STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525108	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Resolve at West Allis Respiratory and Rehab	9047 W Greenfield Ave West Allis, WI 53214

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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 - 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, interview and record review, the facility did not ensure that residents with pressure injuries received necessary treatment and services consistent with professional standards of practice to promote healing and prevent new pressure injuries from developing for 4 (R1, R8, R10 and R25) of 7 residents reviewed for pressure injuries. *R1 was readmitted to the facility on [DATE] with an unstageable Deep Tissue Injury (DTI) to R1's left heel. Surveyor observed R1's heels to not be offloaded on 3 separate occasions (4/26/2026, 4/27/2026 and 4/28/2026). On 4/27/2026, R1's wound has nearly doubled in size since initial assessment. The example regarding R1 is being cited at a scope and severity of a G (actual harm/isolated). The examples regarding R8, R10, and R25 are examples at the scope and severity of a D (potential for harm/isolated). *R8 had a Stage 4 pressure injury to the sacrum that developed osteomyelitis due to the Nurse Practitioner intervention recommendation not being implemented. *R10 had a weight loss from 190.2 pounds on 10/2/24 to 176.9 pounds on 4/7/25. The facility did not reassess the effectiveness of R10's interventions to reduce risk of developing a pressure injury after the weight loss, and R10 developed a pressure injury on 5/2/25 to the left buttock which progressed to a stage 4 pressure injury on 8/18/25. *R25 was admitted with a pressure injury that developed an infection and required hospitalization and antibiotic administration. Findings include: The facility's policy, with no date and titled Pressure Injury Prevention Guidelines documents: 1. Individualized interventions will address specific factors identified in the resident's risk assessment, skin assessment, and any pressure injury assessment (e.g., moisture management, impaired mobility, nutritional deficit, staging, wound characteristics). 2. The goal and preferences of the resident and/or authorized representative will be included in the plan of care. 3. Interventions will be implemented in accordance with physician orders, including the type of prevention devices to be used and, for tasks, the frequency for performing them. 4. Prevention devices will be utilized in accordance with manufacturers' recommendations (e.g., heel flotation devices, cushions, mattresses). 8. The effectiveness of interventions will be monitored through ongoing assessment of the resident and/or wound. Considerations for needed modifications include: a. Development of a new pressure injury. b. Lack of progression towards healing or changes in wound characteristics. c. Changes in the (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 0686 Level of Harm - Actual harm Residents Affected - Few	resident's goals and preferences, such as at end-of-life or in accordance with his/her rights. 1.) R1 was admitted to the facility on [DATE] with diagnoses including respiratory failure (a life-threatening condition where the lungs cannot adequately oxygenate the blood or remove carbon dioxide), hemiplegia (complete paralysis of one side of the body), hemiparesis (a neurological condition causing mild-to-moderate weakness on one side of the body) and pain. R1's Annual Minimum Data Set (MDS), dated [DATE], indicates R1 was assessed to have severely impaired cognition, does not exhibit behaviors, has impairment in both upper and lower extremities, always incontinent of bowel and bladder, is at risk for pressure injuries, has current unhealed pressure injuries including one stage 4 pressure injury (PI) and one Unstageable (PI) presenting as a Deep Tissue Injury (DTI). R1's Care Plan Report with revisions, documents that R1 has impaired skin integrity and is at high risk for further skin breakdown with the following interventions: -SPECIALTY MATTRESS: with the setting at P2. -Bed rest. -Apply house moisturizing lotion as needed to keep skin hydrated. Avoid applying between toes and other moist areas. Staff will not apply lotion to buttocks. -Attempt to off load bony prominences by turning and using pillows, wedges, or other positioning devices as resident allows and tolerates. -Heel boots on at all times for skin protection. - Perform thorough diabetic foot check daily at bedtime. Check all surfaces, including between toes. Notify primary physician and Wound Care Team of any skin abnormalities. - Wound assessment/measurement performed weekly/as needed by Wound Care Team. If unavailable, assessment will be completed at earliest availability. - Wound care treatment to be performed by Wound Care Team/Nursing as ordered - When positioning medical devices (ex- foley, tubing , 0 2 tubing). Attempt to avoid positioning medical devices over a bony prominence. On 04/26/2026, at 2:00 PM, Surveyor observed R1 in R1's bed. Surveyor noted R1's heel boots laying in R1's wheelchair. Surveyor noted that R1 did have any offloading to R1's lower extremities while in bed. On 04/27/2026, at 3:22 PM, Surveyor observed R1 in bed without R1's heel boots on and noted R1's heel boots in R1's wheelchair. Surveyor noted that R1's heels were not offloaded to reduce pressure per R1's plan of care. On 04/28/2026, at 7:45 AM, Surveyor observed R1 in bed without offloading or heel boots on R1's lower extremities. Surveyor observed R1's heel boots in R1's wheelchair. Surveyor noted that R1's (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	heels were not offloaded to reduce pressure per R1's plan of care. On 04/28/2026, at 7:51 AM, Surveyor asked Nurse Manager-N and Certified Nursing Assistant (CNA)-O about R1's heel boots. CNA-O informed Surveyor that CNA-O started at 6:30AM and has not been in to see R1 until now. CNA-O pulled back R1's covers to expose R1's lower body. Surveyor noted a pillow under R1's left side and a pillow under R1's upper thighs. Surveyor observed R's heels directly on the bed and heels were not offloaded to reduce pressure. Surveyor asked CNA-O how staff know what interventions should be in place for R1's skin protection. CNA-O indicated the information is on the care plan and everything is in the computer. Surveyor asked Nurse Manager-N if R1 should have heel protectors on, Nurse Manager-N informed Surveyor Nurse Manager-N will have to confirm how often R1 needs heel boots on, but does not currently have the heel boots on at this time. On 04/28/2026, at 8:11 AM, Nurse Manager-N came back to R1's room and put R1's heel boots on R1. Nurse Manager-N informed Surveyor that according to R1's care plan, heel boots should always be on R1, which protects R1's heels from pressure and prevent R1's DTI from worsening. On 04/28/2026, at 8:47 AM, Surveyor interviewed Wound Registered Nurse (RN)-I. Wound RN-I indicated that R1's DTI to the left heel was discovered on 4/23/2026 after being readmitted to the facility following a hospital stay, unrelated to wounds. R1's current interventions include a restorative program for upper and lower extremities i.e. repositioning every 2-3, specialty mattress, Prevalon heel boots to bilateral lower extremities, protective dressings in place, pain management as needed, arms and elbows off loaded, only supposed to be on a chuck pad to reduce moisture and skin break down, therapy and make sure R1 is not laying on any medical devices. Wound RN-I informed Surveyor that on 4/23/2026, when left heel DTI was first discovered, it measured in centimeters (cm) 2.5 x 2.5 intact, dark purple in color with no depth just intact skin. On 4/27/2026, R1's left heel DTI measured (in cm) 4 x 3 x not measurable- intact skin with purple/maroon discoloration which was an increase in the wound size Wound RN-I indicated if interventions are not being implemented, there is potential for a decline or deterioration in the wound. Wound RN-I informed Surveyor that if heel boots are unavailable, due to being washed, heels can be off loaded with pillows until boots are available. Surveyor reviewed the facility provided documents, titled Weekly Wound Documentation for R1 and noted the following: 4/23/2026- admitted with: Left lateral foot wound- 100% dark purple, non-blanchable, boggy. Measurements in cm: 2.5 x 2.5 x N/A intact skin. Wound MD-H to assess 4/27/2026. Surveyor reviewed the Facility provided (name of medical group) wound notes for R1 and noted the following: 4/27/2026- Unstageable DTI of the left heel- undetermined thickness Etiology- pressure Detail- trauma from patient chewing on lip (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Stage- Unstageable DTI with intact skin Wound size- 4 x 3 x not measurable Surface area- 12.00cm2 Skin- intact with purple/maroon discoloration Surveyor noted since the discovery of R1's left heel DTI, the wound has increased in size. On 04/29/2026, at 12:50 PM, Surveyor interviewed Director of Nursing (DON)-B. DON-B informed Surveyor that R1 is to have heel boots always on. R1's heel boots can only be taken off while providing care and should be put back on right away and is the responsibility of everyone caring for R1 to ensure those interventions are being implemented. On 04/29/2026, at 1:01 PM, Surveyor informed Nursing Home Administrator (NHA)-A regarding concerns involving R1 not having heel boots in place as care planned and R1's left heel DTI increasing in size. No additional information was provided. 2.) R8 was admitted to the facility on [DATE] and had diagnoses of chronic respiratory failure, persistent vegetative state, diabetes, and a Stage 4 pressure injury to the sacral region. R8's Annual Minimum Data Set (MDS) dated [DATE] documented R8 was assessed to be in a vegetative state with a tracheostomy, an indwelling urinary catheter, a feeding tube for all nutrition, and a Stage 4 pressure injury. R8's Actual Skin Impairment Care Plan was initiated on 8/7/2023. Some of the interventions in place on 4/11/2025 were: -Bed rest. -18Fr Foley catheter for wound healing. -Specialty mattress: Air Ranger Pro air mattress per orders – function and setting checked per shift. -Address pain prior to treatment to improve resident tolerance/acceptance of wound care; address pain as needed for resident comfort to encourage adherence to interventions to maintain skin integrity. -Apply lotion to bilateral lower extremities every day with cares. -Attempt to off load bony prominences/heels by urning and using pillows, wedges, heel boots or other positioning devices as resident allows and tolerates. -Change clothes/linens when damp or wet to prevent prolonged moisture to skin; incontinence briefs to be left off when resident in bed; keep abdominal folds dry. -Nursing to monitor dressing integrity with each resident encounter and replace dressing if (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	soiled/loose/missing. -Provide incontinence care as needed to keep skin as clean and dry as possible; utilize barrier cream as ordered/needed to protect skin from incontinence. -Provide assistance with repositioning every 2-3 hours; utilize draw sheet when available for repositioning to reduce risk of friction/shear. R8 was seen weekly by the wound Nurse Practitioner (NP) for a comprehensive assessment of the Stage 4 pressure injury to the coccyx. The pressure injury had been present since December 2023. On 4/11/2025, the wound NP documented: R8's Stage 4 pressure injury to the coccyx measured 6.5 cm x 6 cm x 3.5 cm with circumferential undermining with the deepest measurement of 3.6 cm at 9 o'clock with 100% granular tissue and exposed bone. On 4/12/2025 at 5:12 PM in the progress notes, nursing documented R8 was having loose stool/diarrhea at least once within eight hours. R8 was on continuous tube feeding resulting in soft stool, not loose stool. On 4/18/2025, the wound NP documented R8's Stage 4 pressure injury to the sacrum measured 9 cm x 6 cm x unable to determine depth with 80% necrotic tissue and 20% granular tissue. The wound NP noted a decline in the status of the pressure injury. The wound NP changed the treatment to the wound at that time. On 4/23/2025 at 10:15 AM in the progress notes, the facility NP documented R8 had chronic loose stools for which R8 was being treated with banana flake, however, R8 had frequent hyperkalemia so banana flakes frequency of administration was decreased. Staff were to continue to monitor for loose stools, hyperkalemia and wound status. The facility NP documented R8 needed frequent bed changes to prevent wound breakdown. Surveyor noted the frequent bed changes were not added to R8's Care Plan. On 4/25/2025, the wound NP documented: R8's Stage 4 pressure injury to the sacrum measured 9 cm x 15 cm x unable to determine depth with 70% necrotic tissue and 30% granular tissue. The wound NP documented the wound had a large amount of seropurulent drainage with the surrounding tissue being red and hot to the touch. The wound NP documented there was concern for an acute infection and R8 was transferred to the hospital for further evaluation and treatment. R8 was diagnosed in the hospital with osteomyelitis, an infection of the bone, requiring intravenous antibiotics. The wound NP that had been assessing R8's Stage 4 pressure injury was no longer employed by the facility and unavailable for interview. On 4/27/2026, R8 was seen by Wound Physician (WP)-H. WP-H documented: R8's sacral Stage 4 pressure injury measured 5 cm x 6 cm x 2 cm with tunneling at 4 o'clock that measured 3 cm with 40% necrotic and 60% granulation tissue. In an interview on 4/28/2026 at 1:42 PM, Surveyor asked Licensed Practical Nurse (LPN)-K how often R8 received incontinence care. LPN-K stated R8 was repositioned every two hours and R8 has bowel movements a lot. LPN-K stated R8 has bladder spasms with catheter leakage where they had to put stents in. Surveyor asked LPN-K if R8 had loose stools. LPN-K stated it was very common for (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R8 to have loose stools and R8 gets banana flakes to try and make the stools less watery and that is why they cannot get R8's wound on the coccyx to heal; R8 is constantly stooling, and the stool gets in the dressing. In an interview on 4/29/2026 at 10:22 AM, Surveyor asked Wound Registered Nurse (WRN)-I how often R8 gets incontinence care. WRN-I stated R8 has frequent stools, especially in the morning. WRN-I stated R8 received incontinent care three times in three hours the other day and that is typical for R8. WRN-I stated Certified Nursing Assistant (CNA)-F would have a good estimate of how often R8 is changed per shift since CNA-F often works with R8. CNA-F stated R8 is changed 4-5 times per shift because R8's stool is extremely loose, and the stool gets into the wound. WRN-I stated they offered R8's POA to get an ostomy with a gastrointestinal (GI) consult but R8's POA did not think R8 was medically stable for surgery. WRN-I stated R8 was seen by a plastic surgeon in March 2026 for a flap to cover the wound to help with healing, but the appointment was cancelled because that surgeon did not handle wounds. WRN-I stated they have tried stool supplements to help stop the liquid stool and the wound is drastically better than what it had been. In an interview on 4/29/2026 at 11:53 AM, Surveyor asked WP-H how R8 developed osteomyelitis in April 2025. WP-H stated with the location of the wound, it is hard to keep it from getting osteomyelitis. WP-H stated R8 has an indwelling urinary catheter, but stool gets in the wound and with tube feeding, the stool is very liquid. WP-H stated often, when WP-H is assessing the wound, as soon as R8 is rolled over, R8 has a stool and that contaminates the wound. WP-H stated R8 is immunocompromised with comorbidities and even though R8 is getting supplemental protein, since it is in liquid form for the gastrostomy tube, the protein is not absorbed as well. On 4/29/2026 at 1:09 PM, Surveyor shared with Director of Nursing (DON)-B and WRN-I the concern the facility NP documented to increase changing of linens on 4/23/2025 and the care plan was not revised to incorporate that recommendation. R8 developed osteomyelitis on 4/25/2025 requiring intravenous antibiotics. DON-B agreed the care plan was not revised to reflect the NP recommendation. No additional information was provided. 3.) R10 was admitted to the facility on [DATE] with diagnoses including quadriplegia (weakness of all four extremities), neurogenic bowel (loss of normal bowel function caused by a nerve problem), and neuromuscular dysfunction of bladder (loss of bladder control due to a nerve problem). R10's quarterly Minimal Data Set (MDS) dated [DATE] documents that R10 was assessed to have no current pressure ulcers and that R10 is at risk for pressure ulcers. The MDS documents that R10 was assessed to have a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. R10's pressure injury Care Area Assessment (CAA) dated 11/10/24 documents: [R10] is at risk for development of pressure ulcers due to impaired mobility, diagnosis of quadriplegia and dependent on staff for bed mobility and repositioning. Other risk factors include incontinence of bowel. Pressure relieving device to bed and chair, pericare for incontinence, repositioning every 2-3 hours and as needed (PRN), receiving Pro-Mod to assist with skin integrity. Will proceed to care plan with interventions to reduce risks for development of pressure ulcers. R10's turning/repositioning program care plan initiated 8/24/21 documents the following intervention:-assist with turning/repositioning every 2 hours, revised date 5/21/24 (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R10's impairment to skin integrity care plan initiated 6/3/24 documents the following interventions:-avoid scratching and keep hands and body parts from excessive moisture, keep fingernails short, revised date 11/12/24-educate resident/family/caregivers of causative factors and measures to prevent skin injury, revised date 11/12/24-encourage good nutrition and hydration in order to promote healthier skin, revised date 11/12/24-heels offloaded with pillows when in bed, document compliance and effectiveness every shift, revised date 11/12/24-identify/document potential causative factors and eliminate/resolve where possible, revised date 11/12/24-nursing will assess skin upon admission, weekly on day of scheduled shower, PRN, and with any change in condition. Any abnormalities will be documented in chart and reported to primary physician and wound care team for follow up, revised date 11/12/24-pillows used to offload bony prominences when in bed. Document compliance and effectiveness every shift, revised date 11/12/24-provide incontinence care as needed to keep skin as clean and dry as possible. Utilize barrier cream as needed to protect intact skin from incontinence. Change linens and clothing when wet to prevent prolonged moisture to skin, revised date 11/12/24-suprapubic catheter per orders, revised date 11/12/24 -support surfaces for pressure reduction: alternating pressure mattress and electric wheelchair with pressure reduction cushion. Evaluate for effectiveness/proper function with each resident encounter, revised date 11/12/24 R10's resistive to care and frequently refuses prescribed medications care plan initiated 1/2/25 documents the following interventions:-allow [R10] to make decisions about treatment regime to provide sense of control, date initiated 1/2/25-educate [R10] of the possible outcome(s) of not complying with treatment or care, date initiated 1/2/25 R10's Braden Scale assessment dated [DATE] documents a score of 17.0 indicating R10 is at risk for pressure injury development. In an interview on 4/28/26 at 10:05 AM, R10 confirmed R10 still has a pressure injury on R10's left buttock which opened in May 2025. R10 stated R10 previously had a pressure sore on R10's bottom in 2018 which healed by June 2019, and R10 has not had any pressure injuries since 2019. R10 stated R10 thinks it developed because R10 lost weight at the end of 2024 before the wound opened and because R10 is incontinent of bowel. R10 stated R10 has a tilt in space electric wheelchair which R10 uses during the day and can independently maneuver. R10's electronic health record (EHR) documents the following weights:10/2/24: 190.2 pounds (lbs)11/6/24: 186.6 lbs12/5/24: 189.6 lbs1/2/25: 181.0 lbs2/10/25: 175.2 lbs3/5/25: 176.6 lbs4/2/25: 175.4 lbs4/7/25: 176.9 lbs R10's weights and vitals note dated 2/13/25 documents [R10] triggered for gradual weight loss, refuses meals at time with meal intake variable 0-100%. [R10] has goal of weight reduction toward body weight in the 180s. [R10] reported eating most meals and food from the kitchen is hit and miss. [R10] reported [R10] will refuse meals at times due to them being cold and refuses to let staff reheat them. [R10] refused supplements, on Pro-Med twice per day, also orders food from outside the facility frequently and has food in the fridge in [R10]'s room. Recommended to have snacks at bedside for resident to access. Weight stability recommended. R10's physician orders documents the following order: ProMod Liquid (nutritional supplement), give 30 milliliters (mL) orally two times a day related to quadriplegia, with a start date documented as 11/28/2020. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Surveyor was unable to locate any evidence that the facility reassessed the effectiveness of R10's interventions to prevent the development of pressure injuries after R10 experienced weight loss to ensure interventions in place were appropriate for R10's new weight. A progress note in R10's EHR dated 5/2/25 documents [R10] has a pin sized open area in old scar on left buttock. On 4/28/26 at 9:11 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-E who confirmed LPN-E was working on 5/2/25 when R10's wound was discovered. LPN-E stated the open area was initially the size of a pinprick on the day it was found, then it gradually kept getting bigger and bigger because R10 refused to do what the wound team told R10 to do to help the wound heal. LPN-E stated R10 was told not to stay in the wheelchair for longer than 2 hours at a time, but R10 always gets in the wheelchair around 11:30 AM and does not lay back in bed until 5:30 PM every day. LPN-E stated R10 was turned religiously every 2 hours on the dot in bed before the area opened and continues to be turned every 2 hours in bed. R10's interdisciplinary team review note dated 5/5/25 documents clinical review of new skin integrity alteration. [R10] with pinhole sized open area to left buttocks, no signs or symptoms of infection. Skin alteration/risk and interventions reviewed and remain appropriate. [R10] is provided incontinence cares PRN and currently has low air-loss mattress in place. Site of pinhole opening is to already fragile/weakened area of scar tissue as scar tissue is not as elastic or strong as surrounding skin. Area is also subject to moisture at times with being provided incontinence cares as [R10] is incontinent of bowel. Intervention: encourage right sided and back positioning with intermittent positioning to left until wound resolution, ensure skin/backside dry after performing incontinence cares. R10's skin observation tool dated 5/5/26 documents an open area to left buttock 0.5 centimeters (cm) x 0.5 cm x 0.1 cm, no drainage noted, smooth red skin. A wound nurse practitioner (NP) note dated 5/9/25 documents a stage 2 pressure injury to R10's left buttock measuring 0.3 cm x 0.4 cm x 0.1 cm with 100% smooth red tissue, scant serosanguinous drainage. A wound NP note dated 5/16/25 documents an unstageable pressure injury to R10's left buttock measuring 1 cm x 1.5 cm x 0.3 cm with 60% slough and 40% granular tissue, moderate serosanguinous drainage. A wound NP note dated 6/6/25 documents a stage 3 pressure injury to R10's left buttock measuring 2 cm x 1.7 cm x 1.4 cm with undermining 1.4 cm at 2 o'clock with 100% granular tissue. The wound continued to be comprehensively assessed on a weekly basis without significant changes. A wound NP note dated 8/15/25 documents a stage 3 pressure injury to R10's left buttock measuring 1.5 cm x 0.8 cm x 0.8 cm with 2 cm undermining at 1 o'clock with 100% granular tissue. The wound NP that had been assessing R10's Stage 3 pressure injury was no longer employed by the facility and unavailable for interview. R10's initial assessment by Wound Physician (WP)-H dated 8/18/25 documents a stage 4 pressure (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	injury to the left buttock measuring 3.5 cm x 1.5 cm x 2.0 cm with 50% granulation tissue and 50% slough. On 4/28/26 at 11:13 AM, Surveyor interviewed wound registered nurse (WRN)-I who stated every wound professional is going to look at a wound and interpret the wound differently, so WP-H may have seen different things on WP-H's initial assessment than the wound NP saw a few days prior, or the wound could have been measured from a different perspective by WP-H, which is likely why the wound is described differently within a short timeline. The wound continued to be comprehensively assessed on a weekly basis without significant changes. R10's weekly wound documentation dated 9/22/25, documents damage education was provided to [R10] related to being up in the wheelchair with risk of new wound development, worsening of current wound, infection and up to and including death were shared with [R10]. R10's weekly wound documentation dated 10/6/25 documents a stage 4 pressure injury to the left buttock measuring 4.0 cm x 1.0 cm x 1.5 cm with 70% granulation tissue and 30% slough. A nursing note dated 10/6/25 documents order for x-ray of coccyx and sacrum placed by wound care team to rule out osteomyelitis due to worsening wound. X-ray results negative for evidence of osteomyelitis. In an interview on 4/28/26 at 11:22 AM, WRN-I stated an x-ray was ordered on 10/6/25 because WP-H felt bone and there was increased drainage. The wound continued to be comprehensively assessed on a weekly basis without significant changes. R10's weekly wound documentation dated 11/3/25 documents a worsening stage 4 pressure injury to the left buttock measuring 4.0 cm x 2.0 cm x 4.0 cm with 10% granulation tissue, 70% necrosis, and 20% bone. WP-H obtained bone biopsy due to concern for acute osteomyelitis. [R10] was encouraged to refrain from being up in the wheelchair for extended periods of time to promote wound healing and offloading. [R10] reluctant to education. R10's physician orders document the following:-Ciprofloxacin HCl oral tablet 500 milligrams (MG), give 1 tablet by mouth every morning and at bedtime for osteomyelitis until 12/1/25-Doxycycline Hyclate Oral Tablet 100 MG, give 1 tablet by mouth every morning and at bedtime for osteomyelitis until 12/1/25. In an interview on 4/28/26 at 11:29 AM, WRN-I stated R10's bone biopsy results came back showing acute osteomyelitis. WRN-I stated R10 was extremely noncompliant with any of the wound team's recommendations, especially about being up in the wheelchair for prolonged periods of time and the need for offloading. WRN-I stated R10 is compliant with repositioning in bed, but WP-H recommended R10 only be up in the wheelchair for 1-2 hours per day which R10 does not comply to. WRN-I stated R10 is up in the wheelchair for 5-6 hours and goes outside in the warm heat in the summertime which contributes to moisture in the area of the wound. WRN-I stated R10 also does not have good nutritional intake which impacts wound healing. WRN-I stated you can tell the damage to R10's wound is from sitting upright in the wheelchair because the wound is straight up and down. On 4/29/26 at 11:49 AM, Surveyor interviewed WP-H via phone call. WP-H stated R10's wound (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Actual harm Residents Affected - Few	location is easily compromised with stool. WP-H stated R10 is R10's own person and dictates R10's own care, and WP-H can only recommend and suggest to R10 to stay off the wound and limit the time spent in the wheelchair, but R10 has a right not to follow WP-H's recommendations. WP-H stated R10 has a history of being up all day in the wheelchair especially on the weekends. WP-H stated R10's wheelchair does some repositioning but the tilt in space wheelchair does not offer the same offloading as being in bed and repositioned to truly offload the wound. WP-H stated R10 cannot feel when R10 stools or sweats when up in the wheelchair and does not want to get changed if R10 is up in the wheelchair. WP-H stated these things contribute to bacteria in the wound and R10's comorbidities make R10 immunocompromised, which contributed to R10 developing osteomyelitis. WP-H stated R10's wound is improving with the bone no longer exposed and there is healthy granulation tissue present now. R10's MRI (magnetic resonance imaging) report dated 12/3/25 documents left ischial soft tissue defect extending to the underlying bone and resulting in osteomyelitis of the ischial tuberosity. R10's physician orders document the following:-Cipro oral tablet 500 MG, give 1 tablet by mouth 2 times per day for continued osteomyelitis as seen on MRI for 6 weeks-Doxycycline Hyclate oral tablet 100 MG, give 1 tablet by mouth 2 times per day for continued osteomyelitis as seen on MRI for 6 weeks. The wound continued to be comprehensively assessed on a weekly basis without significant changes. R10's most recent weekly wound documentation dated 4/27/26 documents a stage 4 pressure injury to the left buttock measuring 3.0 cm x 2.0 cm x 1.5 cm with 90% granulation tissue and 10% slough. In an interview on 4/29/26 at 11:02 AM, R10 stated yes, the wound team tells R10 to limit time up in the wheelchair, but R10 stated it is difficult to get in and out of the wheelchair, so R10 prefers to just stay in the wheelchair during the day. R10 confirmed R10 requests to get put in the wheelchair around 11:30 AM every day, then R10 asks staff to put R10 back in bed between 5:20-5:30 PM every day. R10 stated R10 must go outside every day because R10 cannot stay in R10's room all day long. On 4/29/26 at 1:09 PM, Surveyor shared concern with WRN-I and Director of Nursing (DON)-B that R10 had weight loss between October 2024 and April 2025, but there is no evidence the facility reassessed R10's interventions to prevent the development of a pressure injury after this weight loss to ensure their effectiveness at R10's new weight. DON-B and WRN-I stated they were not working in the facility at the time of R10's weight loss, so they cannot speak to why interventions were not readdressed or re-evaluated when R10 lost weight. No additional information was provided. 4.) R25 was readmitted to the facility on [DATE] with diagnoses that include Retention of Urine, Cerebral Infarction, Neuromuscular Dysfunction of Bladder and Malnutrition. R25's Quarterly MDS (Minimum Data Set) dated 8/12/25 documents that R25 was assessed to have no impairment to lower or upper extremities and is fully dependent on staff for R25's transfer and rolling left to right while in bed (bed mobility). The MDS documents that R25 was assessed to not have any pressure injuries at the time of the assessment but at risk for the development of pressure injuries. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R25's pressure injury CAA (Care Area Assessment) dated 11/19/25 documents under the Analysis of Findings section: [R25] has a stage 4 pressure ulcer on her left buttock that was house acquired. She is at risk for further pressure ulcer development due to impaired mobility . Extensive assist for bed mobility. Weekly skin assessments by license

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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 record review, the facility did not ensure it completed accurate mandatory submission of staffing information based on payroll data in a uniform electronic format to the Centers for Medicare & Medicaid Services (CMS). This had the potential to affect all 79 residents residing in the facility.Staffing information for Quarter 1 (October 1 - December 31, 2025) of the Payroll Based Journal (PBJ) was not accurately submitted to CMS.Findings include:The CMS Electronic Staffing Data Submission Payroll-Based Journal, Long-term Care Facility Policy Manual, dated June 2022, indicates: 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: (quarter) 1 October 1-December 31, (quarter) 2 January 1-March 31, (quarter) 3 April 1-June 30, (quarter) 4 July 1-September 30.Surveyor reviewed the facility's PBJ Staffing Data Report, CASPER Report 1705D, for Fiscal year 2026 (run on 4/20/2026) which documented the facility had excessively low weekend staffing and a one-star staffing rating for the 1st Quarter (October 1 - December 31, 2025). Surveyor reviewed the facility's weekend schedules from October 2025 through December 2025. Surveyor noted licensed nurses and certified nursing assistants present on each shift, for each unit. Surveyor noted these schedules indicated call ins, agency staff and staff who picked up shifts. Surveyor noted there were numerous call-ins, however the shifts were filled by staff or agency.On 04/28/2026, at 1:04 PM, Surveyor interviewed Scheduler-D and asked to verify nursing staff per shift scheduled in October to December of 2025. Per Scheduler-D, the minimum scheduled on 1st floor was three nurses and three Certified Nursing Assistants for day shift and two nurses with three Certified Nursing Assistants on the NOC shift. On second floor they scheduled three nurses with four Certified Nursing Assistants on the AM shift, two nurses on PM shift with four Certified Nursing Assistants and on the NOC shift one nurse with three Certified Nursing Assistants.Per Scheduler-D the second half of last year was an adjustment period. With a new company coming in, staff was calling in because they didn't want to work. Staff were upset about the new expectations so quit or went prn (as needed). This was an adjustment period. It was a scramble to call in staff or get agency to fill in the gaps, however with agency the gaps were filled. Scheduler-D uses an application called Cover that alerts staff when there is an opening, if the opening isn't picked up then uses agency.Surveyor noted the schedules documented many staff calling in and the openings being filled by staff or agency.On 4/29/2026, at 09:36 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A regarding the facility's low ratings for staffing on the Payroll-Based Journal. NHA-A stated staffing fluctuates and is based on census and acuity. Surveyor discussed the schedules and gave a list of dates that didn't meet the number of staff to schedule given by Scheduler-D. NHA-A stated will review the dates.On 4/29/2026, at 12:30 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-E regarding staffing and was told it is decent. There are a lot of call ins, replacements are usually found. On 4/29/2026, at 12:42 PM, Surveyor interviewed Certified Nursing Assistant-F who stated staffing is okay, been here awhile and it has gotten better over time. Call ins are replaced and weekends are well covered.On 4/29/2026, at 12:45 PM, Surveyor interviewed NHA-A and Chief Nursing Officer-C regarding staffing during October to December and was shown how they reviewed each date given and compared to the census. On days (continued on next page)

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	that were questionable staffing, there was lower census in the building so less staff were needed. The census and number of staff working correlated. The problem they have identified is that the supervisor should be allocating their hours to what they were doing for the shift. Often, they help out on the floor and do not allocate time to show floor coverage so time is recorded as supervisory. They will do education in order to make a change for the future. They have also hired a consulting company to help with Payroll Based Journal reporting.On 4/29/2026, at 01:08 PM, Surveyor let NHA-A know of the concern with Payroll Based Journal reporting being inaccurate for the first quarter of the 2026 fiscal year.No additional information was provided as to why the facility did not accurately submit staffing information for Quarter 1 (October 1 through December 31, 2025) for the Payroll Based Journal (PBJ).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 for 1 of 4 resident unit refrigerators in the facility and 1 of 1 meat/dairy cooler. *Observations of black, moldlike substances in the kitchen walk in cooler.*Ice buildup in the kitchen freezer*Condiments in kitchen walk in cooler were expired and/or not dated.This deficient practice has the potential to affect 62 of 79 residents whom receive food from main kitchen. Findings:The facility's undated policy, titled Food Safety Requirements documents: 1. Food safety practices shall be followed throughout the facility's entire food handling process. This process begins when food is received from the vendor and ends with delivery of the food to the resident. Elements of the process include the following: . b. Storage of food in a manner that helps prevent deterioration or contamination of the food, including from growth of microorganisms.On 04/26/2026, at 8:03 AM, Surveyor did an initial walk through the kitchen. Surveyor noted that in the kitchen's meat/dairy cooler, was an opened container of Sweet Baby Ray's Barbeque Sauce with no open date and expired on 10/8/2025. Surveyor also observed a container of [NAME] Apple Sauce with no open date. Surveyor noted the wall near the back corner of the cooler, near the door to the freezer, has a black, moldlike substance. Surveyor entered the freezer section of the cooler and noted ice chucks on the ground, and ice built up on a pipe on the ceiling. Surveyor spoke with Dietary Lead-S and asked who is usually responsible for the maintenance of the coolers/freezers, Dietary Lead-S informed Surveyor that the cooks are usually responsible for ensuring logs are completed but indicated Kitchen Director-R would be able to answer Surveyors questions better. On 04/26/2026, at 1:05 PM, Surveyor met with Kitchen Director-R to do the tour of the kitchen. Surveyor noted the kitchen cooler was reorganized and the expired condiments were gone. Kitchen Director-R informed Surveyor that Kitchen Director-R went through the kitchen cooler, removed the expired condiments and indicated the cooks should be checking the cooler for expired foods, every night, when time allows. Surveyor asked Kitchen Director-R about the substance on the wall in the cooler, Kitchen Director-R indicated that has been there for a while and has not mentioned it to anyone but indicated it looks to be mold and Kitchen Director-R scrapped it off with the paint, moved all the stuff, and ran soap on the concrete. Surveyor asked about the ice buildup in the freezer, Kitchen Director-R informed Surveyor that the defrost is leaking and built up. Kitchen Director-R indicated the AC unit wasn't working last summer, and it was hot and when the door opened moisture would get in and believe that may have been how it started. The former Maintenance Director was aware but there is a new Maintenance Director and Kitchen Director-R would inform him.On 04/26/2026, at 3:37 PM, Surveyor interviewed Maintenance Director-Q, who started working for the facility at the end of March 2026. Maintenance Director-Q indicated that he was not aware of the mold in the cooler or build up of ice in the freezer and would need to hire out for the maintenance of cooler/freezers in kitchen. Maintenance Director-Q indicated expecting to be made aware of mold in the kitchen cooler and to be made aware of the ice buildup in the freezer to be able to trouble shoot and address it properly. On 04/29/2026, at 10:26 AM, Surveyor observed the resident refrigerator on the 1 South/Vent unit with Nurse Manager-N. Surveyor observed condensation on the inside back of the refrigerator, a plastic bag with food items not labeled or dated, breaded chicken on a plate with no labeled or date. Surveyor reviewed the temperature log for April and noted on 4/18/2026, 4/19/2026, 4/20/2026, 4/21/2026, 4/25/2026, 4/26/2026, 4/27/2026 and 4/29/2026 all had temperature ranges above 41 degrees Fahrenheit, with no corrective action taken. Nurse Manager-N informed Surveyor she would need to look into the concern further and get back to Surveyor.On 04/28/2026, at 3:23 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B. Surveyor was informed that the facility hired a restoration/remediation company, who is coming at the end of (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the week to look more into the black, mold like substance in the kitchen cooler and the ice buildup in the freezer. NHA-A indicated she expects to be notified, as well as maintenance, right away of these types of concerns so a proper intervention and follow up can occur.On 04/29/2026, at 12:46 PM, Surveyor informed NHA-A and DON-B of the concerns with the 1 South Vent unit refrigerator for resident food. Surveyor was informed that the food in fridge should be dated and labeled with resident name. Any concerns with fridge temperatures should be brought to DON-B and maintenance should be notified to evaluate. DON-B indicated that the 1 South Vent unit refrigerator has a different log than the other refrigerators on the units which are managed by the kitchen. Will update 1 south log for all refrigerators to be uniform and have ranges listed. No additional information was provided.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and interview, the facility did not ensure a safe, clean, comfortable, and homelike environment for 1 (R49) of 18 residents.*The facility experienced water damage to the ceiling in R49's room causing R49 to be concerned of ceiling integrity and organic growth. The facility did not remediate the water damage to R49's ceiling in a timely manner.Findings include:On 04/26/2026, at 9:40 AM, Surveyor interviewed R49. R49 informed Surveyor that water has leaked from ceiling multiple times over last month causing water damage to the ceiling tiles. Surveyor noted brown stained blotches on the ceiling above R49's bed, and above R49's doorway. R49 stated R49 mentioning the concerns to Director of Nursing (DON)-B multiple times but feels it has been shrugged off. R49 informed Surveyor that R49 has also talked to maintenance and they are having a hard time finding tiles. R49 is concerned for the integrity of the ceiling and would like the tiles taken down.On 04/27/2026, at 10:37 AM, Surveyor interviewed Maintenance Director-Q who indicated being newer to his role. Maintenance Director-Q informed Surveyor there have been no leaking pipes over the last month but due to a toilet overflowing on occasions, the ceiling tiles need to be replaced in R49's room due to water damage. Maintenance Director-Q indicated that today is the first Maintenance Director-Q knew of the concern. Maintenance Director-Q stopped by R49's room about an hour ago to say hello, when R49 pointed out the ceiling tiles. Maintenance Director-Q indicated that the facility should be getting replacement tiles for R49's room soon. On 04/27/2026, at 11:13 AM, Surveyor interviewed Maintenance-P who has worked at the facility for 12 years. Maintenance-P indicated being aware of the water damage to the ceiling in R49's room, explaining that an overflowing toilet upstairs came down to R49's room which happened about 2 weeks ago. Maintenance-P was notified by one of the maintenance technicians after the fact and indicated R49's ceilings would need new tiles. Maintenance-P stated the facility now has tiles but Maintenance-P has not got to it yet and that caulk was used previously in some of the areas that had water damage from previous times. Maintenance-P stated none of the new tiles have been taken down or replaced yet, and that Maintenance-P is just waiting for the time to get in there to do it. On 04/28/2026, at 9:13 AM, Surveyor went into R49's room and noted the water damaged ceiling tiles have been taken down. R49 was resting in bed and expressed being very happy that maintenance had now started working on the ceiling.On 04/28/2026, at 3:23 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B and was informed that the water damage to the ceiling tiles in R49's room were from a recent leak and that the facility was waiting for it to dry out, before putting nails in to replace the tiles. No additional information was provided.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility did not ensure all alleged violations of neglect were reported immediately to the State Agency, but not later than 24 hours after the allegation was made for 1 of 2 Facility Reported Incidents (FRI) reviewed. The facility received notification that R10 made an allegation of neglect on 1/23/26 at 7:00 PM and did not report the allegation to the State Agency until 1/26/26 at 3:14 PM. Findings include: The facility policy, entitled Abuse, Neglect and Exploitation, with no implemented or revised date documents: Policy: it is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g. law enforcement when applicable) within specified timeframes: . not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.On 4/27/26, Surveyor reviewed the FRI (facility reported incident) with an initial submission date of 1/26/26 to the State Agency, which documents: On 1/26/26, an email was reviewed by the facility administrator containing an allegation of neglect. The FRI investigation documents an investigation was initiated immediately upon review of the grievance. After a thorough investigation of all potential witnesses, the facility was unable to substantiate the allegation of neglect. The alleged staff member discontinued employment at the facility prior to the grievance being received. On 4/27/26 at 3:06 PM, Surveyor requested the email Nursing Home Administrator (NHA)-A received from R10 on 1/26/26. On 4/28/26 at 7:43 AM, NHA-A provided Surveyor with a copy of the email contents that R10 sent to NHA. Surveyor noted there is no date provided on the email contents and NHA-A stated NHA-A was having issues printing the actual email and was only able to print the contents of the email for Surveyor to review. Surveyor notes the email included a grievance form which documents date submitted as 1/14/26. On 4/29/26 at 8:41 AM, Surveyor asked NHA-A when NHA-A received the email from R10 with a grievance alleging neglect from a staff member. NHA-A stated NHA-A received the email from R10 on 1/23/26 at 7:00 PM. NHA-A stated R10 always emails any grievances to NHA-A because NHA-A is the grievance officer for the facility and R10 prefers to send the grievances in email form due to physical limitations limiting R10's ability to write. NHA-A stated NHA-A often receives emails from R10 with grievances on the weekends or overnight after NHA-A has left the facility for the day. NHA-A stated NHA-A was out of town the weekend NHA-A received the email from R10 on 1/23/26, so NHA-A did not check NHA-A's email until returning to work on 1/26/26. NHA-A stated once NHA-A read the email from R10 on 1/26/26, NHA-A realized R10 was making an allegation of neglect and reported the alleged neglect to the State Agency on 1/26/26.Surveyor shared the concern with NHA-A that R10 notified NHA-A of an allegation of neglect on 1/23/26, but it was not reported to the State Agency until 1/26/26, which is later than 24 hours of receiving the allegation. NHA-A stated R10 should have called NHA-A with any concern about potential abuse or neglect, but R10 emailed NHA-A instead, and NHA-A does not check NHA-A's email 24 hours a day.No additional information was provided regarding why the facility did not report R10's allegation of neglect within 24 hours of receiving notification of the alleged violation.

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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 2 (R25 & R57) of 2 residents were notified of the reason for transfer/discharge & bed hold policy in writing to the resident & their representative and the rate to reserve the resident's bed was not documented in the Transfer, Bed hold Notice form. * There is no evidence R25 and/or R25's representative was provided a copy of the bed hold/ transfer notice for R25's hospitalization on 7/19/2025 and the bed hold notice did not document the bed hold rate for R25's hospitalization on 10/27/2025. * R57 was transferred to the hospital on 3/25/2026 and 4/10/2026. The bed hold and transfer notices for the two separate transfers were combined and not individualized for each transfer. Findings include: The facility policy titled Bed Hold Notice with no initiated or reviewed/revised date documents: It is the policy of this facility to provide written information to the resident and/ or the resident representative regarding bed hold practices both well in advance, and at the time of, a transfer for hospitalization or therapeutic leave. Policy Explanation and Compliance Guidelines:1. at the time of transfer to the hospital . the facility will provide a resident and/ or resident representative written information that specifies:a. The duration of the State bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility.b. The reserve bed payment policy in the state plan policy.2. In the event of an emergency transfer of a resident, the facility will provide written notice of the facility's bed-hold policies to the resident and/ or resident representative within 24 hours. The facility will document multiple attempts to reach the resident's representative in cases where the facility was unable to notify the representative. 3. The facility will keep a signed and dated copy of the bed-hold notice information given to the resident and/or resident representative in the resident's file and/ or medical record. 1.) R25 was admitted to the facility on [DATE] and has diagnoses that include Multiple Sclerosis (autoimmune disease of the central nervous system affecting the brain, spinal cord, and eye nerves), Alzheimer's Disease, anxiety disorder, and metabolic encephalopathy (brain dysfunction). R25's annual Minimum Data Set (MDS) dated [DATE] documents R25 was assessed to have intact cognition with a Brief Interview for Mental Status (BIMS) score of 13. R25's power of attorney (POA) was activated. R25 was transferred and admitted to the hospital on [DATE] and re-admitted to the facility on [DATE]. Surveyor reviewed R25's bed hold/ transfer forms for R25's hospitalization on 7/19/2025. Surveyor noted there is no evidence R25 and/or R25's activated POA signed or received a copy of the bed hold/ transfer form for R25's hospitalization on 7/19/2026. R25 was transferred and admitted to the hospital on [DATE] and re-admitted to the facility on [DATE]. (continued on next page)

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	525108	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Resolve at West Allis Respiratory and Rehab	9047 W Greenfield Ave West Allis, WI 53214

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed R25's bed hold/ transfer forms for R25's hospitalization on 10/27/2025. Surveyor noted there is no evidence R25 and/ or R25's activated POA signed the forms, were notified of the bed hold rate, or were provided copies of the bed hold/ transfer forms for R25's hospitalization on 10/27/2025. On 4/28/2026, at 3:23 PM, Surveyor shared concerns with nursing home administrator (NHA)-A concern R25 and R25's activated power of attorney was not provided the bed hold rate, provided bed hold/ transfer forms to sign, and was not provided a copy of the bed hold/ transfer forms for R25's transfer and admission to the hospital on 7/19/2026 and 10/27/2025. NHA-A replied during those months the facility was not providing a copy to the resident and/or the resident representative. NHA-A was not sure why the rates were not provided or documented for R25's transfers to the hospital on 7/19/2025 and 10/27/2025. 2.) R57 was admitted to the facility on [DATE] with diagnoses of acute respiratory failure with hypoxia, chronic obstructive pulmonary disease, diabetes, Barrett's esophagus, cerebral infarction, dysphagia, and history of cardiac arrest. R57's admission Minimum Data Set (MDS) assessment dated [DATE] documented that R57 was assessed to be cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 and had a feeding tube where the majority of nutrition was provided and on a mechanically altered diet. The MDs documents that R57 was assessed to require suctioning from the tracheostomy and received Speech, Occupational, Physical, and Respiratory Therapies. R57 had an activated Power of Attorney (POA). On 3/25/2026 at 6:09 PM in the progress notes, nursing documented they were called into R57's room by Respiratory Therapy (RT). RT told the nurse R57 was choking on Jello and they needed to bag R57 and increase oxygenation to 10 liters with oxygen saturation at 90%. The nurse contacted the physician, and an order was obtained to send R57 to the hospital for evaluation and treatment. The nurse called R57's POA to provide an update with a verbal confirmation to hold the bed and send R57 to the hospital. A Bed Hold Notice form was completed by the nurse that sent R57 to the hospital. The form indicated the POA gave verbal authorization on 3/25/2026 at 5:35 PM. The facility staff signed the form on 3/26/2026, the following day. The Notice of Resident Transfer or Discharge form was completed on 3/25/2026 documenting R57's needs could not be met by the facility for decreased oxygenation with episodes of choking. The form was signed by R57's POA and dated 3/21/2026, four days before the transfer. On 4/9/2026 at 2;44 AM in the progress notes, nursing documented R57 complained of nausea and dizziness. Vital signs showed an elevated heart rate and low oxygenation. R57 was coughing up clear frothy sputum. R57 was given their scheduled medications and breathing treatment as needed. R57's oxygen saturation would not remain stable even after oxygen was increased to 10 liters. The nurse called the on-call physician and received an order to send R57 to the hospital for evaluation and treatment. The Bed Hold and Notice of Resident Transfer forms were scanned into R57's medical record. The forms were from R57's 3/25/2026 transfer with the addition of R57's POA signing the Bed Hold Notice on 4/12/2026. All other information written on the forms was from 3/25/2026 including R57's POA signature on the Notice of Resident Transfer dated 3/21/2026. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/27/2026 at 3:05 PM, Surveyor asked Director of Nursing (DON)-B what the facility process was for the Bed Hold and Notice of Resident Transfer paperwork. DON-B stated the nurse on the unit who is sending the resident out to the hospital gets a verbal confirmation from the POA for the bed hold and transfer notice. DON-B stated the nurse will then scan the original form to the resident's medical record and when the form comes back with a signature from the POA, they add the second form to the record. Surveyor shared with DON-B the concern R57's Bed Hold and Notice of Resident Transfer forms for 3/25/2026 and 4/9/2026 were the same documents scanned in twice. DON-B stated the nurse uploaded the form from the first hospitalization for both dates and the night nurse put the wrong date on the form originally since R57 went out earlier in the shift when it was 3/25/2026 and later in the shift it was 3/26/2026 since it was then after midnight. DON-B stated the POA signed the completely wrong date and could not explain why that had been done or why it had not been corrected. DON-B agreed R57's second hospitalization did not have the correct forms completed. Nursing Home Administrator (NHA)-A was present at the time of the interview and understood the concern with not having the notices completed correctly. No additional information was provided.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure dependent residents received the necessary services to maintain nail care for 1 (R5) of 5 residents reviewed for activities of daily living (ADLs).R5, an ADL dependent resident, was observed with long and dirty fingernails from 4/26/26 to 4/28/26.Findings include: The facility's undated policy, titled Nail Care, documents: Policy: The purpose of this procedure is to provide guidelines for the provision of care to a resident's nails for good grooming and health. Policy Explanation and Compliance Guidelines: .2. Identify conditions that increase risk for foot or nail problems, such as diabetes, peripheral vascular disease, heart failure, renal disease, or stroke. 3. Routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis. 4. Routine nail care, to include trimming and filing, will be provided on a regular schedule. Nail care will be provided between scheduled occasions as the need arises.R1 was admitted to the facility on [DATE] with diagnoses that include diabetes, atrial fibrillation, chronic obstructive pulmonary disease, depressive and anxiety disorder.R5's Minimum Data Set (MDS) annual assessment, dated 1/10/26, documents a Brief Interview for Mental Status (BIMS) score of 9, indicating moderate cognitive impairment. The MDS documents that R5 was assessed to be dependent for performing oral hygiene, toileting, shower/bathe, upper/lower body dressing and personal hygiene. On 04/26/2026 at 12:05 PM Surveyor observed R5's fingernails long at approximately 1/2 inch in length and dirty under the nails. Surveyor asked R5 if staff cut R5's fingernails and R5 stated, no one has ever cut them or offered to cut them.R5's Care Plan, dated 2/23/25, documents R5 requires assistance with ADL's r/t (related to) weakness, decreased mobility, pain. The goal is R5's risks for decline inADL abilities will be minimized through review date. Interventions include, in part. Dressing Assist: (Total Dependence) Assist of 1. Personal Hygiene Assist: (Total Dependence) Assist of 1, Showering Assist: (Total Dependence) Assist of 1, Toileting Hygiene Assist: (Total Dependence) Assist of 1.R5's Physician Orders, dated 4/13/26, documents, SHOWER DAY (sic): Monday PM; Document refusals. Nurse to perform Skin Observation in Evaluations and verify shower was completed. Document any skin concerns and update MD/management/Wound Team if needed; every evening shift every Mon (sic) for Shower.R5's Skin Monitoring Comprehensive Certified Nursing Assistant (CNA) Shower Review Sheets, dated 11/3/25 through 4/20/26, documents: Nail Care Completed: Yes, No or Not needed at this time. None of the sheets have documented a Yes or a nurse documenting nail care was provided under the comment section. Surveyor noted, six months of shower sheets were reviewed with R5 receiving a shower every Monday evening. On 04/28/2026 at 7:50 AM, Surveyor observed R5 sleeping in bed supine with hands visible. R5's fingernails were long and dirty and several of R5's fingernails were at least 1/2 inch long. On 04/28/2026 at 7:53 AM Surveyor interviewed Licensed Practical Nurse (LPN)-L who stated, if a resident is diabetic, the nurses have to trim the residents' fingernails. Surveyor asked LPN-L, when does fingernail trimming occur. LPN-L stated this typically occurs when the CNA's shower the residents and the need to cut fingernails is evaluated at that time. If the resident's fingernails need trimming, the CNA's tell the nurse and the nurse will trim the fingernails or if the nurse notices a need for fingernail trimming, it will done at that time. Surveyor asked where fingernail trimming is documented and LPN-L stated, it is not documented.Surveyor asked LPN-L if LPN-L noticed R5's fingernails were long and dirty and LPN-L stated LPN-L had not noticed. Surveyor asked LPN-L if LPN-L could accompany Surveyor to R5's room to observe fingernails. LPN-L and Surveyor entered R5's room together and observed R5's fingernails to be long and dirty underneath the nail. LPN-L acknowledged that R5's fingernails were long and dirty, and LPN-L stated LPN-L would be taking care of trimming R5's fingernails today. Surveyor asked if LPN-L would also be cleaning underneath the fingernails and LPN-L stated, LPN-L will clean with an orange stick that is used to specifically clean underneath the nails.On 04/28/2026 at 1:16 PM, Surveyor observed R5 lying in bed (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	supine watching TV with trimmed and clean fingernails.On 04/28/2026 at 3:31 PM, Surveyor asked Director of Nursing (DON)-B what the process for trimming fingernails for diabetic residents. DON-B stated that the CNA's can file the fingernails but cannot cut but the nurses can only cut the fingernails of diabetic residents. The CNA's will notify the nurses on shower days if a diabetic resident fingernails need to be trimmed. The nurse should also be doing the skin assessment after every resident shower and determine if fingernails need to be trimmed as well. On 04/28/2026 at 3:32 PM Surveyor notified Nursing Home Administrator (NHA)-A and DON-B of concerns regarding observations of R5's fingernails long and dirty. LPN-L has since cut and cleaned nails.No additional information was provided.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure 1 (R25) of 18 residents received treatment and care in accordance with professional standards of practice.*R25 had a peripherally inserted central catheter (PICC) line placed on 4/13/26. R25 has an MD order for the PICC line dressing to be changed every 7 days. Surveyor observed R25's PICC line dressing on 4/26/26 and 4/28/26. During observation, R25's PICC line dressing was dated 4/13/26, indicating that R25's PICC line dressing was not changed from 4/13/26 to 4/28/26. R25's IV medication care plan was not initiated until 4/27/26, which is 2 weeks after the PICC line was placed. Findings include:The facility policy dated 10/2024 and titled, Dressing change for vascular access devices, documents, in part: Purpose-To prevent local systemic infection related to the IV catheter. Policy- A sterile dressing is maintained on all peripheral and central vascular access devices to protect the site, provide a microbial barrier and to provide vascular access device securement. Central venous access device and peripheral midline dressings are changed every 7 days and immediately if the integrity of the dressing is compromised, if moisture, drainage or blood is present, or for further assessment if infection is suspected. Central venous access device dressing change procedure. Remove old dressing. Assess site. Clean an area larger than dressing to be applied. Apply transparent dressing. Secure catheter and IV tubing. Apply label on dressing with date and nurse's initials.R25 was admitted on [DATE] and had diagnosis that include Stroke (an instance where blood flow to the brain is blocked), Alzheimer's disease (progressive irreversible brain disorder that destroys memories), Pulmonary embolism (life threatening blockage in a lung artery), Pressure ulcer (localized skin and tissue damage caused by prolonged pressure, friction, or shear, usually over bony areas) and Osteomyelitis (serious bone infection).R25's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documents that R25 is cognitively intact.R25's progress note dated 4/13/26 documents: Per new orders [R25] needs PICC line for IV [antibiotics] therapy and new IV [antibiotics]. [Nurse Practitioner] to place orders.R25's progress note dated 4/13/26 documents: Dynamic access placed 44cm single lumen PICC to right brachial [vein].R25's MD order with a start date of 4/13/26 documents: Intermittent IV medication infusion- Flush using [saline-administer-saline] technique with 10 [milliliters (ml)] normal saline before med and 10 ml after med. Two time a day for PICC patency.R25's MD order with a start date of 4/14/26 documents: Change catheter site dressing with site change [Every] 7 days and [as needed]. Label with date/time/initials. One time a day every 7 days.R25's IV Medication care plan initiated 4/27/26 documents the following pertinent interventions, in part: If IV is infiltrated: stop infusion and thoroughly examine the site. If the catheter appears to be lodged in the tissues, an attempt to aspirate any fluid remaining in the catheter can be made in order to lessen the amount of drug at the site. IV dressing: Observe dressing with each med administration. Change dressing and record observations of site per order, [as needed]. Monitor/document/report [as needed] [signs and symptoms] of infection at the site: drainage, inflammation, swelling, redness, warmth. Monitor/document/report [as needed] [signs and symptoms] of leaking at the IV site.Surveyor noted that facility staff initiated an IV care plan on 4/27/26, which is 2 weeks after R25 had R25's PICC line placed.On 4/26/2026 at 10:44 AM, Surveyor observed R25. R25 had antibiotic medication running into right arm PICC line. The date on the PICC line dressing is 4/13/26.On 4/28/26 at 1:13 PM, Surveyor observed R25. R25's PICC line dressing is dated 4/13/26.Surveyor noted that R25's MD order documented that R25's PICC line dressing should be changed every 7 days and labeled with date, time and initials. Surveyor noted that during observations, R25's date on R25's dressing was labeled with the date of 4/13/26 indicating that R25's dressing had not been changed and re-labeled from 4/13 through 4/28/26.On 4/28/26 at 1:15 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-G. Surveyor asked what is needed if a resident has a PICC line. LPN-G indicated that the resident would have orders for a PICC line dressing change every 7 days and would (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have a care plan.On 4/29/2026 at 9:21 AM, Surveyor observed R25. The date on R25's PICC line dressing is 4/28/26. Surveyor noted that facility staff changed and re-labeled R25's PICC line dressing after Surveyor's observation on 4/28/26.On 4/29/26 at 9:33 AM, Surveyor interviewed Director of Nursing (DON)-B. Surveyor asked what the expectation is for nursing staff regarding PICC lines. DON-B stated that there is an order for a dressing change every 7 days. When it is due, if there is an LPN working, the LPN will let the Registered Nurse (RN) Supervisor know that the dressing is due for a change. The RN Supervisor will change the dressing and document that. Surveyor asked if there should be a care plan and asked if DON-B would expect staff to follow the MD order. DON-B indicated that there should be a care plan, and staff should follow the MD order. Surveyor shared the following concerns that R25 had a PICC line placed on 4/13/26. A care plan was not initiated until 4/27/26. Surveyor observed on 4/26/26 and 4/28/26, that R25's PICC line dressing was dated 4/13/26. R25's MD order states that the dressing should be changed and dated with the date of change. When Surveyor observed R25's PICC line today 4/29/26, the dressing was dated 4/28/26 indicating that R25's dressing was changed after Surveyor's observation on 4/28. R25 went from 4/13/26 to 4/28/26 without a dressing change. DON-B understood the concerns.On 4/29/26 at 2:45 PM, Surveyor informed Nursing Home Administrator (NHA)-A of the above concerns. No additional information was provided.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure staff followed infection control procedures for 1 (R25) of 2 residents reviewed with an indwelling catheter.* R25's catheter bag was observed lying directly on the ground without a barrier. R25 is considered high risk for infection with a history of urinary tract infections (UTIs) with sepsis.Findings include:R25 was admitted to the facility on [DATE] and has diagnoses that include Multiple Sclerosis (autoimmune disease of the central nervous system affecting the brain, spinal cord, and eye nerves) , Alzheimer's Disease, obstructive and reflex uropathy (blockage in the urinary tract that stops urine from flowing), anxiety disorder, metabolic encephalopathy (brain dysfunction) , neuromuscular dysfunction of the bladder, retention of urine and history of urinary tract infections with Sepsis.R25's annual Minimum Data Set (MDS) dated [DATE] documents that R25 was assessed to have intact cognition with a Brief Interview for Mental Status (BIMS) score of 13 and needing extensive assist with 1 staff member for Activities of Daily Living (ADLs). The MDS also assessed R25 to have an indwelling catheter with a history of Urinary Tract Infections (UTIs) and always incontinent of bladder. R25's chronic indwelling foley catheter related to neurogenic bladder, . and is at risk/ has a history of UTI's care plan initiated on 1/11/2023 has the following interventions:- CATHETER: (R25) has a 16F coude (angled tip on catheter tubing instead of a straight tip) catheter. Position catheter bag and tubing below the level of the bladder and away from entrance room door.- Check tubing for kinks every shift.- Observe for pain/ discomfort due to catheter.- Observe as needed for signs/ symptoms of UTI: .- Change Catheter bag as needed (Initiated: 10/3/2023).- Change foley catheter when occluded (blocked) or unable to flow freely as needed for patency. - Provide foley catheter care every shift and as needed.- Secure indwelling catheter tubing using an anchoring device to prevent movement and urethral traction every shift.On 4/26/2026, at 11:04 AM, Surveyor observed R25 lying in bed watching TV. Surveyor observed R25's catheter bag hanging off the right side of the bed, viewable from the room entrance doorway and the bottom of the catheter bag was touching the ground directly without a protective barrier. Surveyor asked R25 how often facility staff provide care to R25's catheter and how often they empty the catheter bag. R25 stated staff just emptied the bag and was unable to recall how often staff provided cares or emptied R25's catheter bag. Surveyor asked if the catheter has been in place for a while and if R25 ever got UTI's. R25 stated having the catheter for a very long time and frequently got UTI's but was unable to provide when R25 last had a UTI. On 4/29/26 at 1:11 PM, Surveyor informed WRN-I and DON (Director of Nursing)-B, of the observation of R25's catheter bag lying on the ground without a protective barrier and R25 is already considered a high risk for developing UTI's. No additional information was provided.