aware, but she wasn't surprised based on some of R6's behaviors. Surveyor asked MT F if R6's PTSD was something that should be on her care plan. MT F indicated that was something that should probably be on R6's care plan, but that R6 did have a lot of other things like anxiety and depression that she took medication for and that had interventions on her care plan. On 12/10/25 at 1:01 PM, Surveyor interviewed CNA G (Certified Nursing Assistant). Surveyor asked CNA G if R6 ever ate in the dining room. CNA G stated no, that R6 always eats her meals in her room. Surveyor asked CNA G if she knew why R6 never ate in the dining room. CNA G stated she wasn't sure and would have to ask the nurses. Surveyor asked CNA G how she would know if a resident were a trauma survivor and what she would need to do differently for that resident. CNA G stated she would ask one of the nurses. Surveyor asked CNA G if she was aware that R6 had a diagnosis of PTSD. CNA G stated no, that she was not aware of that. On 12/10/25 at 1:07 PM, Surveyor interviewed CNA H. Surveyor asked CNA H if R6 ever ate in the dining room. CNA H stated no, that R6 always eats her meals in her room. Surveyor asked CNA H if she knew why R6 never ate in the dining room. CNA H (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525660	A. Building B. Wing	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Dominic Villa	2375 Sinsinawa Rd Hazel Green, WI 53811

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she thought it was just R6's personal preference. Surveyor asked CNA H how she would know if a resident were a trauma survivor and what she would need to do differently for that resident. CNA H stated she would check their CNA Kardex and care plan. Surveyor asked CNA H if PTSD was on R6's Kardex. CNA H reviewed R6's Kardex with Surveyor and indicated that it did not say PTSD anywhere on the Kardex. On 12/10/25 at 2:22 PM, Surveyor interviewed SW I (Social Worker). Surveyor asked SW I how he would know if a resident is a trauma survivor? SW I stated that when residents come in there is a form that is trauma informed care and social history that he completes with the resident. Surveyor asked SW I what he would need to do differently for a resident who was a trauma survivor. SWI stated that PTSD was his specialty, and that everyone is different. SW I indicated that observation is important and seeing if someone is in distress or something causes them distress and identify the triggers so that you can reduce those from occurring. SW I stated that he tries to establish a relationship with the residents and observe if anything appears to make them uncomfortable. SW I stated that he watches the resident for nonverbal cues and then its important to get those triggers on the resident's care plan. Surveyor asked SW I about R6's PTSD diagnosis and if that was on R6's care plan. SW I indicated that with R6 it was difficult because she can be very guarded and that R6 sometimes changes her story. SW I stated that R6 told him that she was born in [NAME] and that the British soldiers had raped her and that she didn't like British people. Surveyor asked if that was on R6's care plan so that staff could be made aware that R6 may be triggered by British accents, etc. SW I stated that he didn't think it was but that he doesn't update the care plans. Surveyor asked SW I if he was aware of R6's trigger about not wanting to eat in the dining room. SW I stated that he was aware that R6 had a lot of apprehension because she doesn't eat pork or has a special diet and she doesn't want people to know about that. SW I indicated that R6 likes to sit in her room with her own particular diet and that R6 told him that she is more comfortable in her room with her dietary restrictions so she doesn't have to explain that to everybody. Surveyor asked SW I if he was aware that R6 was triggered by eating in the dining room because of her fear of making a mess with her food in front of her peers. SW I stated he had never heard that, but that R6 was very inconsistent in what she does. SW I stated that his job was to validate the resident's reality, not question them, and that R6's diagnosis of PTSD and her triggers should absolutely be integrated into her care plan. On 12/10/25 at 3:21 PM, Surveyor interviewed DON B (Director of Nursing) and asked her if R6's diagnosis should be on her care plan. DON B reviewed R6's care plan and stated that she did not see PTSD on her care plan. DON B indicated that it would be a good idea to have that on R6's care plan. DON B stated that R6 does have behavioral issues and they are on the CNA Kardex, which indicates that staff is to be respectful of her beliefs, etc. DON B indicated that MDS Coordinator/ADON D (Assistant Director of Nursing) was responsible for updating the resident's care plans. On 12/10/25 at 3:30 PM, Surveyor interviewed ADON D, who stated that she is responsible for updating the care plans, but that R6 was admitted before she started with the facility in that role. ADON D stated that typically she will update the resident's care plans with new medications, therapy, etc. Surveyor asked ADON D if R6 had a current diagnosis of PTSD, should it be included on her care plan. ADON D stated yes, that should be on R6's care plan.

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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 interview and record review, the facility has not established an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 1 wound care observations. Staff did not perform hand hygiene in between glove changes during wound care for R48. Evidenced by:The facility policy entitled Hand Hygiene, dated 12/5/2024, states, in part: . I. Policy: The organization will promote clean hands as the single most important factor in preventing the spread of pathogens, antibiotic resistance, and incidence of infections. II. Procedure: A. Specific Indications for Hand Hygiene.4. After touching a patient or the patient's immediate environment.6. Immediately after glove removal. Evidenced by:R48 admitted to the facility on [DATE] and has diagnoses that include Type II Diabetes Mellitus (Type 2 diabetes happens when the body cannot use insulin correctly and sugar builds up in the blood) and pressure ulcer of left ankle stage 3 (involves full-thickness skin loss, where the wound extends through the dermis into the fatty (subcutaneous) tissue, creating a crater). R48's Minimum Data Set (MDS) Quarterly Assessment, dated 11/4/2025, shows no score of a Brief Interview of Mental Status (BIMS) score indicating R48 is not cognitively intact. On 12/10/25 at 9:52 AM, Surveyor observed LPN C (Licensed Practical Nurse) perform wound care on R48. During wound care LPN C removed gloves and applied new gloves without performing hand hygiene in between. LPN C pulled R48's curtain and raised bed with foot board control and then proceeded with wound care without changing gloves or completing hand hygiene. On 12/10/25 at 10:14AM, Surveyor interviewed LPN C and asked when hand hygiene should be performed during wound care. LPN C indicated when going from dirty to clean. Surveyor asked LPN C if hand hygiene should be performed with removal of gloves, and LPN C indicated yes, and he should have performed hand hygiene with glove removals. On 12/10/25 at 10:16A M, Surveyor interviewed ADON D (Assistant Director of Nursing) and asked if hand hygiene would be expected in between glove changes. ADON D indicated yes if touching things in between. Surveyor informed ADON D of observation of LPN C with no hand hygiene in between glove changes and touching R48's curtain and bed control with no hand hygiene and glove change. ADON D indicated she would have expected hand hygiene in between glove changes.