STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525061	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincoln Park Nursing and Rehab LLC	1700 C A Becker Dr Racine, WI 53406

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure 1 (R86) of 3 sampled residents at risk for falls had interventions in place to prevent a fall with major injury. On 5/23/25 R86 sustained a fall out of bed and was sent to the hospital due to R86 being on a blood thinner and R86 being unable to vocalize if she hit her head. At the hospital R86 was found to have a left subacute infarct of left parietal and frontal lobe with petechial hemorrhage along acute infarct (brain bleed). R86 was at high risk for falls, had right sided weakness from a stroke, had contradictory assessments regarding bed mobility and interventions to be used, was on an anticoagulant and was on an air mattress which are risk factors for a fall. The facility did not assess the various risk factors and the need for possible interventions to prevent a fall with a major injury. Findings include:The facility fall prevention program dated 1/3/23 documents .5. Low/Moderate risk protocols: implement universal environmental interventions that decrease the risk of resident falling, including, but not limited to:Clear pathway to the bathroom and bedroom doors, bed is locked and lowered to a level that allows the resident's feet to be flat on the floor when the resident is sitting on the edge of the bed, call light and frequently used items are within reach, adequate lighting and wheelchairs and assistive devices are in good repair.Implement routine rounding schedule, monitor for changes in resident's cognition, gait, ability to rise/sit, and balance, encourage residents to wear shoes or slippers with non slip soles when ambulating, .High risk protocolsImplement interventions from low/moderate risk protocols, provide interventions that address unique risk factors measured by a risk assessment tool: medications, psychological, cognitive status, or recent change in functional status. Provide additional interventions as directed by the resident's assessment including but not limited to:Assistive devices, increased frequency of rounds, sitter if indicated, medication regimen review, low bed, alternate call system access, scheduled ambulation or toileting assistance .R86 was admitted to the facility on [DATE] with diagnoses including hypertension, cerebral infarction with right side hemiplegia, and aphasia.R86's admission Minimum Data Set (MDS) dated [DATE] documents R86 is severely cognitively impaired and dependent with activities of daily living (ADLs). R86 is always incontinent of bladder and bowel. R86 is dependent upon staff for rolling left to right in bed and transferring from bed to a chair. Other mobility assessments including sit to lying, lying to sitting on side of bed, and transfer to toilet were not attempted due to R86's medical condition and/or safety concerns.R86's Care Assessment Area (CAA) for pressure injuries dated 5/10/25 documents: R86 has decreased mobility requiring assistance for her mobility and repositioning which is a contributing issue for potential pressure ulcer development in addition to incontinence issue due to exposure of skin to moisture. (R86) is s/p (status post) hospitalization due to right hemiparesis and aphasia effected (sic) by left cerebral infarction resulting to (sic) generalized weakness and a decline in her functional status.R86's fall risk evaluation dated 5/8/25 documents a score of 7; a score of 5 or above is high risk for falls.The care plan for risk for falls related to right hemiparesis due to stroke, impaired mobility and general weakness dated 5/7/25 documents the intervention, Anticipate and meet the resident's needs. No other interventions are documented to prevent falls or ensure R86's safety due to their risk of falls (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 0689 Level of Harm - Actual harm Residents Affected - Few	and diagnoses that contribute to R86's safety risk from falls.R86's Activities of Daily Living (ADLs) Care Plan for the resident has potential for an ADL self-care deficit r/t (related to) generalized weakness initiated 5/7/25 with a goal of improving current level of function through review date initiated 5/8/25, target date 8/5/25. Bed mobility interventions:The resident is an assist of 1 with turning and repositioning in bed. Initiated 5/8/25The resident uses enabler bars to maximize independence with turning and repositioning in bed. Initiated 5/8/25The resident uses (SPECIFY assistive device) to maximize independence with turning and repositioning. Initiated 5/8/25R86's care plan for cerebral vascular accident (stroke) affecting right side of body, aphasia, and intercranial (sic) hemorrhage initiated 5/8/25 with a goal to show improvement to maximum potential to perform ADL's by review date was initiated 5/8/25 with a target date of 8/5/25. This care plan includes an intervention to turn and reposition q (every) 2 hours and PRN (as needed) Keep body in good alignment. Initiated 5/8/25.A nurse's note dated 5/26/25 documents: Writer (Licensed Practical Nurse (LPN) N) was walking back to the nurse's station when the nurse's aide (sic) to the writer to hurry and come into the room. When writer walked into the room the resident was laying on the floor. Resident had RN assess the patient, vital signs were stable. No complaints of pain outside of the resident's baseline. Resident was sent out due to not being able to tell if she hit her head or not and being on blood thinners. POA (power of attorney) and NP (nurse practitioner) were notified, and NP gave writer permission to have her sent out for observation.Hospital record dated 5/26/25 documents R86 had a brain bleed and remained at the hospital until 5/31/25.The Hospital discharge documentation dated 5/31/25 documents for History of Illness/Hospital course: .history of CVA (cerebral vascular accident) causing right sided hemiparesis and aphasia. Patient was rolled onto her side for hygiene purposes and fell out of the bed at the SNF (skilled nursing facility). Patient on aspirin and Eliquis. EMS (emergency medical services) called and patient transported to the ER (emergency room). CT (computerized tomography) head with left subacute infarct of left parietal and frontal lobe with petechial hemorrhage along acute infarct. Kcentra (medication used for the rapid, urgent reversal of acquired blood coagulation factor deficiency caused by vitamin K antagonist (ex. anticoagulant medication) therapy in adults with acute major bleeding.) was given to reverse anticoagulation. admitted to ICU (intensive care unit).On 4/21/26 at 9:44 AM Surveyor spoke to R86's family member-R regarding R86's fall and need to go to the hospital. Family member-R stated they were told (R86) fell out of bed during cares because 1 CNA (certified nursing assistant) was working with (R86) instead of 2. R86 was readmitted to the facility on [DATE].On 4/21/26 at 12:34 p.m. Surveyor interviewed Licensed Practical Nurse (LPN)-N. Surveyor asked LPN-N If she remembers any details of the fall R86 sustained on 5/26/25. LPN-N Referred to her documentation and stated she doesn't remember much about the incident. Review of the facility Fall details dated 5/26/25 at 11:06 am document the above nurse's note as a description of the incident. It is additionally documented the resident was unable to give a description and it was unwitnessed. Immediate action taken documents notified POA, DON (Director of Nursing), and NP. Got order to send her out. Helped put resident back into the bed. The report asks was resident taken to hospital? It is documented N (no). Surveyor noted this is despite R86 being transferred to the hospital.No injuries observed at the time of incident. No pain, Alert and wheelchair bound for mobility. Mental status: oriented to person and situation. Resident does not respond well to questions asked, speech is hard for her. None is documented for predisposing environmental factors. Predisposing physiological Factors document antianxiety use, confused, difficulty with communication, gait imbalance, incontinent, and weakness. Predisposing situation factors are documented as specialty bed.Surveyor noted the risk factors identified as predisposing factors were not assessed or addressed in a care plan prior to this fall. Surveyor noted the documentation does not include any statements or details from staff to accurately determine if the fall was witnessed or not and whether the fall occurred while providing cares as indicated in the hospital documentation.The verification of investigation for R86's fall dated 5/26/25 documents the nursing progress note as documented above regarding LPN-N being called into room while walking (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	back to nurses station. Resident was unable to describe fall, BIMs (brief interview for mental status) 4/15 indicating severe cognitive impairment. Contributing factors and interventions documented include: CVA with affecting dominant right side, able to move independently in bed, high BMW (body mass index; weight (193-202). Modified interventions to the plan of care to prevent re-occurrence: upon return from hospital - staff to position resident with pillows to help identify perimeter of mattress.Summary of factual investigative findings documents: IDT (interdisciplinary team) met regarding fall on 5/26 in resident room. No injury occurred initially noted. Resident is receiving assistance with transfers, toileting, and ADLs (activities of daily living). Resident unable to state what occurred, has BIMs score 4/15. Resident noted to be laying on side of bed. No pain indicators noted. Neuro check negative. NP notified, new orders received to send to ED (emergency department) for eval (evaluation) and treat due to resident on anticoagulant and unable to state if hit head, POA notified. Resident admitted to hospital for intracranial hemorrhage. Resident will benefit upon return from positioning resident with pillows to assist with defining bed perimeter, care plan updated and reviewed.Verification of Investigation: The facility conducted a thorough investigation which included staff interviews, review of clinical records, care plans, mattress settings, and safety interventions in place at the time of the incident. Staff confirmed that the air mattress was appropriately set and functioning as intended and that routine care and monitoring were provided in accordance with the resident's care plan. Staff involved demonstrated understanding of the resident's needs and adherence to established protocols. No environmental hazards or equipment malfunctions were identified. The investigation supports that appropriate interventions were in place, and the incident was not the result of noncompliance or deficient practice. Findings were reviewed with the interdisciplinary team, and opportunities for enhanced monitoring and individualized fall prevention strategies were identified and implemented to mitigate future risk.Root Cause Analysis: A comprehensive root cause analysis was conducted following the resident's fall with injury resulting in intracranial bleeding. The resident, who is capable of independently repositioning, was placed on an air mattress appropriately calibrated to her weight (193 lbs) and comfort level to support an existing wound. Due to clinical contraindications related to both the air mattress and the resident's history of stroke, the use of enablers (eg side rails) was not appropriate. The resident was last provided care and monitoring at approximately 9:30 am and the fall occurred around 11:00 am when the resident rolled out of bed. Emergency protocols were immediately initiated, and the resident was transferred to the hospital approximately 11:24 am. The identified root cause is multifactorial, including the resident's mobility and ability to reposition independently, the inherent reduced boundary support associated with an air mattress, and the inability to utilize restrictive safety devices. There is evidence of staff neglect or failure to follow established care protocols.Surveyor noted the admission MDS for R86 assesses R86 to be dependent upon staff for rolling in bed. A nursing progress note for resident usual performance self-care/mobility charting dated 5/8/25 at 02:10:33 (2:10 am) documented Resident is independent with rolling left and right in the bed. All other mobility areas are noted as not attempted due to medical condition or safety concerns. The MDS was completed 5/10/25. R86's fall occurred 5/26/25. Surveyor also noted R86 was supposed to have interventions in place on the bed to aid in mobility that were not on the bed; according to the post fall investigation. R86's ADL care plan documents interventions for bed mobility including the use of enabler bars to maximize independence with turning and repositioning in bed and the resident uses (assistive device not specified) to maximize independence with turning and repositioning in bed. Surveyor noted the air mattress was not included on R86's care plan until 6/2/25.On 4/21/26 at 12:34 p.m. Surveyor interviewed DON-B. Surveyor asked DON-B if additional interventions were considered to prevent falls prior to R86's fall on 5/26/25. DON-B stated that when someone has a history of falls or are presenting with behaviors that indicate they would fall then different interventions would be considered at that time. On 4/24/26 DON-B submitted additional information to review regarding R86's fall and request the fall be considered unavoidable. The information was reviewed as part of the survey process.

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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 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, record review, and interview, the facility did not ensure food was prepared, distributed, and served in accordance with professional standards for food service safety (Wisconsin Food Code) in the main kitchen and the nourishment freezer. *Dietary aide (DA)-O was observed in the main kitchen preparing and handling food without wearing a hair restraint that covered facial hair. *Food debris and sticky floors were observed over several days on the main kitchen floor. *Ground beef patties were observed unwrapped resting directly on the bottom of an opened cardboard box in the main kitchen freezer. *The freezer in the nourishment refrigerator did not have a thermometer or temperature log to ensure freezer food is kept at appropriate temperatures. This deficient practice has the potential to affect all 78 residents who receive food from the main kitchen. Findings include:On 4/20/26 at 8:15 AM, Surveyor conducted an initial tour of the facility's main kitchen with Food Services Director (FSD)-Q. FSD-Q stated the facility follows Wisconsin Food Code for safe food practices. The Wisconsin Food Code documents: . food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles . facilities shall be cleaned as often as necessary to keep them clean . food packages shall be in good condition and protect the integrity of the contents so that the food is not exposed to adulteration or potential contaminants. store frozen foods shall be maintained frozen . at any temperature if the food remains frozen. 1. Hair RestraintsOn 4/21/26 at 9:50 AM, Surveyor observed DA-O preparing and handling food in the main kitchen while not wearing a hair restraint for exposed facial hair. On 4/21/26 at 11:29 AM, Surveyor observed DA-O preparing and handling food in the main kitchen while not wearing a hair restraint for exposed facial hair.On 4/21/26 at 1:14 PM, Surveyor shared concern with FSD-Q that DA-O was observed several times not wearing a hair restraint for exposed facial hair while preparing and handling food in the main kitchen, FSD-Q was not aware DA-O should have been wearing a beard restraint and stated FSD-Q would make sure DA-O wears one. 2. Food StorageOn 4/20/26 at 8:15 AM, during the initial kitchen tour, Surveyor observed food debris and sticky floors in the food preparation and cooking area in the main kitchen.On 4/20/26 at 8:24 AM, Surveyor observed several ground beef patties in the main kitchen freezer that were out of the wrapper and resting directly on the bottom of an opened cardboard box. FSD-Q stated FSD-Q would throw the patties away. On 4/21/26 at 11:29 AM, Surveyor observed food debris and sticky floors in the food preparation and cooking area in the main kitchen. On 4/21/26 at 1:14 PM, Surveyor shared concerns with FSD-Q that several ground beef patties were observed unwrapped in the freezer resting directly on the bottom of an opened cardboard box and that Surveyor observed the floor in the main kitchen food preparation and cooking area was sticky and had visible food debris on them over several days. FSD-Q stated FSD-Q did throw away the unpackaged ground beef patties and FSD-Q would educate kitchen staff. On 4/21/26 at 10:39 AM, Surveyor observed the nourishment refrigerator and freezer located behind the nurse's station on the rehab unit. Surveyor observed two boxes of ice cream products labeled with [resident name]. Surveyor was unable to locate a thermometer to measure the freezer temperature or a temperature log for the freezer. On 4/21/26 at 11:56 AM, Surveyor interviewed assistant director of nursing (ADON)-P who stated residents are able to use the nourishment refrigerator and freezer on the rehab unit for any overflow food or freezer food and nursing staff manages the items inside of the nourishment refrigerator and freezer. On 4/21/26 at 1:17 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-N who confirmed nursing staff take care of the resident food items inside of the refrigerator and freezer in the nourishment refrigerator on the rehab unit. LPN-N was not sure if the freezer temperatures are monitored and was only able to locate a temperature log for the refrigerator temperatures. LPN-N was not able to locate a thermometer inside of the freezer. LPN-N confirmed the (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	two boxes of ice cream products are for a resident who is still currently a resident at the facility. On 4/21/26 at 1:38 PM, Surveyor shared the above concerns with Nursing Home Administrator (NHA)-A. No additional information as to why food was not prepared, distributed, and served in accordance with professional standards for food service safety.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and policy review, the facility did not ensure accurate reporting of the mandatory submission of staffing information based on payroll data to the Centers for Medicare and Medicaid Services (CMS). The facility failed to enter accurate data in their Payroll Based Journal (PBJ) system which triggered the facility as having excessively low weekend staffing. This has the potential to affect all 78 residents residing in the facility. Findings include:Centers for Medicare & Medicaid Services (CMS) Electronic Staffing Data Submission Payroll-Based Journal, Long-term Care Facility Policy Manual, dated June 2022, states in part: Chapter 1: Overview, 1.1 introduction .(U) mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.1.2 Submission Timelines and Accuracy. Direct care staffing and census data will be collected quarterly and is required to be timely and accurate . Report Quarter: staffing and census data will be collected for each fiscal quarter. Staffing data includes the number of hours paid to work by each staff member each day within a quarter. Census data includes the facility's census on the last day of each of the three months in a quarter. The fiscal quarters are as follows: Fiscal Quarter, Date range: 1 October 1 - December 31, (quarter 1) 2 January 1 - March 31, (quarter 2) 3 April 1 - June 30, (quarter 3) 4 July 1 - September 30 (quarter 4) . PBJ Staffing Data Report, CASPER Report (Certification and Survey Provider Enhanced Reports) 1705D for Fiscal year Quarter 1 2025 (October 1 - December 31), ran on 4/15/2026, indicates the following: Submitted Weekend Staffing data is excessively low. On 04/20/2026 at 2:10 PM, Surveyor conducted a review of the schedules provided by the facility for the weekends during October- December, 2025. It was noted that there was an RN(Registered Nurse) or LPN (Licensed Practical nurse) on each shift as well as CNAs (Certified Nursing Assistants) designated for each shift and units. If the facility had any unfulfilled hours, they would use agency although this was not frequently a concern. The schedules designated the charge nurse on each shift. Surveyor conducted a review of the facility's Assessment Tool, last reviewed/ updated 2/16/26 ;The facility uses the (name of) Payroll System) which is a time collection system used by hourly and salaried employees. (It) is a fully integrated system that assists the facility in better management of employee time, costs, and performance. Staffing: RN (registered nurse), LPN (licensed practical nurse), LVN (licensed vocational nurse) providing direct care. DON (Director of Nursing): 1 DON RN full time days. ADON (Assistant Director of Nursing) : 1 ADON full-time. UM (Unit Manager): 1 full time days. Wound Nurse: 1 full time days. RN or LPN Charge Nurse- 1 each shift. Direct Care Staff: Direct care staff is calculated based upon acuity of resident needs and ADL (activities of daily living) index scored; flexibility is allowed due to the nature of admissions and discharges for short term and long-term care resident needs reflected in the activities of daily living index reflected on the MDS (Minimum Data Set). Staffing is adjusted based on resident clinical needs.On 04/22/2026 at 9:56 AM , Surveyor interviewed Scheduler-M who has been in this position since December 2025. Scheduler-M stated that she makes the schedule the same for the weekends as during the week. If there is a call-in, they will send out a message for staff to help and a bonus is offered. Scheduler-M stated that she will also help as she is a Certified Nursing Assistant. Scheduler-M stated that the facility will also use agency staffing for last-minute call-ins. Scheduler-M stated that she does not know why the report would indicate there is low weekend staffing. On 4/22/26 at 11:00AM, Surveyor interviewed Administrator-A and Regional Nurse-L regarding the submission of information to the Payroll Based Journal. Administrator- A and Regional Nurse-L stated that this is done at the corporate level and would provide the telephone number for who to talk with.On 4/22/26 at 2:31PM, Surveyor interviewed Director of Acquisitions (Corporate) - K regarding the submission of the Payroll Based Journal (continued on next page)

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	information. Director of Acquisitions- K stated that he does not personally submit the information but does review ahead of time. He stated that he felt the staffing was on par with what is required and would need to do a deeper dive into the submissions to find out where the error may have occurred.As of the time of exit, the facility was not able to provide additional information regarding the inaccurate submission of staffing information triggering excessively low weekends from October 1- December 31, 2025.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, the facility did not ensure Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN) and Notice of Medicare Non-Coverage (NOMNC) forms were provided in writing and signed for 2 (R2 and R88) of 3 residents reviewed for notification. *R2's Guardian was not given the SNF ABN notice and the NOMNC was not signed before Medicare coverage ended. *R88 did not have a signed SNF ABN or NOMNC before Medicare coverage ended. Findings include: The SNF ABN notice documents: Medicare does not pay for everything, even some care that you or your healthcare provider think you need. The skilled Nursing Facility (SNF) or its Utilization Review Committee believes that the care listed below does not meet Medicare coverage requirements. Beginning on (insert date), you may have to pay out of pocket for this care if you do not have other insurance that may cover these costs. The notice provides three options which the resident or resident representative must select one: continue daily skilled services, bill to Medicare, and the resident can appeal to Medicare; continue daily skilled services the resident had been receiving but do not bill Medicare and the resident will be responsible for payment; or do not continue with the care the resident had been receiving and Medicare Part B may cover some of the care for which the resident will be responsible for paying. Signing below means that you have received and understand this notice. You will also get a copy for your records. *If a representative signs for the patient, write ?(rep)' or ?(representative)' next to the signature. If the representative's signature is not clearly legible, the representative's name must be printed. The NOMNC notice documents: You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal. The notice provides directions on how to request an appeal by providing step by step instructions. The second page of the notice has instructions for providing the information over the phone. Telephone delivery does not require a representative's signature and should only occur when the member is unable to understand the NOMNC and the representative is not available to sing in person. A copy of the annotated NOMNC should be mailed to the representative the day telephone contact is made and a dated copy should be placed in the member's medical file. The following section is to be completed by the provider delivering the NOMNC by telephone. The section contains who delivered the information with title, date and time of call, who was spoken to, their telephone number, their relation to the resident, the last covered date of services, instructions on how to file an appeal, and the date the notice is mailed to the representative which should be the same day the phone call was made. 1.) R2's last covered day of Medicare services was 2/13/2026. No SNF ABN notice was provided to R2 or R2's Guardian and the NOMNC telephone delivery section was completed by Business Office Manager (BOM)-E with a blank line where the date the notice was mailed to the representative. In an interview on 4/22/2026 at 1:31 PM, Surveyor asked BOM-E why R2 did not have a SNF ABN notice and if R2's Guardian was mailed a copy of the NOMNC. BOM-E stated R2 had a Guardian through (name of organization) and they will not appeal the Medicare benefit because the resident will go back to Medicaid payment, so BOM-E did not provide the SNF ABN notice. BOM-E stated BOM-E asks if BOM-E can mail the NOMNC and most times the Guardian or Power of Attorney will not want them mailed so BOM-E does not mail them. 2.) R88's last covered day of Medicare services was 1/25/2026. The SNF ABN notice had handwritten notation by Business Office Manager (BOM)-E that the information on the notice was provided over the phone to R88's activated Power of Attorney (POA) and R88's POA had no concerns. R88's POA did not select one of the three options that was required and there was no signature on the form by R88's POA. R88's NOMNC telephone delivery section was completed by BOM-E with a blank line where the date the notice was mailed to the representative. In an interview on 4/22/2026 at 1:31 PM, Surveyor asked BOM-E why R88's SNF ABN was not signed or have an election of appeal and if R88's NOMNC was mailed to R88's POA. BOM-E stated R88's POA never came in so the notices were not signed. BOM-E stated BOM-E called R88's POA and documented everything but did not get a (continued on next page)

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	signature. BOM-E stated BOM-E asks if BOM-E can mail the NOMNC and most times the Guardian or Power of Attorney will not want them mailed so BOM-E does not mail them. On 4/22/2026 at 2:01 PM, Surveyor shared with Nursing Home Administrator (NHA)-A the concern R2 and R88 did not have signed or mailed SNF ABN or NOMNC notices. NHA-A stated they will have to look into having a process to address the beneficiary notices.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure proper notification was sent to the State Long-Term Care Ombudsman for 3 (R7, R19, R45) of 8 residents reviewed for transfers or discharges. R7 was transferred from the facility to the hospital on 2/27/26 and 3/8/26, R19 was transferred from the facility to the hospital on [DATE], and R45 was transferred from the facility to the hospital on 3/26/26. The facility was unable to provide evidence the State Long-Term Care Ombudsman was notified in a timely manner of R7's, R19's, or R45's transfers to the hospital. Findings include: 1.) R19 admitted to the facility on [DATE] and had an activated power of attorney (POA) for healthcare decisions. Surveyor reviewed R19's electronic health record (EHR) and located a nursing progress note dated 12/30/25 which documented R19 had critical labs and R19 was sent out to the hospital. R19 was admitted to the hospital with hyperkalemia, acute kidney injury, and acute cystitis with hematuria. R19 returned to the facility on 1/5/26. Surveyor reviewed the list the facility emailed to the State Long-Term Care Ombudsman with notification of residents who transferred or discharged from the facility between the dates of 12/1/25 and 1/7/26 and did not locate R19's hospitalization from 12/30/25 on the list. On 4/21/26 at 3:13 PM, Surveyor shared concern with Nursing Home Administrator (NHA)-A that Surveyor was unable to locate evidence the Ombudsman was notified of R19's hospitalization on 12/30/25. NHA-A stated NHA-A would look into it. On 4/22/26 at 8:09 AM, NHA-A stated the wrong reports were being pulled and sent to the Ombudsman and did not include all residents that went out to the hospital. NHA-A fixed the report and now the report includes all residents who have been sent to the hospital. NHA-A stated NHA-A will send the updated reports from the last 6 months to the Ombudsman so that the Ombudsman has accurate information. 2.) R45 admitted to the facility on [DATE] and made their own healthcare decisions. Surveyor reviewed R45's electronic health record (EHR) and located a nursing progress note dated 3/25/26 which documented R45 had abnormal vital signs and a low oxygen level and R45 was sent out to the hospital. R45 was admitted to the hospital with hypokalemia and respiratory failure. R45 returned to the facility on 3/30/26. Surveyor reviewed the list the facility emailed to the State Long-Term Care Ombudsman with notification of residents who transferred or discharged from the facility between the dates of 3/1/26 and 4/7/26 and did not locate R45's hospitalization from 3/25/26 on the list. On 4/21/26 at 3:13 PM, Surveyor shared concern with Nursing Home Administrator (NHA)-A that Surveyor was unable to locate evidence the Ombudsman was notified of R45's hospitalization on (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/25/26. NHA-A stated NHA-A would look into it. On 4/22/26 at 8:09 AM, NHA-A stated the wrong reports were being pulled and sent to the Ombudsman and did not include all residents that went out to the hospital. NHA-A fixed the report and now the report includes all residents who have been sent to the hospital. NHA-A stated NHA-A will send the updated reports from the last 6 months to the Ombudsman so that the Ombudsman has accurate information. 3.) On 2/27/2026, R7 was admitted to the hospital for hyperkalemia and a fistula problem (the fistula is the port for dialysis). R7 was readmitted to the facility on [DATE]. On 3/8/2026, R7 was admitted to the hospital for a clogged fistula. R7 was readmitted to the facility on [DATE]. A review of the resident list of discharges that was provided to the Ombudsman did not have R5 listed for the month of February 2026 or March 2026. On 4/21/2026 at 3:09 PM, Surveyor shared with Nursing Home Administrator (NHA)-A the concern R5 was not on the resident list of discharges that was provided to the Ombudsman. NHA-A stated NHA-A would look into why R5 was not on the list because R5 should have been. On 4/22/2026 at 8:09 AM, NHA-A stated NHA-A had been pulling the wrong report to send to the Ombudsman; the list did not include all the residents that went out to the hospital. NHA-A stated NHA-A has gotten clarification on how to pull the report and it now does include all residents.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interviews, the facility did not ensure they provided the appropriate treatment and services to 3 out of 4 (R26, R5, R86) residents reviewed for the development of pressure injuries. R26 was admitted to the facility with a pressure injury to the buttocks. The facility did not complete a comprehensive assessment of the pressure injury upon admission and did not obtain an order for treatment of the pressure injury until 2 days after the admission. R5 was readmitted to the facility after a hospital admission and R5's Stage 4 pressure injury was not comprehensively assessed on the day of readmission. R86 was readmitted to the facility on [DATE] following a hospitalization and the facility did not complete a comprehensive assessment of R86's skin until 6/2/26. Findings include: The facility's policy dated as revised 1/23/26 and titled Pressure Injury Prevention and Management documents: This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable and to provide treatment and services to heal the pressure injury/injury, prevent infection and the development of additional pressure injuries/injuries. Policy Explanation and Compliance Guidelines(includes) :2. The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors, monitoring the impact of the interventions; and modifying the interventions as appropriate. c. Licensed nurses will conduct a full body skin assessment on all residents upon admission/re-admission, weekly, and after any newly identified pressure injury, Findings will be documented in the medical record. Findings should include type of wound, wound measurements (measured upon discovery and at least weekly thereafter), other wound characteristics (color, exudate, odor pain, tissue type in the wound bed) and treatment and interventions implemented. 1.) R26 was admitted on [DATE] with diagnoses that included Hypertension, acute respiratory failure, Diabetes Mellitus type II and Pneumonia. R26's nursing note dated 4/11/2026 at 7:05 PM and written by Licensed Practical Nurse (LPN)- I documents: (R26) recently admitted w (with)/rehab and strengthening d/t (due to) generalized weakness and deconditioning r/t AMS (altered mental status), hypoxia, tachypneic w/ tachycardia requiring intubation IV (intravenous) [NAME] (antibiotics) and vasopressor therapy. After transferred out of ICU (intensive care unit) pt (patient) found unresponsive w/ mult (multiple) acute infarcts. Alert and oriented; able to make needs known. Skin warm dry w/ adequate turgor. No tenting, dry oral mucosa or obvious signs of dehydration. Dressing to buttocks CDI (clean, dry, intact). Some swelling to bilat (bilateral) upper thighs. No BLE (bilateral lower extremity) edema. INC of B&B (incontinent of bowel and bladder). Requires extensive assist w/repositioning, cares and transfers x2 (2 staff) w/lift. Appetite good; eating 75% of dinner. Currently no indications or c/o (complaints of) increased pain or discomfort. All safety precautions in place per POC (plan of care). PMD (primary medical doctor) updated and all orders verified. Will cont. (continue) to eval (evaluate) and anticipate pt needs. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R26's Advanced Clinical admission Assessment, dated 4/11/26 at 7:55 PM documents: (R26) has a skin issue- location: coccyx. Laterality/ Orientation: Medial. Issue type: pressure. Progress: stable. previously deteriorating wound characteristics plateaued. Pressure injury staging: Stage 3 - full thickness skin loss. Wound was present on admission. Length 3.6 cm x 3.4 cm width and 0 undermining. There are no additional characteristics, tissue type, or wound bed details documented. Surveyor reviewed the discharge summary from the hospital dated 4/11/26. Surveyor noted that there were no instructions regarding the care and treatment of a coccyx pressure wound. The hospital problem list did not include R26 having a pressure injury to the coccyx and the discharge medication list did not include any type of treatments for R26. R26's Braden Skin assessment dated [DATE] (assessed the risk of developing a pressure injury) documents a score was 15 points, indicating R26 is at risk for pressure injuries.R26 has potential for impairment to skin integrity r/t (related to) decreased mobility documents: admission: Unstageable; bilateral buttocks Date Initiated: 04/11/2026.The resident will remain free of new skin impairment through the review date. Date Initiated: 04/14/2026.Under the Interventions section it documents: Air Mattress; set to weight and/or comfort level. Initiated: 04/11/2026Monitor skin when providing cares, notify nurse of any changes in skin appearance. Date Initiated: 04/11/2026Use wedge to improve positioning. Date Initiated: 04/11/2026Wheelchair pressure reduction cushion. Date Initiated: 04/11/2026Encourage resident to wear bilateral heel boots when in bed. Date Initiated: 04/18/2026Encourage that heels are elevated while resident is lying in bed. Date initiated: 4/11/26 R26's nursing note dated 4/13/2026 at 08:00; AM documents: Skin Check Skin: Skin warm & dry, skin color WNL and turgor is normal. R26 does not have an external device. Foot evaluation completed. Skin Issues: Skin Issue: 001: New skin Issue. Location: Buttocks - generalized. Laterality / Orientation: Right. Laterality / Orientation: Left. Additional location information: bilateral buttocks (medial) Issue type: Pressure injury / injury. Progress: New: new wound. Pressure injury staging: Unstageable pressure injury / injury. Unstageable injury due to slough and / or eschar. Wound was present on admission. Staged by: In-house nursing. Length (cm): 3.6 Width (cm): 3.4 Depth (cm): 0. Skin Issue: #002: New skin Issue. Location: Front left thigh. Issue type: Other skin issue. Other skin issue description: scabs Progress: New: new wound. Wound was present on admission. R26's physician order dated 4/13/25 at 8:15 AM documents: Buttocks: Cleanse bilateral buttocks with NS, apply xeroform and bordered gauze everyday shift for wound care AND as needed for wound care. R26's physician order dated 4/13/26 at 2:00 PM documents: Monitor bilateral buttocks for changes in skin alteration, report changes to provider every shift for wound care. Surveyor conducted a review of the Treatment Administration Record for April 2026. Surveyor noted that there was no physician order for the treatment of the pressure injury to R26's buttocks until 4/13/26, or two days after R26 was admitted . Surveyor also noted that there was no documentation in R26's TAR for April 2026 that treatment was provided to R26's pressure injury until 4/14/26, or three days after R26 was readmitted to the facility. R26's nursing note dated 4/15/2026 at 11:40 AM documents: Adv - Skin Issues: Skin Issue: #001: Skin issue has been evaluated. Location: Buttocks - generalized. Laterality / Orientation: Left. Laterality / Orientation: Right. Additional location information: bilateral buttocks (medial) Issue type: Pressure (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	injury / injury. Progress: Improving: overall wound characteristics improved. Length (cm): 4.17 Width (cm): 4.53 Depth (cm): 0 Area (cm2): 10.48 Undermining: No. Tunneling: No. Odor after cleansing: None. Surrounding tissue: Intact. Edema: No swelling or edema. Periwound temperature: Normal. Dressing appearance: Intact. Dressing saturation: Minimal < 25%. On 4/16/26, R26 had an initial assessment with the Wound Physician. The following was documented: presents with wounds on her/ his left buttock, right buttock and left anterior thigh. Left Buttock-unstageable /necrosis. Present less than 1 day. Measures 6 x 4 x 0.1 cm with a surface area of 24 centimeters. 80% necrotic tissue and 20% granulation tissue. No pain is present and no signs of infection. Treatment: xeroform gauze apply once daily and as needed if saturated soiled or dislodged. Gauze island with border apply once daily and as needed. Debridement procedure. Right Buttock-unstageable due to necrosis. Present less than 1 day. Measures 4 cm x 4 cm x 0.1 cm. Surface area-16 cm. 80 % necrotic tissue and 20 % granulation tissue. No pain and no signs of infection. Debridement procedure. Treatment same as above. On 4/22/26 at 9:20 AM, Surveyor interviewed DON (Director of Nursing)-B regarding R26 being admitted on [DATE] with a pressure injury to the buttocks. Surveyor asked DON- B about the facility not conducting a comprehensive assessment of the wound on 4/11/26 and also not obtaining a treatment order. DON- B stated that R26's room was already set up for R26's arrival and an air-mattress was in place for R26. DON-B stated that the nurse who admitted R26 to the facility observed a treatment in place on R26's buttocks when completing the head-to-toe assessment. DON-B stated that the nurse removed the dressing and measured the area and then replaced the dressing with a new/clean treatment that R26 had in place upon his arrival to the facility. Surveyor asked DON- B how the nurse knew what treatment was in place prior. DON- B stated that the nurse replaced it with the equivalent in what was in place prior. DON- B stated that typically staff would be expected to call the Doctor/ Nurse Practitioner and either get clarification for a treatment or get a new order for a treatment when a wound is observed. DON- B stated that because there was a dressing in place from the hospital, the nurse just put the same type of dressing back in its place. DON- B also stated that the dressing can be in place for up to 72 hours and this is how long it was going to be before the facility's wound nurse was going to assess the pressure injury. On 4/22/26 at 11:25 AM, Surveyor interviewed Wound Nurse- C regarding R26's pressure injury to the buttocks. Surveyor asked Wound RN- C if a Registered Nurse has assessed R26's pressure injury upon admission on [DATE]. Wound RN- C stated that LPN-I assessed R26 and provided a measurement and staged the area. Wound RN- C stated that the RN on duty probably had other residents to take care of and she was not available to assess R26 on 4/11/26. Wound RN- C stated she told LPN- I to just put a new dressing on and she would assess it on Monday 4/13/26 when she returned to work. On 4/22/26 at 2:12 PM, Surveyor interviewed LPN- I regarding R26's admission on [DATE] and the assessment of the pressure injury to the buttocks. LPN- I stated that she was conducting a head-to-toe assessment of R26 and when the Certified Nursing Assistant and herself turned R26 over she noticed a dressing to R26's buttocks. LPN- I stated that there was nothing in the hospital paperwork that documented R26 had a pressure injury upon discharge from the hospital. LPN- I stated she took the dressing off and cleaned the area. LPN- I stated she then got her measuring tool and measured the area. LPN- I stated that she has been a nurse for 20 years and is familiar with pressure injuries. LPN- I stated she cleansed the wound with normal saline, patted it dry and applied a border gauze because that was what was in place prior. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor asked LPN- I if she had called the Physician or Nurse Practitioner to obtain an order for treatment because there was no order in the hospital paperwork. LPN- I stated that she does not recall if she spoke with Nurse Practitioner or the Physician to get an order. LPN- I stated she had a lot of admissions that day and was very busy. LPN-I stated that she doesn't remember if she asked the Registered Nurse who was also working that shift to assess the area. Surveyor noted that R26's pressure injury did not have a comprehensive RN assessment upon admission and the facility did not document a physician order for treatment of the pressure injury until 4/13/26, or two days after R26 was readmitted to the facility. Despite this, Surveyor noted that R26's pressure injury remained consistent in size and staging. No additional information was provided. 2.) R5 was admitted to the facility on [DATE] with diagnoses of paraplegia, diabetes, chronic pancreatitis, schizophrenia, and chronic obstructive pulmonary disease. R5's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented R5 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 13 and needed maximum to total assistance with activities of daily living. R5 developed a pressure injury to the left gluteal fold on 4/23/2025. On 7/2/2025 at 11:44 AM in the progress notes, nursing documented R5 was sent to the hospital for evaluation and treatment of the left gluteal fold wound which showed signs of infection with increased pain and foul-smelling drainage. R5 was agreeable to go out and be evaluated. R5 was noted to be non-compliant with offloading which is likely contributing largely to the decline in R5's wound. R5 was continually educated on the importance of offloading and proper nutrition. On 7/11/2025, R5 was readmitted to the facility. On the Nursing Evaluation form, Licensed Practical Nurse (LPN)-G documented in the Skin Integrity section R5 had a decubitus ulcer to the left buttock. No measurements or wound characteristics were documented. On 7/14/2025, R5's left gluteal fold Stage 4 pressure injury was comprehensively assessed by the facility wound Registered Nurse (RN), three days after readmission. On 8/21/2025 at 7:20 AM in the progress notes, nursing documented R5 was using accessory muscles to breathe, and breathing was labored. R5's oxygenation on 3 liters of oxygen was 88%. The nurse increased the oxygen to 10 liters and R5's oxygenation increased to 95-98%. R5 was not arousable with sternal rub prior to the increase in oxygen administration and after the oxygenation increased, R5 was arousable but unable to open eyes. R5's abdomen was distended with no bowel sounds present. R5 was sent to the hospital for evaluation and treatment. On 8/30/2025, R5 was readmitted to the facility. On the Nursing Evaluation form, an LPN documented in the Skin Integrity section R5 had a wound to the left gluteal fold. The LPN documented at 5:11 PM in the progress notes R5 had a wound to the left buttock that measured approximately 4 cm x 3 cm x 6 cm with no drainage and the wound base was beefy red. Surveyor noted the pressure injury was not comprehensively assessed by an RN. On 9/3/2025, R5's left gluteal fold Stage 4 pressure injury was comprehensively assessed by the (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility wound RN, four days after readmission. On 9/29/2025, R5 was transferred to the hospital for evaluation and treatment for septic shock. On 10/7/2025, R5 was readmitted to the facility. On the Nursing Evaluation form, an RN documented in the Skin Integrity section R5 had a Stage 4 pressure injury to the left buttock. No measurements or wound characteristics were documented. On 10/8/2025, R5's left gluteal fold Stage 4 pressure injury was comprehensively assessed by the facility wound RN, one day after readmission. On 10/26/2025 at 12:32 PM in the progress notes, nursing documented R5 was being sent to the hospital for evaluation and treatment of a possible bowel obstruction. On 11/2/2025, R5 was readmitted to the facility. On the Nursing Evaluation form, an LPN documented in the Skin Integrity section R5 had a Stage 4 pressure injury to the left gluteal fold. No measurements or wound characteristics were documented. On 11/5/2025, R5's left gluteal fold Stage 4 pressure injury was comprehensively assessed by the facility wound RN, three days after readmission. On 4/20/2026 at 10:03 AM, Surveyor observed R5 lying in bed on an air mattress. Surveyor asked R5 if R5 had any open areas on the skin or any wounds. R5 stated R5 had a wound on the bottom, and it was R5's fault there was a wound there because R5 sits too long in the wheelchair. R5 stated the wound has slowly been getting better after going to the hospital where it was debrided. R5 stated the facility staff changes the dressing daily to the wound. On 4/21/2026 at 10:05 AM, Surveyor observed Wound RN-C assisted by Certified Nursing Assistant (CNA)-D complete the treatment to R5's left gluteal fold Stage 4 pressure injury. Wound RN-C stated Wound RN-C had been working for the facility for a little over a month so did not know the progression of R5's pressure injury. Wound RN-C stated R5 was not compliant but has become much more compliant recently. Wound RN-C thought R5 understands the problem of sitting up in the chair for so long is what is causing the wound to not heal, but R5 is a smoker so Wound RN-C stated the facility has to accommodate R5's wishes as well. In an interview on 4/22/2026 at 9:19 AM, Surveyor asked Director of Nursing (DON)-B what the process was for a newly admitted or readmitted resident that has a skin concern. DON-B stated the nurse on the floor puts the location of the wound in the charting and then the wound nurse will follow up on the resident during weekly wound rounds. DON-B stated the nurses had been documenting a wound as a pressure injury when it is a venous ulcer so the nurses have been instructed to just put the location of the wound on the form and then the wound nurse along with the wound physician would document the etiology of the wound so it was not entered in wrong the first time. Surveyor shared with DON-B the concern R5 was admitted to the hospital four times in the last year with a pressure injury and on readmission to the facility, the wound is not comprehensively assessed for up to four days after readmission. Surveyor shared the concern that without documentation on the day of readmission, the progression of the wound cannot be followed to know if it is improving or declining. DON-B agreed stating the system is broken. On 4/22/2026 at 1:37 PM, Surveyor shared with Nursing Home Administrator (NHA)-A the concern (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5's Stage 4 pressure injury was not comprehensively assessed on four readmissions until one to four days after readmission. No further information was provided at that time. 3.) R86 was admitted to the facility on [DATE] with diagnoses that included hypertension, cerebral infarction with right side hemiplegia, aphasia and dysphagia. R86's Minimum Data Set (MDS) dated [DATE] documents that R86 was assessed to be severely cognitively impaired and dependent with activities of daily living (ADL). The MDS also documents that R86 was assessed to be incontinent of bladder and bowel. R86's Care Assessment Area (CAA) dated 5/10/25 documents: R86 has decreased mobility requiring assistance for her mobility and repositioning which is a contributing issue for potential pressure ulcer development in addition to incontinence issue due to exposure of skin to moisture. (R86) is s/p (status post) hospitalization due to right hemiparesis and aphasia effected by left cerebral infaction resulting to generalized weakness and a decline in her functional status.Heels off bed, incontinence care and skin checks will be maintained per facility's protocol. R86's care plan dated 5/7/25 documents potential for skin impairment with an intervention of -Monitor skin when providing cares, notify nurse of any changes in skin appearance. R86's treatment administration record (TAR) for May 2025 documents reposition every 2 hours with start date of 5/7/25. The TAR also documents skin checks completed every Tuesday and Friday. R86's nurses note dated 5/23/25 documents: R86 developed a new open area to the coccyx. R86's Wound MD-H assessment dated [DATE] documents: pressure injury to the sacrum that presents as deep tissue injury (DTI) measuring 12 centimeters (cm) by 7 cm by 0.1 cm. A treatment was ordered for leptospermum honey applied to wound with foam bordered dressing three times a week. R86's nurses note dated 5/26/25 documents: R86 fell out of bed and was sent to the hospital. R86's hospital record dated 5/26/25 documents: R86 sacrum wound as unstageable measuring 10 cm by 4 cm with 10% slough. There is no further documentation from the hospital regarding R86 pressure injury R86 was readmitted to the facility on [DATE] with a readmission physician treatment order that documented: Medihoney with foam bordered dressing to be changed Monday, Wednesday and Friday. Surveyor was unable to locate a comprehensive wound assessment for R86's sacrum unstageable pressure injury that was completed on 5/31/25 when R86 was readmitted to the facility. The facility completed a skin and wound evaluation dated 6/2/25 which documents: R86 sacrum pressure injury is unstageable measuring 13.3 cm by 10.3 cm with 100% slough. Surrounding tissue presents as denunded and erythema. It documents R86 was readmitted from the hospital with her wound to her sacrum substantially deteriorated. R86's care plan documents dated 6/2/25 documents air mattress implemented along with repositioning every 2 hours. (continued on next page)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R86's nurses note dated 6/2/25 documents: R86 had been refusing to eat and was pocketing crushed medications. R86's Power of attorney (POA) and Nurse practitioner (NP) were made aware. Discussion with R86's POA regarding R86 DNR status and R86 not eating and drinking was conducted. R86's POA was educated on the importance of nutrition and tube feeding was discussed. R86 POA stated R86 did not wish to have a feeding tube. R86's Wound MD-H assessment dated [DATE] documents: R86 sacrum pressure injury as unstageable necrosis measuring 10 cm by 5 cm by 0.1 cm. The assessment also documents (R86) requiring an increase in the level of care. Doxycycline 100 mg (milligrams) po (by mouth) X 14 days, probiotic 2 tabs daily for 30 days for cellulitis. The treatment was changed to cleanse with dakins 1/2 strength and apply alginate calcium followed by foam bordered dressing twice daily. Wound MD-H assessment dated [DATE] documents: R86 sacrum pressure injury as stage 4 measuring 10 cm by 5 cm by 6 cm with 100% necrotic tissue. Wound MD-H documents (R86) requiring an increase in the level of care. Recommendation ER for further evaluation and/or for debridement. The nurses note dated 6/13/25 documents R86 was sent to the hospital for evaluation of the sacrum wound. R86 did not return to the facility after this hospitalization. The hospital record dated 6/13/25 documents WBC (white blood cell) elevated to 23. Lactic acid elevated. Concerns for sepsis. Fluids ordered. Will start broad spectrum antibiotics. On 4/22/26 at 9:22 a.m. Surveyor interviewed DON-B. Surveyor explained to DON-B when R86 was readmitted to the facility on [DATE], a comprehensive wound assessment was not completed. A wound assessment was completed on 6/2/25. DON-B stated the wound nurse that was here while R86 was at the facility no longer works for the facility and DON-B can't answer why an assessment wasn't completed on 5/31/25. Surveyor asked DON-B what contributed to R86 wound deteriorating to the point of needing antibiotics. DON-B stated R86 had a poor appetite and R86's family did not want R86 to have a feeding tube. On 4/22/26 at 9:33 a.m. Surveyor interviewed Wound MD-H. Surveyor asked Wound MD-H what contributed to R86 pressure injury to deteriorate. Wound MD-H stated when R86 returned from the hospitalization on 5/26-5/31/25, R86 wound was brewing an infection deep internally but because they couldn't see the wound base due to the necrotic tissue, it was presenting as cellulitis and the antibiotic was not helping. Wound MD-H stated he recommended R86 be sent to the hospital on 6/13/25 because he could not debride the wound enough at bedside and R86 would need surgical debridement to treat whatever infection was underneath it. Wound MD-H stated he had no concerns with R86 being repositioned and interventions were in place to aid in healing of the pressure injury. On 4/22/26 at 11:19 a.m. Surveyor explained to NHA-A the concern R86 was readmitted to the facility on [DATE] and a comprehensive wound assessment was not completed until 6/2/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525061	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincoln Park Nursing and Rehab LLC	1700 C A Becker Dr Racine, WI 53406

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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 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, interview, and record review, the facility did not maintain an infection prevention and control program designed to reduce the transmission of disease and infection for 1 (R45) of 3 residents observed receiving care while on enhanced barrier precautions. During the observation of catheter care for R45, registered nurse (RN)-F did not wear a gown when enhanced barrier precautions (EBP) were in place for R45.Findings include:The facility's policy titled Enhanced Barrier Precautions with implemented date 1/13/23 and revised date 1/26/26 documents: . It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms.All staff receive training on enhanced barrier precautions upon hire and at least annually and are expected to comply with all designated precautions. All staff receive training on high-risk activities and common organisms that require enhanced barrier precautions. An order for enhanced barrier precautions will be obtained for residents with any of the following: . indwelling medical devices (e.g., . urinary catheters.) even if the resident is not known to be infected or colonized with a MDRO. PPE (personal protective equipment) for enhanced barrier precautions is only necessary when performing high-contact care activities . High-contact resident care activities include: . device care or use: . urinary catheters . Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until . discontinuation of the indwelling medical device that placed them at higher risk. R45 admitted to the facility 1/27/25. R45's quarterly Minimum Data Set (MDS) dated [DATE] documents R45 has an indwelling urinary catheter. R45's indwelling catheter care plan documents the following interventions with an implemented date of 4/18/25:-check tubing for kinks each shift-monitor and document output-monitor for signs/symptoms of discomfort on urination and frequency-monitor/document for pain/discomfort due to catheter-monitor/record/report to doctor for signs/symptoms of urinary tract infection (UTI)R45's physician order dated 7/24/25 documents foley catheter output every shift. R45's physician order dated 5/29/25 documents enhanced barrier precautions due to indwelling catheter and history of MDRO (multi-drug resistant organism) every shift. On 4/20/26 at 9:44 AM, Surveyor observed an Enhanced Barrier Precautions sign posted on R45's door. The sign documents: . Everyone must: Clean their hands, including before entering and when leaving the room. Providers and staff must also: wear gloves and a gown for the following high-contact resident care activities. device care or use: . urinary catheter .On 4/22/26 at 8:36 AM, Surveyor observed RN-F complete catheter care for R45. Surveyor observed RN-F complete the process of emptying R45's catheter without donning a gown. On 4/22/26 at 8:39 AM, Surveyor shared concern with RN-F that Surveyor did not observe RN-F wear a gown while providing catheter cares to R45. RN-F stated yes RN-F should have worn a gown and RN-F does not usually care for R45, so the EBP sign must be new. In an interview on 4/22/26 at 8:41 AM with Director of Nursing (DON)-B, DON-B stated all residents with a catheter should be on enhanced barrier precautions, and staff should follow the EBP sign to know what PPE staff should wear when performing cares. DON-B stated staff should wear a gown and gloves when performing catheter cares. Surveyor shared concern with DON-B that Surveyor observed RN-F perform catheter cares for R45 without wearing a gown. DON-B stated RN-F would be educated. On 4/22/26 at 1:26 PM, Surveyor shared concern with Nursing Home Administrator (NHA)-A that Surveyor observed RN-F complete catheter cares for R45 without wearing a gown. No additional information was provided.