STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525172	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jewish Home and Care Center	1414 N Prospect Ave Milwaukee, WI 53202

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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on interview and record review, the facility did not ensure residents' advanced directives were implemented. This was observed with 2 (R102 and R24) of 2 residents reviewed for advanced directives. The failure to implement advanced directives has the potential to affect all 82 residents in the facility. * R102 elected a DNR (Do Not Resuscitate) status, and the paperwork was not processed as required. The facility did not honor R102's request and R102 received CPR on [DATE]. * R24 completed paperwork to request a Do Not Resituate (DNR) status and the facility did not honor this request and performed Cardiopulmonary Resuscitation (CPR). The facility's failure to honor residents' advance directives requesting no CPR created a finding of Immediate Jeopardy that began on [DATE]. Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B were notified of the Immediate Jeopardy on [DATE] at 10:40 AM. The immediate jeopardy was not removed at the time of exit on [DATE]. Findings include:The facility's policy and procedure CPR-Cardiopulmonary Resuscitation dated 1/17 documents It is the policy that (name of the corporation) will provide basic life support, including CPR-Cardiopulmonary Resuscitation, when a resident requires such emergency care, prior to the arrival of emergency medical services, subject to physician order and resident choice indicated in the resident's advance directives.Nurses and other staff are educated to initiate CPR, as recommended by the American Heart Association (AHA) unless: A valid Do Not Resuscitate order is in place. Resident presents with obvious signs of clinical death (e.g., rigor mortis, dependent lividity, decapitation, transection or decomposition) are present. Initiating CPR could cause injury or peril to the rescuer. 1.) R102 was admitted to the facility on [DATE] with diagnoses of cellulitis of left lower limb, dementia, and anxiety. The admission Minimum Data Set (MDS) assessment dated [DATE] documents R102 had severe cognitive impairment and needed maximum assistance with showers and dressing. R102 was able to move in bed independently. R102's medical record documents R102 was deemed incapacitated at the hospital on [DATE]. R102's Power of Attorney for Health Care (POAHC) document dated [DATE] documents R102's (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525172	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/06/2026
NAME OF PROVIDER OR SUPPLIER Jewish Home and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1414 N Prospect Ave Milwaukee, WI 53202	

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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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	POAHC agents. R102's advanced directives include a living will which documents R102 did not want a feeding tube if there was a diagnosis of a terminal condition, did not want life-sustaining procedures used in a persistent vegetative state, and no feeding tubes if in a vegetative state. R102's POAHC signed R102's Cardiopulmonary Resuscitation (CPR) preference form upon R102's admission to the facility. R102's CPR preference form was dated [DATE] and documents in the event of a Cardiopulmonary Arrest, R102 did not want cardiopulmonary resuscitation (CPR) attempted. The form also documents, I understand that if I have chosen not to receive CPR attempts in the event of a cardiopulmonary arrest, my physician must provide, for inclusion in my medical record, an order to withhold CPR, based in part on my preferences indicated above. This form was signed by R102's activated POAHC agent. Surveyor notes on [DATE], R102's activated POAHC elected a DNR status for R102 and signed the State of Wisconsin, Department of Health Services, Emergency Care Do Not Resuscitate Order (DNR) form. Surveyor notes the State of Wisconsin DNR form documents, only the Do Not Resuscitate (DNR) bracelet identifies to the Emergency Medical Service Responders that you are DNR. This form cannot be used to communicate your wishes to Responders. This form is a legal document and is used to request a DNR bracelet by the attending physician on the patient's behalf. This form also provides specific care instructions for health care providers responding to emergency calls. If this form is appropriately completed, emergency personnel should limit care as outlined. The document clarifies what emergency providers will and will not provide if a patient has the DNR bracelet. Emergency providers as appropriate will provide: clear airway, administer oxygen, position for comfort, splint, control bleeding, provide pain medication, provide emotional support and contact hospice or home health agency if either has been involved in patient's care or patients attending physician. Emergency provider will not: Perform chest compressions, insert advanced airways, administer cardiac resuscitation drugs provide ventilator assistance and defibrillate. On [DATE] R102's nurses note documents, (R102) brought to nurses' station at 1547 (3:47 p.m.) by PT (physical therapist) due to breathing heavy, cool and clammy and not responding, attempted to take blood sugar, seizure start lasting 3 mins (minutes) at 1550 (3:50 p.m.) attempted to take vital signs resident became unresponsive @ (at) 1551(3:51 p.m.), Supervisor checked for response tap shoulder, checked for stimuli on cheek, sternal rub. At 1552 (3:52 p.m.) 911 and POA called message left for a return call. @ 1554 (3:54 p.m.) Oxygen applied, @1555 (3:55 p.m.) CPR started. At 1558 (3:58 p.m.) Front desk call due to STAT (immediately, without delay) announcement, POA and other family members called messages left on voice mails for return call. At 1600 (4:00 p.m.) Announcement made on overhead for stat to 2nd floor. At 1601 (4:01p.m.) Paramedics arrived CPR continued. At 1605 (4:05 p.m.) Fire Department arrived and made aware of DNR. At 1614 (4:14 p.m.) CPR stopped. Resident was pronounced dead at 1620 (4:20 p.m.). Surveyor notes R102's State of Wisconsin DNR form was not signed by a physician until [DATE] after R102 received CPR and passed away on [DATE]. The paramedic report dated [DATE] documents the paramedics arrived at 4:01 p.m. and found the facility staff performing high quality CPR. The facility staff explained to the paramedics R102 was in (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	physical therapy and collapsed in the hallway. The staff explained to the paramedics they started CPR immediately and continued until the fire department arrived on scene. The report documents the paramedics stated R102's cardiac rhythm was asystole (life-threating form of cardiac arrest characterized by the total cessation of electrical and mechanical activity of the heart.). The report also documents the facility staff informed the paramedics they thought R102 was a DNR. The paramedics informed the staff R102 did not have any DNR identification on such as a DNR bracelet, so CPR continued. The paramedic report continues to indicate manual CPR was switched over to mechanical CPR and they obtained intraosseous (A rapid, temporary vascular access method used in emergencies to deliver fluids and medications directly into the bone marrow when intravenous (IV) access is unattainable) access in the left tibia. Also, a laryngeal mask airway (a device used during emergency care to maintain an open airway.) was placed. The report documents staff were trying to produce various types of paperwork regarding R102's code status. The report documents staff produced the State of Wisconsin DNR form, but it lacked the signature of the physician. Other documentation was produced for the paramedics. The report documents they waited for a second State of Wisconsin DNR form with the physician's signature. The report documents the signature was digital and they communicated with the paramedic's supervisor with the information gathered and it was decided to stop CPR at 4:20 p.m. During the resuscitation, the paramedic report documents R102 received twice 1 milligram (MG) of epinephrine. R102 remained asystole the whole-time resuscitation efforts were being performed. On [DATE], at 10:34 a.m., Surveyor interviewed Assistant Director of Nursing (ADON)-C. ADON-C stated she is the manager of the 2nd floor, where R102 resided. Surveyor asked ADON-C what her role was on [DATE], when R102 went unresponsive. ADON-C stated she was on the unit and saw someone from PT wheel R102 to the nurse's station and tell the floor nurse, who was an agency nurse, that R102 wasn't feeling well. ADON-C stated the floor nurse asked a CNA to get a set of vitals when R102's head went back. ADON-C stated the floor nurse then tried to get a set of vitals but was unable to get readings. The floor nurse did a sternal rub with no response from R102. They lowered R102 to the floor and did another sternal rub. They called for a nurse STAT, which is for additional nursing support. ADON-C stated they did rescue breaths and attached the AED to R102. ADON-C stated she then looked at R102's chart and told the floor nurse R102 is a DNR. Surveyor asked how did she know R102 was a DNR. ADON-C stated R102's chart in the nurse's station had a red cover and that indicates DNR status. ADON-C stated she was called to a different floor for a resident who had fallen and Licensed Practical Nurse (LPN)-S, House Supervisor, was left with the floor nurse. ADON-C stated the agency floor nurse was also an LPN who was not familiar with R102. ADON-C stated she received a phone call stating the paramedics were at the facility and were doing CPR and needed information regarding R102's CPR status. ADON-C stated she gave the paramedics the State of Wisconsin DNR form, that was not signed by the physician at that time. ADON-C stated she also gave them R102's POAHC and living will forms. ADON-C stated the paramedics stated they were unable to verify R102's CPR status from those forms. ADON-C stated they called R102's physician, but he did not call back. They also called R102's family and they also did not call back. ADON-C stated eventually the paramedics called their lieutenant and were able to stop CPR. Surveyor asked ADON-C who called the nurse stat and 911. ADON-C stated Health Information Coordinator (HIC)-N was the one who called nurse stat and 911. On [DATE], at 10:40 a.m., Surveyor interviewed HIC-N. Surveyor asked HIC-N if she called the nurse stat and called 911 on [DATE]. HIC-N stated she was told to call a nurse stat by a nurse but doesn't remember which nurse. HIC-N stated it was so busy that day that she doesn't recall much of what happened on [DATE]. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE], at 1:11 p.m., Surveyor interviewed Director of Nursing (DON)-B. Surveyor asked DON-B what is the expectation when a resident's wishes are to be a DNR. DON-B stated if the resident is a DNR and they experience a change in condition the staff treat the change, can give oxygen and can call 911 but no chest compression is to be performed. On [DATE], at 3:46 p.m., Surveyor interviewed LPN-S. LPN-S stated she doesn't remember much about that incident. LPN-S stated she remembers PT bringing R102 to the nurse's station because R102 was feeling unwell. LPN-S stated the floor nurse told her R102 was having a seizure and LPN-S told the floor nurse to time the seizure. LPN-S stated she reached out to check R102 pulse and didn't find a pulse. LPN-S stated they then called a code. LPN-S stated she doesn't know who called 911. LPN-S stated everything moved so fast. Surveyor asked LPN-S if someone checked the code status on R102. LPN-S stated she knows someone did and told them R102 was a DNR but doesn't remember much after that. On [DATE], at 3:10 p.m., during the daily exit meeting with Nursing Home Administrator (NHA)-A and DON-B, Surveyor explained the concern R102's wishes were to be a DNR and R102's POAHC signed the State of Wisconsin DNR form, but the facility did not have the physician sign the form. Surveyor also explained the concern the facility staff proceeded with CPR even though they had knowledge of R102's wishes for no life saving measures. Surveyor explained there was lack of clear information provided by the facility staff to the paramedics that arrived to assist R102 so CPR continued until R102's code status could be clearly identified. On [DATE], at 9:18 a.m., Surveyor interviewed DON-B. DON-B stated as a nurse if there isn't a legally signed DNR form by the physician, nurses are required to do CPR. Surveyor explained the concern is R102 was admitted to the facility with wishes for no life sustaining measures, and the facility did not follow through with obtaining the physician signature to ensure the DNR form was legal and valid. R102 received intensive life saving measures due to the facility's lack of follow-through regarding R102's wishes. DON-B understood the concern and had no additional information. 2.) R24 was admitted to the facility on [DATE] with a diagnosis of lung cancer and breast cancer. R24's Brief Interview of Mental Status (BIMS) assessment completed on [DATE] documents no cognitive impairments. On [DATE], R24 completed a CPR (Cardiopulmonary Resuscitation) Preference Form. The form documented R24's treatment preference in the event of a cardiac arrest (heart stops). R24 documented they do not want CPR attempted. On [DATE], R24's Advance Directive for Emergency Care DNR form was signed by R24's Medical Doctor (MD) – X. On [DATE], R24 received fish for lunch and has a documented allergy to fish. A Facility Reported Incident (FRI) was completed by the facility related to the incident. The completed FRI investigation documents include a statement by Licensed Practical Nurse (LPN)- Y. (LPN-Y was assigned to care for R24 on [DATE].) LPN-Y was taking vitals on R24 when R24 became unresponsive. LPN-Y called out R24's name and R24 raised their arms and took a recovery breath. When R24 opened their eyes R24 started breathing heavy. Vitals documented blood pressure 175/55, pulse 44, respirations 22 and pulse oxygen saturation 94% on 4 liters of oxygen. R24's skin was pale, warm, and clammy. LPN-Y told R24 they wanted to send R24 to the hospital. R24 stated they trusted LPN-Y's decision and (continued on next page)

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	525172	A. Building B. Wing	04/06/2026

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	agreed to go to the hospital. LPN-Y left the room to complete paperwork (for the hospital transfer) when LPN-Y heard LPN-S yelling R24's name. LPN-Y ran back to R24's room and R24 was unresponsive again. LPN-Y ran and grabbed the Automated External Defibrillator (AED), placed pads on R24, and started CPR on R24 until the Paramedics arrived. R24's body left the building at 1840 (6:40 PM). Surveyor notes 911 was called by the facility staff and facility staff started CPR. The Paramedic Report (911) dated [DATE] documents: Arrived on the scene to nursing staff performing CPR on adult PNB (Pulseless Non-Breathing). Staff stated they witnessed PNB. Pt (Patient) was laying supine on the floor, staff began CPR with mechanical ventilation, and she (R24) was hooked up to an AED.Paramedics immediately took over and performed an initial assessment and confirmed [R24] was pulseless, non-breathing (PNB). Paramedics began CPR and started switching [R24] over to our equipment. During CPR another nursing home staff presented a form that showed pt was a DNR, initially CPR was stopped by we resumed because the document presented was only a request for DNR (bracelet form). Staff then also remembered pt wears a DNR bracelet but stated she is not wearing it today. Because of those factors, CPR and life saving measures were resumed. Just to confirm what the staff had told us I instructed [E1] (Paramedic crew) to double check for a DNR bracelet and it was found around [R24's] forearm, under her jacket. CPR was ceased and pt was called 1099, no ALS (Advanced Life Support) at 1530 (3:30 PM). Surveyor notes R24 was provided CPR against their Advance Directives requesting a DNR status. On [DATE], at 3:46 PM, Surveyor interviewed LPN-S who was the Supervisor on [DATE]. LPN-S stated LPN-Y called them to R24's room via the supervisor's phone. LPN-S went to R24's room and observed LPN-Y had R24 hooked up to the vital machine. R24's pulse oxygenation was dropping and R24 was speaking. LPN-S notified Medical Doctor (MD)-X and Director of Nursing (DON)-B of the situation. LPN-S stated R24's pulse oxygenation continued to drop. Someone at the nurse's desk called 911. LPN-S stated LPN-Y was getting the paperwork ready and then returned with the AED machine. LPN-S stated she never left the (R24's) room and did not know R24's code status. LPN-S and LPN-Y started CPR on R24 until the paramedics arrived. LPN-S did not observe a DNR bracelet on R24. LPN-S stated she would look in the electronic record, or paper chart, for a resident's code status. LPN-S stated she did not know R24's Advance Directives status prior to starting CPR. On [DATE], at 7:43 AM, Surveyor interviewed DON-B. DON-B did not know why staff started CPR on R24. The facility completed an FRI (Facility Reported Incident) investigation due to the concern R24 had been served fish with a fish allergy. Surveyor notes the facility did not investigate the concern R24 received CPR, which is not in accordance with R24's Advance Directives which documented a no CPR status. The facility's failure to ensure R102 and R24's advance directive wishes were honored created a reasonable likelihood for serious harm, thus leading to a finding of immediate jeopardy. The immediate jeopardy was not removed at the time of exit on [DATE].

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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, interview, and record review, the facility did not ensure the environment was homelike and did not impose a safety risk for 1 (R94) of 24 residents reviewed for the environmental concerns. R94's room had a large opening in the wall from a panel being removed exposing the internal aspect of the wall. Findings include: On 3/23/2026 at 11:10 AM, Surveyor observed R94's room during the screening process of the survey. Surveyor observed a panel that covered the interior workings in the wall to be leaning against the wall and not covering the opening. A filter could be seen as well as other electric components. The panel measured approximately three feet by one-and-a-half feet. On 3/25/2026 at 7:37 AM, Surveyor observed the panel in R94's room to continue to lean against the wall and not cover the opening. In an interview on 3/25/2026 at 8:23 AM, Surveyor asked Director of Plant Operations (DPO)-F how maintenance is notified of equipment needing repairs or any rooms that need to have a repair completed. DPO-F stated the front desk would notify maintenance by radio if any situations needed their attention. Surveyor asked if DPO-F had been notified of a panel in R94's room was not in place. DPO-F stated the other day, maybe Monday 3/23/2026, a panel was a little loose and DPO-F was able to replace it right away. Surveyor asked DPO-F if DPO-F could recall what room the repair to the panel was made. DPO-F stated the room number and Surveyor verified it was not R94's room. Surveyor asked DPO-F if DPO-F was aware of the panel being off the wall in R94's room. DPO-F stated DPO-F did not know about R94's room but would look to see if there was a work order for the repair or if anyone in the maintenance department was aware of the situation. Surveyor asked DPO-F to provide the work order if there had been one submitted. On 3/25/2026 at 8:41 AM, DPO-F stated there was no notification for the panel in R94's room being off. DPO-F stated DPO-F assigned a maintenance staff member to fix the panel. On 3/25/2026 at 3:17 PM, Surveyor shared with Nursing Home Administrator (NHA)-A the concern R94's wall had a panel off that had been covering electrical equipment for the past three days. Surveyor shared with NHA-A the conversation Surveyor had with DPO-F and DPO-F had fixed the panel that morning.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 2 (R107 and R82) of 6 residents reviewed for allegations of abuse was had the allegation reported to the State Agency and local law enforcement within the required timeframe. *On 1/24/26, at 7:55 PM, R107 alleged Certified Nursing Assistant (CNA)-CC pushed R107 down and R107 hit their head on the wall. The facility reported the abuse allegation for R107 to the State Agency on 1/25/26, at 10:56 AM. The facility did not submit the initial allegation of abuse to the State Agency within 2 hours as required. *On 1/29/26, the facility became aware that R82 was found with a right femur fracture after she was admitted to the hospital for complaints of right leg pain. R82 was unable to state how the injury occurred. The facility began an investigation into R82's injury of unknown origin on 1/29/26 by interviewing staff and R82's peers if they had any knowledge of how R82 fractured her right femur. Findings include: The facility's policy titled Freedom of Abuse, Neglect and Exploitation, last reviewed 6/12/25, documents: It is the policy of [Name of corporation] that abuse allegations (abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property) are reported per Federal and State Law. The facility will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made. It is the policy of [Name of the corporation] that reports of abuse (mistreatment, neglect, or abuse, including injuries of unknown source, exploitation and misappropriation of property) are promptly and thoroughly investigated. All reports of suspected crime and/or alleged sexual abuse must be immediately reported to local law enforcement to be investigated. Facility staff will fully cooperate with the local law enforcement designee. R107 was admitted to the facility on [DATE]. R107's admission Minimum Data Set (MDS) completed on 1/25/26, documents that R107 requires partial/moderate assistance with toileting hygiene, showering self, sit to stand and transfers. R107 is occasionally incontinent of bowel and bladder. R107 was documented as having a Brief Interview for Mental Status (BIMS) score of 13, indicating R107 is cognitively intact. On 3/24/26, Surveyor reviewed a facility self-report dated 1/25/26 which documents the following: On 1/24/26, at 7:55 PM, R107 alleged CNA-CC was rough with cares while CNA-CC was helping toilet R107. R107 alleged CNA-CC pushed R107 down on the toilet and R107 hit their head on the wall. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor notes the initial allegation of abuse of R107 occurred on 1/24/26, and the facility submitted a report of allegation to the State Agency on 1/25/26 at 10:56 AM. Surveyor notes, the abuse allegation report was not submitted to the State Agency within 2 hours from the time the facility became aware of the allegation as required. On 3/25/26, at 12:56 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-M who stated CNA-CC notified LPN-M that R107 was requesting medication for pain. LPN-M stated she went into R107's room approximately 5 minutes later. At this time, R107 notified LPN-M that CNA-CC pushed R107 on the toilet and R107 hit R107's head on the back of the wall when CNA-CC pushed R107 on the toilet. LPN-M stated she notified the supervisor right away of the abuse allegation and an investigation was started immediately. On 3/25/26, at 4:02 PM, Surveyor interviewed Registered Nurse (RN)-FF who stated she was the nurse supervisor and 1/24/26. RN-FF stated she was notified of an abuse allegation on 1/24/26, with CNA-CC pushing R107 on the toilet and R107 hitting R107's head on the wall. RN-FF stated an investigation was started immediately. RN-FF notified Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B of the abuse allegation. On 3/26/26, at 7:44 AM, Surveyor interviewed Director of Social Services (DOSS)-G who stated she submits self-reports to the state agency as she is the only one that has a password. DOSS-G stated abuse allegations are to be submitted to the state agency within 2 hours after the allegation. DOSS-G stated she was notified by nursing staff of the allegation of abuse with CNA-CC pushing R107 on the toilet and R107 hitting R107's head on the wall. DOSS-G stated she does not recall who and when the abuse allegation was reported to her. Surveyor notified DOSS-G of concerns with the facility self-report not being submitted to the state agency within the 2-hour timeframe from the abuse allegation on 1/24/26. DOSS-G acknowledged this concern. On 3/26/26, at 7:57 AM, Surveyor notified NHA-A of concern with the facility reporting the abuse allegation for R107 to the State Agency on 1/25/26, at 10:56 AM and the facility did not submit the initial allegation of abuse to the State Agency within 2 hours as required. NHA-A acknowledged this concern. 2.) R82 was admitted to the facility on [DATE]. On 1/29/26, the facility became aware that R82 was found with a right femur fracture after she was admitted to the hospital for complaints of right leg pain. R82 was unable to state how the injury occurred. The facility began an investigation into R82's injury of unknown origin on 1/29/26 by interviewing staff and R82's peers if they had any knowledge of how R82 fractured her right femur. The facility submitted the F- 62617 Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report, to the state survey agency on 1/29/26. The report indicates the allegation type is: injury of unknown source: Injury was not observed and is suspicious because of the extent or location. In Summary: R82 complained of pain to the right leg. X-ray was obtained. R82 was found to have a right femur fracture. R82 is unable to state how the injury occurred. Surveyor conducted further review of the facility's investigation and noted that they did not contact law enforcement of the suspected abuse, per policy. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/26/26 at 12:45 PM, Surveyor interviewed Director of Social Services (DSS)- G stated that she did prepare and submit the investigation into R82's injury of unknown source. Surveyor asked DSS- G why the police were not notified. DSS- G stated that the Administrator would decide if law enforcement needed to be notified per regulation and policy. On 3/26/26 at 2:10 PM, Surveyor interviewed Nursing Home Administrator- A regarding law enforcement notification when a suspected crime / suspected abuse has occurred. Nursing Home Administrator- A stated she will notify the police if the alleged abuse is a physical type of thing or if the misappropriation of resident property is of a substantial amount. Surveyor asked Administrator- A why law enforcement wasn't notified of R82's injury of unknown source that was not observed by staff and is suspicious because of the extent of the injury and/ or location. Administrator- A stated that usually they will call law enforcement if they don't have some type of summation of what might have happened R82 had a fall on 1/19/26 so we think the fracture could have happened then. Administrator- A did confirm that R82 could not state what happened and that R82 did not have any complaints of pain after her fall until 1/28/26. Administrator- A did not provide any additional information as to why law enforcement wasn't notified on 1/29/26 of the suspicious injury of unknown source for R82.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety 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 provide care consistent with standards of practice by failing to ensure changes in medical conditions were immediately addressed. This was observed with 2 (R24 and R17) of 18 resident record reviews. *R24 received fish for lunch and has a documented allergy to fish. After consuming some of fish R24 experienced a low heart rate and became unconscious. Staff failed to administer anaphylaxis interventions immediately. Staff texted R24's Medical Doctor (MD)-X with the observed change in condition and did not call for consultation. R24 passed away due to allergic reaction to the fish. The facility's failure to identify an allergic reaction to fish and to administer anaphylaxis interventions immediately created a finding of Immediate Jeopardy that began on 3/15/26. Nursing Home Administer (NHA)-A and Director of Nurses (DON)-B were notified of the Immediate Jeopardy on 3/26/26 at 10:40 AM. The Immediate Jeopardy was not removed at the time of exit on 4/6/26. *R17 was readmitted to the facility on [DATE] with a wound to the distal end of the right foot where the toes had been amputated. A treatment was obtained for the right heel, not the area where the wound was located. The diabetic ulcer was not comprehensively assessed until 3/11/2026 when R17 was seen by the wound physician. Findings include: 1.) R24 was admitted to the facility on [DATE] with diagnoses of lung cancer and breast cancer. Upon admission R24 has a documented fish allergy with severity unknown. R24's Brief Interview of Mental Status (BIMS) assessment dated [DATE] documents a score of 15 indicating no cognitive impairments. On 1/28/26 a Nutrition Assessment was completed by Registered Dietitian (RD) – AA which documents R24 has an allergy to fish. The facility completed an investigation, FRI (Facility Reported Incident) into this event on 3/15/26. The FRI investigation included a statement by CNA-Z which documented on Sunday, March 15th, 2026, around the time between 2:40 PM-3 PM resident in room (R24's room number) light was on. CNA-Z got to R24's room and R24 asked CNA-Z if they could heat up their left over food they had not finished. When CNA-Z grabbed R24's plate R24 asked CNA- Z if she thought the food looked like a chicken quesadilla. CNA-Z told R24 no, they had fish. R24 stated it was chicken. CNA-Y showed R24 that it was fish on the plate. R24 said it bet (sic) not be fish because they are allergic to fish. CNA-Z grabbed R24's meal ticket to look and noticed (the fish allergy listed). CNA-Z went to the nurse that was on that side (LPN-Y) to confirm and let her know. LPN-Y went to go check on R24 and CNA-Z took the plate of food back to the kitchen and saw the supervisor (LPN-S) and told her what was going on. CNA-Z finished helping other residents while the nurses took over with R24. The FRI includes LPN-Y's statement which documents right after shift change Certified Nursing Assistant (CNA)-Z came out of R24's room with R24's (meal) tray. CNA-Z was concerned R24 had eaten fish, and R24 has a food allergy to fish. LPN-Y was in R24's room already due to R24 coughing and requesting cough medicine and an anxiety pill. R24 did not have hives, tongue swelling or itchy mouth/throat. LPN-Y was taking vitals and R24 became unresponsive. LPN-Y called out R24's name (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and R24 raised their arms and took a recovery breath. Vitals were taken and documented as blood pressure 175/55, pulse 44, respirations 22 and pulse oxygen saturation 94% on 4 liters of oxygen. R24's skin was pale and clammy. LPN-Y told R24 they wanted to send R24 to the hospital. R24 agreed to go to the hospital and LPN-Y left the room to complete paperwork. LPN-Y then heard yelling from LPN-S. LPN-S was yelling out R24's name and R24 became unresponsive again. LPN-Y then grabbed the AED (Automated External Defibrillator), placed pads on R24, and initiated CPR (cardiopulmonary resuscitation) on R24 until the Paramedics arrived. R24's body left the building (passed away) @ (at) 1840 (6:40 PM). On 3/25/26, at 3:46 PM, Surveyor interviewed LPN-S. LPN-S was the Nursing Supervisor on 3/15/26. LPN-S stated LPN-Y called them to R24's room via the Supervisor's phone. LPN-S went to R24's room and LPN-Y had R24 hooked up to the vital machine. R24's pulse oxygenation was dropping and R24 was talking to LPN-Y. LPN-S notified MD-X and DON-B of the situation. R24's pulse oxygenation continued to drop. Someone at the nurse's desk called 911. LPN-S spoke with DON-B on the phone and did not recall details. LPN-Y left R24's room to get the paperwork ready (for R24's transfer to the hospital) and then returned to R24's room with the AED (Automated External Defibrillator) machine. LPN-S never left the room and did not know R24's code status. LPN-S stated she was not aware if R24 had any food allergies or reactions. On 3/15/26, at 18:48 (6:48 PM) R24's medical record documents a progress note written by Licensed Practical Nurse (LPN)- S which documents: Approx (approximate)1500 (3:00 PM) writer received call from 2nd floor. Upon arrival observed floor nurse doing vitals. Resident sitting in armchair alert and verbalizing with nurse. Writer noticed VS (vital sign) T (temperature) - 97.2, R (respiration)-22, BP (blood pressure)-163/66 and P (pulse)-40 Pox (oxygen saturation)-94% Resident with O2 (oxygen) 4L (liters) n/c (nasal cannula). Resident with no SOB (shortness of breath)/cough or difficulty breathing. Skin warm and dry, and no cyanosis (a bluish or grayish discoloration of the skin, lips, nail beds or mucous membranes caused by a lack of oxygen in the blood.) noted. Following verbal commands and answering questions. Resident denied pain when asked. Writer noted resident's pulse began to drop and began tiger text notification to MD (Medical Doctor). Noted further drop in pulse and writer gave instruction to staff to call 911. (approx. 1510) (3:15 PM). Administrator called to update on resident status, and received MD reply and informed her 911 had called already. Writer remained with resident in room for safety precautions. Resident became a little anxious in regard to being sent out to hospital r/t (related to) low pulse. Resident began to tremble and lose consciousness and slumped forward at the waist while still in sitting position. Writer was able to catch resident to prevent her falling to the floor. Resident (sic) assisted resident upright and resident responsive to verbal and tactile stimuli. Resident seem to become slightly agitated and removed O2 (oxygen) tubing from nose. Writer was able to calm resident and replace nasal cannula in nose. Resident pupils were dilated and she began to shake, arms flailing and passed out. Writer called for assistance both writer and nurse in room and assessed the resident and no pulse could be felt. EMTs (Emergency Medical Technician) arrived to unit approx. 1520 (3:20 PM). EMTs packed up supplies if (sic) next of kin had been notified. DON (Director of Nursing) made aware at time of incident. On 3/26/2026, at 7:43 AM, Surveyor interviewed Director of Nursing (DON)-B. DON-B stated LPN-S called and informed her R24's heart rate was low. LPN-S informed DON-B R24 received fish and has an allergy to it. DON-B directed LPN-S to call 911. DON-B stated she would expect staff to look for an epinephrine pen (epi-pen) and call 911. DON-B stated in this event there were no epi-pens in the medication carts. Surveyor notes the facility does not have an anaphylaxis policy and procedure. On 3/25/2026, at 1:37 PM, Surveyor interviewed Medical Doctor (MD)-X. MD-X stated they were with (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	another patient when they received a text message about R24. MD-X received information that R24 received fish and their heartrate was low. MD-X responded back to call 911 and administer an epi-pen by this time R24 had already passed away. Surveyor notes R24 was experiencing an allergic reaction to fish which was served to R24 at the noon meal on 3/15/26. The facility staff did not recognize R24 was served fish and was experiencing an allergic reaction/going into anaphylactic shock. R24's change in condition continued at which time R24 experienced cardiac arrest and passed away at the facility. The facility did not have systems in place to implement immediate steps to address the change in condition by immediately administering an epi-pen. The facility staff texted R24's MD for consultation for the change in condition however they called the MD who was busy with another patient which delayed the response to the facility. The facility's failure to ensure R24 received treatment and care in accordance with the comprehensive care plan, and the resident's choices led to a finding of immediate jeopardy. The immediate jeopardy was not removed at the time of exit from the facility on 4/6/26. 2.) R17 was admitted to the facility on [DATE] with diagnoses of end stage renal disease requiring dialysis, diabetes, coronary heart disease, and anxiety. R17's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented R17 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 and did not have any wounds to the skin. R17 did not have an activated Power of Attorney. On 3/5/2026 at 10:47 PM in the progress notes, Licensed Practical Nurse (LPN)-U documented R17 returned from the hospital that day after having bilateral nephrostomy tubes placed. Necrosis was noted to the right foot and the physician was made aware. LPN-U completed an eInteract form documenting: Necrotic wound noted to Right foot 1x1 0.2x0.2 (sic). LPN-U's documentation did not describe where the wound was located on the right foot and had two sets of length x width measurements. A treatment order was entered into R17's medical record by Registered Nurse Manager (RNM)-J for wound care to the deep tissue injury (DTI), a pressure injury, to the right heel: cleanse area with normal saline, swab with iodine, and cover with mepilex twice daily. Surveyor notes the wound was not comprehensively assessed and documented. On 3/6/2026 at 10:16 AM in the progress notes, RNM-J documented R17 had a necrotic wound on the right heel with a past medical history of gangrene. R17's daughter would like R17 to be sent out to prevent an infection. The physician was updated and gave an order to send R17 to the hospital after dialysis treatment. At 5:00 PM in the progress notes, LPN-S documents the emergency room called with an update on R17's status. An x-ray was completed which showed possible degenerative changes and bone resorption. Blood work results were negative for sign or symptoms of infection. An ultrasound was to be completed to check blood flow to the extremity. At 10:44 PM in the progress notes, LPN-S documented R17 returned to the facility with treatment order to cover the right foot ulcer with gauze and change daily. Surveyor noted this treatment order was not transcribed into R17's medical record; the treatment to the right heel continued as ordered on 3/5/2026. On 3/11/2026, R17 was seen by Wound Physician-BB for an initial assessment. Wound Physician-BB documented R17 had a diabetic wound to the right plantar foot measuring 0.8 cm x 0.8 cm x 0.2 cm and 100% necrotic tissue with moderate serous drainage. The treatment was changed at that time to be applied to the right plantar foot. Surveyor notes this was the first comprehensive assessment of the wound, six days after discovery. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R17's Diabetic Ulcer of the Right Plantar Foot care plan was initiated on 3/13/2026. In an interview on 3/25/2026 at 7:35 AM, Surveyor asked Wound Physician-BB what wounds were present on R17's foot. Wound Physician-BB stated R17 was just assessed that morning and has a diabetic ulcer to the right plantar foot. Surveyor shared with Wound Physician-BB the confusing documentation of R17 having a DTI to the right heel. Wound Physician-BB stated the only wound on R17's right foot was the plantar foot diabetic ulcer and nothing on the heel. Surveyor was unable to visualize R17's diabetic ulcer due to R17 having to leave the facility for dialysis. In an interview on 3/25/2026 at 1:30 PM, Surveyor asked Medical Director (MD)-X if MD-X was involved in R17's wound care or assessments. MD-X stated wounds are talked about in clinical meetings and MD-X can see the notes scanned in by Wound Physician-BB. MD-X stated R17 has a history with diabetes, end stage renal disease, and a past history of diabetic foot ulcers with gangrene. MD-X stated R17 had toe amputations on the left foot and the right foot has a midfoot amputation with the history of gangrene. MD-X stated R17 developed two black spots on the end of the stump along the surgical line. Surveyor asked MD-X if MD-X had personally seen R17's right foot. MD-X stated yes, and there were two distinct areas on the lateral and medial aspects of the foot stump. MD-X stated they were concerned about possible gangrene and that is why R17 was sent to the hospital where it was determined it was not infected. MD-X stated the wound team looks at wounds on Wednesdays so MD-X knew R17 would be seen at that time. Surveyor shared with MD-X the progress notes and orders from 3/5/2026 and the concern the wound was not comprehensively assessed until 3/11/2026. MD-X was unable to explain the documentation on 3/5/2026 and did not see any necrotic wounds to the heel. MD-X stated R17 had two spots that were black and distinct. In an interview on 3/25/2026 at 4:00 PM, Surveyor asked RNM-J and RN Supervisor (RNS)-Q if they had observed R17's right foot wound or wounds. RNM-J stated R17 was seen that morning by Wound Physician-BB and pulled up Wound Physician-BB's notes from that day. RNM-J stated R17 had the toes amputated so the wound is where the toes would be on the stump. RNM-J stated RNM-J first saw R17's foot on 3/6/2026 and there were two distinct black wounds that turned into one wound with the smaller wound resolving. RNM-J stated RNM-J documented the wound when RNM-J saw it on 3/6/2026. RNS-Q stated the end of the right foot had two separate wounds with a piece of skin between that were close together. RNS-Q stated RNS-Q sent an encrypted text to MD-X with a picture and got an order for a treatment. Surveyor shared with RNM-J and RNS-Q the order was for a DTI to the right heel. RNM-J stated the order was put in for the wrong body area and could not say why RNM-J put the order in that way. Surveyor noted the treatment order and the progress note entered by RNM-J both documented the wound was to the right heel. On 3/26/2026 at 3:16 PM, Surveyor shared with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B the concern R17's diabetic foot ulcer was discovered on 3/5/2026 and was not comprehensively assessed until 3/11/2026 with conflicting documentation of where the wound was located on the right foot.

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F 0689 Level of Harm - Minimal harm or potential for 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 record review and staff interviews, the facility did not ensure the residents' environment was free of accident hazards and residents received adequate supervision and assistance devices to prevent accidents for 2 (R7 and R106) of 4 residents reviewed for accidents. R7 was observed to be smoking outside the facility and was not comprehensively assessed whether she was safe to be smoking unsupervised and if she could hold onto her own smoking materials. The facility did not develop a care plan addressing R7's wishes to smoke, including interventions for her to do so safely. R106 was assisted to the floor during a transfer with one Certified Nursing Assistant (CNA) from the shower chair to the wheelchair. R106's Activities of Daily Living Care Plan and R106's High Risk for Falls Care Plan had the intervention of R106 having assistance of two people when transferring from the wheelchair to the shower chair. The CNA did not follow R106's Care Plan resulting in a witnessed fall. Evidenced by: Policy Review: Smoking Policy last revised 3/13/2019.Procedures: .2. A resident who has been deemed safe for smoking independently through the facility smoking assessment may keep their smoking materials with their personal belongings.3. If a resident is deemed unsafe per the facility smoking assessment, the resident's smoking materials will be kept with nursing or social services and be given to the resident upon request and staff will accompany them.4. Residents admitted who currently smoke will be given a smoking safety screen assessment.5. Upon completion of assessment, IDT (Interdisciplinary Team) will determine if resident is safe to smoke without supervision. 6. Residents who wish to smoke will need to do so off of our premises.7. Residents who need supervision to smoke will be accompanied by available staff. a. A proposed smoking schedule for each resident can be implemented if needed. 1.) R7 was admitted to the facility on [DATE] with diagnosis including anxiety disorder, major depressive disorder, mild intermittent asthma and rheumatoid arthritis. R7's admission MDS (minimum data set), dated 2/27/25 documents R7 does not smoke. R7's nursing progress note dated 12/7/2025 at 4:13 PM, documents R7 noted to be going outside during the day, it was reported to writer by another nurse that R7 has been going outside to smoke. Writer asked R7 who reported starting to smoke 4 days ago. Supervisor made aware, lighter confiscated. On 12/7/25 the facility completed a Smoking Safety Screen. Surveyor noted the screen was signed as completed on 1/28/26 and dated 12/7/2025. The screen documents the following: Category- safe to smoke without supervision. R7 is documented to smoke 2-5 cigarettes a day in the morning, afternoon and evening. Section E- Safety: R7 needs supervision and does need facility to store lighter and cigarettes. Plan of care is used to assure resident is safe while smoking? - Yes. Notes on safety from the IDT (interdisciplinary team): R7 evaluated by PT (Physical Therapy) and OT (Occupational Therapy) and is not considered a safe smoker due to not being able to safely wheel self-off the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility property. R7 requires supervision and assistance when going out to smoke off of the property. MD (Medical Doctor) is aware an order for NRT (nicotine replacement therapy) was given and R7 declined to take it. Team Decision: Safe to smoke without supervision. Rationale/conditions: R7 is not safe to smoke per OT (occupational therapy). Per policy, R7 has been informed they are not to smoke in or around the facility. A review R7's medical record was conducted, and it was noted R7's Smoking Safety Screen, dated 12/7/25 was the only screen completed for R7. Surveyor notes the screen had contradictory information as to whether R7 was safe to smoke unsupervised or not. The screen indicates the care plan will address smoking. Surveyor noted R7's care plan did not provide documentation R7 was smoking while residing at the facility. On 3/5/26, a quarterly Social Services Review was conducted for R7. The review documents R7 is able to make all needs known. The additional comments section documents that the team spent an extensive amount of time discussing smoking policy and safe smoking practices. R7's nursing note dated 3/6/2026 at 7:01 PM, documents R7 informed staff that she would like to quit smoking and is agreeance with beginning nicotine replacement therapy. MD updated and a prn (as needed) order for Nicotine lozenges 4mg every two hours. R7 told writer she would inform her family. On 3/24/26 at 1:50 PM, Surveyor interviewed Licensed Practical Nurse (LPN)- W who states they are familiar with R7. LPN -W stated R7 has been assessed by therapy who determined R7 can't go out to smoke by herself because it is unsafe for her to go out by herself. Surveyor asked LPN-W if staff go out with R7 when she does want to smoke. LPN- W stated that no, staff don't go with her, so she doesn't smoke. R7's nursing note dated 3/12/2026 at 11:52 PM, documents R7 returned from having a smoke outside. On 3/25/26, Surveyor conducted a review of R7's individual plan of care. Surveyor noted R7's plan of care did not reflect R7 as being a smoker. The care plan also did not identify if R7 was to be supervised or able to smoke independently. The care plan did not identify if R7 was able to keep her smoking materials or needed to turn them into staff. The care plan did not contain any documentation regarding R7 smoking. R7's nurses note dated 3/25/26 at 6:50 PM, documents during rounds, R7 was found smoking outside in front of the building. When approached, staff questioned R7 about where she obtained the cigarette and lighter from. R7 replied with my brother brought it in for me. Staff re-educated R7 on facility's nonsmoking policy and confiscated smoking paraphernalia. DON-B (Director of Nursing) directed staff to do a room sweep for any other medications or smoking paraphernalia. Risks discussed with R7 that cigarettes are leading cause of fire deaths, making smoking in unauthorized areas a high risk. Re-enforced facility policy to maintain smoke-free environment. R7 remains non-compliant. On 03/26/2026 at 8:55 AM, Surveyor interviewed SW (Social Worker)-P regarding R7's history of smoking at the facility. SW-P stated when R7 was admitted , she was not smoking and was attending physical and occupational therapy. SW-P stated staff did not notice R7 smoking until December 2025. R7 reported she had started smoking about 4 days prior to 12/7/25. SW-P stated on 12/8/25, the facility completed the smoking safety screen. On 12/9/25 the assessment was completed when therapy worked on R7 navigating the building to the patio area in her wheelchair. SW-P confirmed the patio is not a designated smoking area. After this assessment, staff did not observe R7 smoking. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the floor in the shower room. R106 was noted to be leaning up against the wall with no apparent injuries. On 10/23/2025 at 4:34 PM, in the progress notes, Registered Nurse Manager (RNM)-J documented an interdisciplinary review note of R106's fall on 10/17/2025. RNM-J documented R106 slipped and lost their balance and the CNA lowered R106 to the floor while in the shower. Surveyor noted the documentation did not state R106 was being transferred by a CNA from the shower chair to the wheelchair at the time of the witnessed fall. Surveyor reviewed the Fall Scene Investigation Report provided by the facility. The report documented R106's fall on 10/17/2025 at 4:30 PM, happened while transferring to the wheelchair. The CNA stated R106's leg gave out causing R106 to lose balance. The attached Fall Investigation Statement completed by the CNA documented R106 stood up fine and while the CNA was scooting the wheelchair underneath R106, R106 said their leg had given out and started to slide so the CNA lowered R106 slowly to the shower room floor. No other staff statements were attached to the investigation. All documentation reviewed indicated R106 was transferred in the shower room with one CNA rather than two staff members R106 was assessed to require as per the care plan. In an interview on 3/25/2026 at 3:50 PM, Surveyor asked RNM-J what RNM-J could recall of R106's fall on 10/17/2025. RNM-J stated RNM-J was at home at the time of the fall and found out about the fall the next morning at stand-up meeting. RNM-J stated R106 was in the shower, transferring from the shower chair to the wheelchair and one CNA lowered R106 down and then three staff members lifted R106 back up. R106 did not have any injuries but did have a urinary tract infection after the assessment. Surveyor asked if the facility addressed the CNA that did not follow the care plan to have two staff members assist with the transfer. RNM-J stated the CNA was giving R106 a shower by themselves but cannot say what happened with the transfer because RNM-J was not there when it happened. RNM-J stated Surveyor needed to talk to Licensed Practical Nurse (LPN)-S because LPN-S would have been there at the time. On 3/26/2026 at 3:16 PM, Surveyor shared with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, and Assistant DON (ADON)-C the concern R106 had a witnessed fall in the shower when transferring from the shower chair to the wheelchair and was lowered to the ground. The Care Plan intervention at that time was R106 required two persons assist for transfers in the shower. In an interview on 3/30/2026 at 10:02 AM, Assistant Director of Nursing (ADON)-C provided R106's Fall Scene Investigation Report. Surveyor shared with ADON-C the concern R106 was transferred with an assist of one from the shower chair to the wheelchair, not following the care plan intervention of R106 needing two staff members to transfer in the shower room, resulting in R106 having a witnessed fall. ADON-C agreed the documentation indicated R106 was transferred with one CNA instead of two per the care plan. In a phone interview on 3/30/2026 at 10:41 AM, LPN-S could not recall R106's fall or how many people were assisting with the shower room transfer.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff and resident interviews, the facility did not ensure pain management was provided to 1 (R7) of 2 residents reviewed for pain, in accordance with the resident's goals and preferences and with the comprehensive person-centered plan of care.R7 experienced an increase in pain due to the discontinuation of medication, and the facility did not comprehensively assess R7's increased pain and update the plan of care with interventions that may decrease R7's pain level and frequency.Evidenced by: R7 was admitted to the facility on [DATE] with diagnosis that included Fibromyalgia, Anxiety Disorder, Major Depressive Disorder, and Rheumatoid Arthritis (multiple sites).R7 was admitted for rehabilitative services and was receiving physical and occupational therapy. A review of the physician orders for R7 noted the following:*NURSING ORDER PAIN MED MONITORING: Monitor for the following: constipation, nausea, vomiting, dry mouth, decreased respirations, sleepiness, dizziness, confusion, itching, sweating. Document Y for yes (document note in progress note) and N for no. Every shift for pain management AND every 1 hours as needed for pain medication monitoring. Active 2/21/2025.*Non-pharmacological interventions attempted for pain goal not met 1.) repositioning, 2.) distraction, 3.) warm blanket, 4.) back rub, 5.) ice 6.) other-place in progress note. Every 1 hours as needed for pain. Active2/21/2025.R7's care plan documents R7 has actual pain r/t (related to) RA (Rheumatoid Arthritis), FibromyalgiaDate Initiated: 03/07/2025. Revision on: 03/07/2025. Interventions included: R7 will not have an interruption in normal activities due to pain through the review date. Date Initiated: 03/07/2025. Revision on: 04/15/2025. Administer analgesia per orders. Date Initiated: 03/07/2025. Revision on: 04/07/2025. Evaluate the effectiveness of pain interventions. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition. Date Initiated: 03/07/2025. Revision on: 03/07/2025. Observe and report changes in usual routine, sleep patterns, decrease in functional abilities, decrease ROM (Range of Motion), withdrawal or resistance to care. Date Initiated: 03/07/2025.R7's EMR (electronic medical record) contained an Initial Pain Evaluation, dated 4/7/25. The evaluation documented R7 has a mild pain risk score. The EMR also flagged an additional pain evaluation is 260 days overdue- due date 7/7/25.Nursing note dated 11/6/2025, at 2:36 PM, documents R7 in bed today with ongoing complaints of left hip pain. No bruising, redness or swelling noted to left hip region. No peripheral edema. Recent hip x-ray showed osteoarthritis. Stated she felt something pop in left hip. Medicated with hydromorphone by nurse effective per resident. Secure text sent to Physician- HH to update.Nursing note dated 11/8/2025, at 4:25 PM, documents R7refuses to get out of bed for dinner. Writer was in room with residents roommate when R7 asked if someone was going to get her up for dinner. Writer told resident someone would get her up if she wanted to. R7 told writer she did want to get out of bed. Writer informed CNA (Certified Nursing Assistant) who went to the room with another CNA to get resident out of bed. R7 refused, writer went back to talk to resident who says she didn't say she wanted to get up. Writer reminded of the conversation they had a few minutes ago. Resident said yeah I said that then but now I'm not going to get up Writer told CNA to get resident a room tray.Nursing note dated 11/8/2025, at 5:46 PM, documents Writer went into R7's room to give her PM (evening) medication. R7 c/o (complained of) back pain and started to cry with sitting up in bed. Writer told R7 she was just given Tylenol with PM medication. Writer explained to resident that she may continue to have pain until she starts getting up and moving.Nursing note dated 11/11/2025, at 2:23 PM;, documents F/u (follow up) status- R7 is being monitored for left hip pain, x 2 c/o pain/discomfort scheduled Tylenol given and muscle relaxer was effective, R7 has change to pain analgesics Hydromorphone order is PRN (as needed) Q (every) 8 hr. (hours) as needed. Writer called pharmacy for refill Narc (Narcotic) (last one given on Noc's (nights) per pharmacy MD (Medical Doctor) sent new script order as PRN will be here on next delivery today noted Writer updated R7 on changes PRN Tylenol was given in its place until NOR (New Order (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Received)/refill is delivered.A review of the quarterly MDS (minimum data set), dated 11/20/25 notes R7 has a BIMS (brief interview for mental status) score of 15 indicating R7 is cognitively intact. The MDS also documents R7 received scheduled pain medication and administered as needed pain medication over the 7-day reference period. Non-medication interventions for pain were not received. Under the Pain Presence section; have you had pain or hurting at any time in the last 5 days?- answered NO. Pain has not had an interference with sleep or therapy activities.The facility conducted the Quarterly Pain Interview (MDS 3.0) on 11/26/25. The interview documents R7 has pain frequently. The pain has made it hard to sleep. The pain has not limited R7's day to day activities. The pain intensity is rated at a 7-severe. R7 makes vocal complaints of pain daily. Scheduled medications include Gabapentin three times daily and as needed Tylenol and Dilauded. The pain interview did not have a description of interventions/effectiveness and no other comments noted regarding R7's pain. Surveyor noted there are no updates to R7's care plan regarding experiencing severe pain at a level 7 and complaints of pain daily.On 11/28/2025, at 1:03PM, a Quarterly Activity Participation Note was written in R7's medical record which documents R7 remains highly independent and capable of pursuing independent recreational and leisure activities. In the past three months R7 has attended bingo, movement, social, movie, spiritual, art, games, resident council, music, trivia, intergenerational, reminiscing, and trivia groups. R7 continues to engage independently and show interest in a variety of activities. Care plan reviewed and remains appropriate.Nursing note dated 1/28/2026, at 6:59 PM, documents Floor Nurse informed this nurse that R7 c/o pain to right lower left/calf area, is crying and inconsolable. Dr. notified, R7 wants to go to any hospital. Will notify ambulance and send for evaluation. R7 did return to the facility with no new orders.Nursing note dated 1/31/2026, at 04:37 AM, documents Knee pain throughout the night. PRN muscle spasm and pain pills given. Snack requested. PB&J (Peanut Butter and Jelly) with yogurt given. R7states that pills isn't helping. Nurse informed her about elevating her legs and offered other non-pharma pain relievers.Nursing note dated 2/10/2026, at 8:08 PM, documents MD sent a refill request to pharmacy for Hydromorphone 4mg every 8 hours for pain related to fibromyalgia and RA (Rheumatoid Arthritis) for specified pain level of 7-10. Script for 90 tablets was sent to [name of company] pharmacy.Nursing note dated 2/16/2026, at 11:53 PM, documents pm med pass R7 asked when she could have another pain pill. Writer asked R7 her pain level. resident stated I don't know. you pick one. writer informed her she could have one now if needed, but asked she'll rather wait to see if her pain subsides with her scheduled meds. R7 stated Ok. but I can get one tonight, right. Writer replied sure. for HS (hour of sleep) meds. Writer had difficulty waking resident. Sternal rub ineffective. Writer began taking vitals. RR (respiration rate) 13, shallow. BP (blood pressure) 98/62 HR (heart rate) 82 SOP2 (oxygen levle) 93% 96.2. R7 awoke, drowsy, said Oh, Hey! enthusiastically with a smile, before closing eyes again. Writer had a conversation with R7, explaining why her vitals where being taken. R7 acknowledged her low RR and low systolic. Took her scheduled hs meds. Asked if she could have a prn pain med. Writer explained that her RR was low, it wouldn't be safe to give. R7 nodded her head and went back to sleep. At 11:30 PM, R7 called writer to room to discuss the situation. stating she didn't know I tried to wake her and that hasn't happened before. Writer replied that it happened the other night, RR of 13, requested PRN but was ok with it not be given due to low RR. Writer explained what we can try other methods to relieve discomfort. Writer inquired several times on where resident's pain was located and type. R7 stated I thought I had a foot spasm, but it's gone now. Writer stated that she had a medication for spasms, if she needed it. R7 didn't respond to that question. Continued asking in various ways why she couldn't just have the Hydromorphone.On 2/28/26, the facility completed the Annual MDS. The MDs documented that yes, R7 receives scheduled pain medications and frequently has pain. R7 is documented to frequently have a hard time sleeping at night due to the pain and it frequently interferes with therapy and day to day activities. R7's pain is documented to be severe. The pain CAA (care area assessment) documents R7 has pain related to severe RA and takes scheduled Tylenol and Gabapentin and as needed Dilaudid for breakthrough pain. Diseases and conditions that may cause (continued on next page)

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pain- Arthritis and Osteoporosis. R7 has a long history of pain related to long history of RA. Proceed to care plan. Overall objective of care plan is improvement and symptom relief. Surveyor's continued review of R7's care plan and noted the plan of care had not been updated due to R7 experiencing an increase in the pain intensity from no pain documented on the quarterly MDS dated [DATE] to severe pain that is affecting sleep, therapy and day to day activities. Surveyor notes there were no new interventions put into place or any further assessment of what pain level is tolerable/acceptable to R7. On 3/2/2026, at 3:40 PM, an Activity Participation Note Text: Annual documented: R7 expresses that her interests and preferences have not changed. R7 continues to attend programming of interest when her pain levels are tolerable. Care plan reviewed and remains appropriate. A Nursing Order was obtained on 3/19/26 which documents: R7's ACCEPTABLE level of pain is 4/10. Document whether pain goal met yes/no/sleeping IF NOT MET-ATTEMPT PRN NON-PHARMACOLOGICAL AND/OR PHARMACOLOGICAL INTERVENTION every shift for pain management. A review of the nursing weekly summary dated 3/25/26, documents R having generalized pain (location) blank, and on a scale of (0-10) R7's pain is at a 5. Surveyor conducted a review of the Medication Administration Record for March 2026 for R7. The following was documented to be administered to R7 from 3/1/26 through 3/25/26.*Acetaminophen 500 milligram tablet, give 2 tablets by mouth two times daily for pain.* Plaquenil oral tablet 200 milligrams, give 1 tablet by mouth every morning and at bedtime for arthritis pain related to Rheumatoid Arthritis. (hold dated 3/19/26 to 4/1/26)* Gabapentin oral tablet 800 milligrams, give 1 tablet by mouth three times a day for pain. * Nursing order- acceptable level of pain is met. Document pain goal met, yes/no/sleeping. If not met, attempt a as needed nonpharmacological and/or pharmacological intervention. Every shift for pain management. Surveyor notes from 3/1/26 - 3/25/26, goal not met was documented 6 times.* Acetaminophen oral tablet 500 milligrams, give 2 tablets by mouth every 6 hours as needed for pain. Surveyor notes seven (7) days, from 3/1/26- 3/25/26, this prn pain medication was administered to R7. Pain levels ranged (scale 0-10) from 3 to 10. *Hydromorphone (a potent semi-synthetic opioid agonist, roughly 5 times more potent than morphine, used for severe pain-Wikipedia) oral tablet, give 1 tablet by mouth every 8 hours as needed for pain with a level of 7-10 related to Rheumatoid Arthritis and Fibromyalgia. Surveyor notes this as needed pain medication was administered to R7 43 times from 3/1/26 to 3/25/26. This is in addition to scheduled medications and additional supplemental pain medications. Pain levels ranged from 4 to 10.*Non-pharmacological interventions attempted for pain goal not met. 1) repositioning. 2) distraction. 3) warm blanket. 4) back rub. 5) ice. 6) other- place in progress note. From 3/1/26- 3/25/26 there was no documentation that any non-pharmacological interventions had been administered to R7. At the daily exit meeting on 3/25/26, at 3:30 PM, Surveyor shared concerns about R7's increase in pain and increased use of as needed medication for breakthrough pain. Nursing Home Administrator- A, DON (Director of Nursing)-B and Physician- HH (R7's primary Physician) were present during this discussion. Physician- HH stated he was aware R7 would have an increase in her pain levels because a particular medication she was taking for the Rheumatoid Arthritis was no longer being given because insurance said it was too expensive and won't pay for it any longer. Physician- HH stated this was about 1-2 months ago the medication had to be changed and what he thought would work is not working. Physician-HH stated R7 is on some really strong pain medications for her arthritis. R7 will complain of shoulder and knee pain. Physician- HH stated the pain happens with mobility. The previous medication really helped R7, and they will have to figure out something. Physician- HH stated he knowns R7 has a lot of breakthrough pain. Surveyor asked Physician- HH about nonpharmacological interventions being used in addition to scheduled medications. Physician -HH did not acknowledge if/any additional interventions were helpful or being used. Nursing Home Administrator- A and DON-B did not have any additional information to share regarding R7's increase in pain at this time.On 3/26/26, at 1:35 PM, Surveyor interviewed LPN (Licensed Practical Nurse)-W about R7's use of pain medications. LPN-W is familiar with R7 and stated R7 usually has the most amount of pain in the morning before she gets out of bed. After R7 receives her scheduled pain (continued on next page)

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	525172	A. Building B. Wing	04/06/2026

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications, in the morning, R7's pain is usually controlled. LPN- W stated she starts her morning medication pass with R7 to be sure she gets her pain pills first thing in the morning. On 3/26/26, at 3:05 PM, Surveyor interviewed R7 regarding her pain management while at the facility. R7 stated she has her good days and bad days. R7 stated her pain levels have been getting worse, and she has dealt with pain for many years due to arthritis. R7 stated she always makes sure she gets her medications, and the nursing staff takes good care of her. Surveyor asked R7 is there was anything that helped relieve the pain other than medications. R7 stated she does use a cream that she rubs on her shoulders and knees and that sometime laying down helps. R7 stated she doesn't like that she has to wait so long in between receiving her pain pills so she will often take Tylenol. Surveyor asked R7 what impact the pain has on her day-to-day activities. R7 stated she has lived with the pain for a long time, and it could always be worse. R7 stated she doesn't go to as many activities as she used to because of her pain.As of the time of exit, the facility did not provide additional information as to why they had not comprehensively assessed R7's increase in her pain levels and frequency. The facility did not update the plan of care with interventions that would provide R7 with some pain relief besides oral medications. The facility did not seek out alternatives to the arthritis medication, which previously had good effects, which had been discontinued by insurance due to cost.

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F 0806 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not ensure a resident's food allergy, once identified, was thoroughly assessed to determine how best to manage the resident's allergy and to ensure the resident did not receive food to which the resident was allergic. This was observed with 1(R24) of 1 resident experiencing a food allergy response.*R24 had a documented allergy to fish. R24 was served fish for lunch on 3/15/26 and experienced an anaphylactic response that was not identified and treated as anaphylaxis and R24 passed away at the facility.This created a finding of Immediate Jeopardy that began on 3/15/26. Nursing Home Administer (NHA)-A and Director of Nurses (DON) -B were notified of the Immediate Jeopardy on 3/26/26 at 10:40 AM. The Immediate Jeopardy was not removed at the time of exit on 4/6/26.Findings include:R24 was admitted to the facility on [DATE] with diagnoses of lung cancer and breast cancer. On 1/23/26 R24's Brief Interview of Mental Status (BIMS) assessment documented a score of 15 indicating no cognitive impairment. The Nursing Data Base Assessment completed upon admission dated 1/23/26 does not document R24 has food allergies.On 1/28/26 R24's medical record documents a Nutrition Assessment completed by Registered Dietitian (RD)-AA. This assessment documents an allergy to fish. Surveyor notes the assessment does not document what types of fish or R24's reaction or the severity of the reaction.R24's admission MDS (minimum data set) assessment and CAA (care area assessment) for Nutritional Status was completed on 1/30/26 by RD-AA. The nutritional summary does not document an allergy to fish or any other food allergy.R24's Plan of Care was reviewed. Surveyor notes R24's care plan does not document R24's allergy to fish including type of fish and severity of the reaction.Surveyor notes the Physician Plan of Care for R24 does document fish as an allergy.On 3/25/2026, at 11:52 AM, Surveyor interviewed RD-AA. RD-AA stated they spoke with R24, and R24 voiced they had a fish allergy. RD-AA stated they assume a fish allergy is all types of fish and did not ask for specific details. RD-AA stated they did not ask R24 what the reaction response was to the allergy. RD-AA states she does not do any of the care planning and would think all food allergies are written in the care plan. RD-AA stated she will always review any hospital paperwork for food allergies. R24 did not have any food allergies documented in the hospital paperwork.On 3/25/2026, at 9:33 AM, Surveyor interviewed Director of Food Services (DFS)-D. DFS-D stated the dietary staff involved in serving fish to R24 on 3/15/26 are no longer working at the facility. DFS-D stated the menu for 3/15/26 does not document fish quesadillas. DFS-D stated the menu has a small combo, cheese and spinach quesadilla, cream corn, and Mediterranean baked fish. DFS-D stated a combo would be a little bit of everything and the fish would be [NAME]. DFS-D stated the Diet Tech or RD would meet with new admissions for like and dislikes and allergies would go through PCC (electronic medical records system) and PCC communicates with the facility menu system. DFS-D stated R24's meal ticket did identify the fish allergy, and the cook did not follow it. DFS-D stated since 3/15/26, they have re-educated staff on allergies and use pink colored meal tickets to identify food allergies.Surveyor notes the facility completed an investigation into R24's change of condition and death that occurred on 3/15/26. The investigation found that R24 received fish for lunch on 3/15/26 and had an allergic reaction. Survyoer notes R24 passed away related to this event.The FRI investigation included a statement by CNA-Z which documents on Sunday, March 15th, 2026, around the time between 2:40 PM-3 PM resident in room (R24's room number) light was on. CNA-Z got to R24's room and R24 asked CNA-Z if they could heat up their left over food they had not finished. When CNA-Z grabbed R24's plate R24 asked CNA- Z if she thought the food looked like a chicken quesadilla. CNA-Z told R24 no, they had fish. R24 stated it was chicken. CNA-Y showed R24 that it was fish on the plate. R24 said it bet (sic) not be fish because they are allergic to fish. CNA-Z grabbed R24's meal ticket to look and noticed (the fish allergy listed). CNA-Z went to the nurse that was on that side (continued on next page)

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F 0806 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(LPN-Y) to confirm and let her know. LPN-Y went to go check on R24 and CNA-Z took the plate of food back to the kitchen and saw the supervisor (LPN-S) and told her what was going on. CNA-Z finished helping other residents while the nurses took over with R24. On 3/15/26, at18:48 (6:48 PM) R24's medical record documents a progress note written by Licensed Practical Nurse (LPN)- S which documents: Approx (approximate)1500 (3:00 PM) writer received call from 2nd floor. Upon arrival observed floor nurse doing vitals. Resident sitting in armchair alert and verbalizing with nurse. Writer noticed VS (vital sign) T (temperature) - 97.2, R (respiration)-22, BP (blood pressure)-163/66 and P (pulse)-40 Pox (oxygen saturation)-94% Resident with O2 (oxygen) 4L (liters) n/c (nasal cannula). Resident with no SOB (shortness of breath)/cough or difficulty breathing. Skin warm and dry, and no cyanosis (A bluish or grayish discoloration of the skin, lips, nail beds or mucous membranes caused by a lack of oxygen in the blood.) noted. Following verbal commands and answering questions. Resident denied pain when asked. Writer noted resident's pulse began to drop and began tiger text notification to MD (Medical Doctor). Noted further drop in pulse and writer gave instruction to staff to call 911. (approx. 1510) (3:15 PM). Administrator called to update on resident status, and received MD reply and informed her 911 had called already. Writer remained with resident in room for safety precautions. Resident became a little anxious in regard to being sent out to hospital r/t (related to) low pulse. Resident began to tremble and lose consciousness and slumped forward at the waist while still in sitting position. Writer was able to catch resident to prevent her falling to the floor. Resident (sic) assisted resident upright and resident responsive to verbal and tactile stimuli. Resident seem to become slightly agitated and removed O2 (oxygen) tubing from nose. Writer was able to calm resident and replace nasal cannula in nose. Resident pupils were dilated and she began to shake, arms flailing and passed out. Writer called for assistance both writer and nurse in room and assessed the resident and no pulse could be felt. EMTs (Emergency Medical Technician) arrived to unit approx. 1520 (3:20 PM). EMTs packed up supplies if (sic) next of kin had been notified.Cross reference F684.The facility's failure to ensure a resident's food allergy, once identified, was thoroughly assessed to determine how best to manage the resident's allergy and its failure to ensure R24 did not receive food to which R24 was allergic created a reasonable likelihood for serious harm, thus leading to a finding of immediate jeopardy. The Immediate Jeopardy was not removed at the time of exit on 4/6/26.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interview and record review the facility did not implement an effective Infection Control program to prevent the spread of infection. This includes infection surveillance, tracking and outbreak investigation. This has the potential to affect all 82 residents in the facility.*The Infection Preventionist (IP) did have documentation of infection surveillance logs with tracking for the last 3 months.* The IP did not have documentation of a covid outbreak to determine etiology and implementation of preventative measures.CROSS REFERENCE F883 and F887Findings include:1.) On 3/25/2026, at 11:03 AM, Surveyor requested infection control documents from Assistant Director of Nurses (ADON) -C, the facility designated Infection Preventionist, IP-DD is currently out of the facility. IP-DD started in this role in January 2026. On 3/26/2026, at 11:31 AM, ADON-C provided Surveyor with the surveillance and tracking of infections from the last 3 months. Surveyor noted the January 2026 surveillance log is not filled out for the surveillance of infections. There is a line list for a covid outbreak for residents and staff and there is a generated email included which documents a covid outbreak started on 1/6/26 and ended 1/16/26. Surveyor notes there is no investigation summary for the covid outbreak to determine etiology and preventative measures implemented.Surveyor notes the February 2026 Surveillance Log does not document organisms identified or tracking of infections. There is a line list for Gastrointestinal Illness that started on 2/1/26 with residents and staff. There is no additional documentation to interpret this line list data.Surveyor notes the March 2026 Surveillance Log does not thoroughly document organisms, criteria definition and tracking of infections. On 3/26/2026, at 12:33 PM, ADON-C informed Surveyor they did not locate any additional outbreak investigation information. On 3/26/2026, at 1:07 PM, ADON-C informed Surveyor IP-DD has terminated their employment today. ADON-C stated the facility did not have documents for tracking and trends of infections or outbreaks for the last 3 months. ADON-C stated they were the facility's IP before January. The infection surveillance, and tracking and trending, was completed prior to January 2026. ADON-C did track antibiotic use in the facility separate from the IP program. ADON-C has provided antibiotic tracking for the last 3 months.On 3/26/2026, at 1:37 PM, Nursing Home Administrator (NHA)-A stated IP-DD has not returned to work since Monday.

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NAME OF PROVIDER OR SUPPLIER Jewish Home and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1414 N Prospect Ave Milwaukee, WI 53202	

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did ensure residents were offered the pneumococcal and influenza vaccines, along with the risks and benefits of the vaccines, upon admission. This was observed with 5 (R17, R5, R35, R7 and R6) of 5 residents immunization review.*R17 was admitted to the facility on [DATE] and is [AGE] year. R17 received PPSV (pneumococcal polysaccharide vaccine) 23 in 2017. R17 had no documentation upon admission for PCV (pneumococcal conjugate vaccine) 15, PCV 20 or PCV21. * R5 was admitted to the facility on [DATE] and is [AGE] year. R5 received PPSV 23 in 2019. R5 had no documentation upon admission for PCV 15, PCV 20 or PCV21. * R35 was admitted on [DATE] and is [AGE] year. There is no documentation, of any pneumococcal and influenza vaccines, in their medical record.* R7 was admitted on [DATE] and is [AGE] year. There is no documentation of their pneumococcal vaccine upon admission. They were offered PPSV 23 a year after admission, and it was administered a month later, however they already received this vaccine in the community. *R6 was admitted on [DATE] and is [AGE] year. There is no accurate pneumococcal vaccine documentation in the medical record. There is no documentation of any pneumococcal vaccines being offered upon admission.Findings include:The facility's policy and procedure Influenza Vaccine revised 6/11/23. The Policy: All residents are offered and encouraged to obtain influenza immunization annually unless contraindicated or otherwise exempt by the primary care physician. Procedure: Residents: .5. Consent for the immunization including resident education regarding the risks and benefits of immunization is documented.6. The medication administration record should reflect that the resident either received or refused the immunization.7. If the resident is offered the vaccine and refuses education of risk and benefits will be reviewed with the resident but the resident still refuses the refusal would be documented in the medical record.The facility policy and procedure Pneumococcal Vaccine revised 11/2024.The Policy: All residents are encouraged to obtain the pneumovax (pneumococcal polysaccharide vaccine PPSV 23 and the pneumococcal conjugate vaccines PCV 15 or PCV 20) to aid in preventing pneumococcal infections example pneumonia. This is especially important to reduce the risk of secondary infections that can occur after exposure to some respiratory viruses.1.) R17 was admitted to the facility on [DATE] and is [AGE] year. R17's medical record documents they received the PPSV23 in 2017. R17 would be eligible a year later for PCV 20 or PCV 21; then a year after that PCV 15. The medical record, upon admission, does not document these vaccines were offered.On 3/26/2026, at 11:31 AM, Surveyor interviewed Assistant Director of Nurses (ADON)-C. The facility Infection Preventionist (IP)-DD terminated their employment this week. ADON-C stated the immunization process is admissions are reviewed on WIR (Wisconsin Immunization Registry), then the residents are screened for vaccine history and offered the required vaccines. They also obtain consents and review the risks and benefits. R17 signed a Pneumonia Vaccine Consent on 3/20/26 to receive the PPSV 23. This form documents, R17 received the PCV 20 vaccine on 3/26/26. This includes the risks and benefits for a pneumococcal vaccine. R17 was not offered PCV 20 or PCV 21 upon admission. R17 did not consent to receive PCV 20 which they received.On 3/26/2026, at 1:07 PM, Surveyor reviewed R17's pneumococcal vaccines with ADON-C. ADON-C stated there has been no PCV administered for the last couple years. This is the first year the PCV has been ordered. On 3/26/2026, at 3:21 PM, at the facility exit meeting with Nursing Home Administrator (NHA) -A, Director of Nurses (DON) -B and ADON-C. Surveyor shared the concerns with resident vaccines. 2.) R5 was admitted to the facility on [DATE] and is [AGE] year. R5's medical record documents they received the PPSV23 in 2019. R5 would be eligible a year later for PCV 20 or PCV 21; then a year after that PCV 15. The medical record, upon admission, does not document these were offered.On 3/26/2026, at 11:31 AM, Surveyor interviewed Assistant Director of Nurses (ADON)-C. ADON-C stated the immunization process is admissions are reviewed on WIR (Wisconsin Immunization Registry). Then the residents are screened (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for vaccine history and offered the required vaccines. They also obtain consents and review the risks and benefits. R5 signed a Pneumonia Vaccine Consent on 3/26/26 to receive the PPSV 23. This form documents, R5 received the PCV 20 vaccine on 3/26/26. This includes the risks and benefits for a pneumococcal vaccine. R5 was not offered PCV 20 or PCV 21 upon admission. R5 did not consent to receive PCV 20.On 3/26/2026, at 1:07 PM, Surveyor reviewed R5's pneumococcal vaccines with ADON-C. ADON-C stated there has been no PCV administered for the last couple years. This is the first year the PCV has been ordered. On 3/26/2026, at 3:21 PM, at the facility exit meeting with Nursing Home Administrator (NHA) -A, Director of Nurses (DON) -B and ADON-C. Surveyor shared the concerns with resident vaccines. 3.) R35 was admitted on [DATE] and is [AGE] year. R35's medical contains no documentation of any pneumococcal vaccines. There is no documentation the Influenza vaccine was offered. On 3/26/2026, at 11:31 AM, Surveyor interviewed Assistant Director of Nurses (ADON)-C. ADON-C stated the immunization process is admissions are reviewed on WIR (Wisconsin Immunization Registry). Then the residents are screened for vaccine history and offered the required vaccines. They also obtain consents and review the risks and benefits. On 3/26/2026, at 1:07 PM, Surveyor reviewed R35's pneumococcal vaccines with ADON-C. ADON-C stated there has been no PCV administered for the last couple years. This is the first year the PCV has been ordered. ADON-B did not have and additional information regarding the Influenza vaccine.On 3/26/2026, at 3:21 PM, at the facility exit meeting with Nursing Home Administrator (NHA) -A, Director of Nurses (DON) -B and ADON-C. Surveyor shared the concerns with resident vaccines. 4.) R7 was admitted on [DATE] and is [AGE] year. R7 medical record does not document any pneumococcal vaccines.On 3/26/2026, at 11:31 AM, Surveyor interviewed Assistant Director of Nurses (ADON)-C. The facility Infection Preventionist (IP)-DD terminated their employment this week. ADON-C stated the immunization process is admissions are reviewed on WIR (Wisconsin Immunization Registry). Then the residents are screened for vaccine history and offered the required vaccines. They also obtain consents and review the risks and benefits. R7 signed a Pneumonia Vaccine Consent on 3/27/26 to receive the PPSV 23. This form documents, R5 received on 3/26/26, the PCV 20 vaccine. This includes the risks and benefits for a pneumococcal vaccine. R7 was not offered PCV 20 or PCV 21 upon admission. R5 did not consent to receive PCV 20.On 3/26/2026, at 1:07 PM, Surveyor reviewed R5's pneumococcal vaccines with ADON-C. ADON-C stated there has been no PCV administered for the last couple years. This is the first year the PCV has been ordered. On 3/26/2026, at 3:21 PM, at the facility exit meeting with Nursing Home Administrator (NHA) -A, Director of Nurses (DON) -B and ADON-C. Surveyor shared the concerns with resident vaccines. 5.) R6 was admitted on [DATE] and is [AGE] year. The medical record documents PPSV 23 were administered in 2019. R6 would be eligible a year later for PCV 20 or PCV 21; then a year after that PCV 15. The medical record, upon admission, does not document these were offered.On 3/26/2026, at 11:31 AM, Surveyor interviewed Assistant Director of Nurses (ADON)-C. The facility Infection Preventionist (IP)-DD terminated their employment this week. ADON-C stated the immunization process is admissions are reviewed on WIR (Wisconsin Immunization Registry). Then the residents are screened for vaccine history and offered the required vaccines. They also obtain consents and review the risks and benefits. R6 signed a Pneumonia Vaccine Consent on 3/26/26 to receive the PPSV 23. This form documents, R6 received on 3/26/26, the PCV 20 vaccine. This includes the risks and benefits for a pneumococcal vaccine. R6 was not offered PCV 20 or PCV 21 upon admission. R6 did not consent to receive PCV 20.On 3/26/2026, at 1:07 PM, Surveyor reviewed R6's pneumococcal vaccines with ADON-C. ADON-C stated there has been no PCV administered for the last couple years. This is the first year the PCV has been ordered. On 3/26/2026, at 3:21 PM, at the facility exit meeting with Nursing Home Administrator (NHA) -A, Director of Nurses (DON) -B and ADON-C. Surveyor shared the concerns with resident vaccines.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not ensure residents were offered the covid vaccine, along with the risks and benefits. This was observed with 3 (R35, R7 and R6) of 5 resident immunization reviews.*R35 was admitted to the facility on [DATE]. There is no documentation R35 was offered the covid vaccine, along with risks and benefits, upon admission.*R7 was admitted to the facility on [DATE]. There is no documentation R7 was offered the covid vaccine, along with risks and benefits, upon admission.*R6 was admitted to the facility on [DATE]. There is no documentation R6 was offered the covid vaccine along with risks and benefits, upon admission.Findings include:The facility's policy and procedure COVID 19 vaccination policy- residents and employees revised 8/24 documents The Procedure includes: .8. The facility will educate and offer the COVID-19 vaccine to residents and staff and maintain documentation of such.14. The resident medical record will include documentation of the following: a. Education to the resident or resident representative regarding the risks, benefits and potential side effects of the COVID-19 vaccine.b. Each dose of the vaccine administered to the resident, orc. If the resident did not receive the COVID-19 vaccine due to medical contraindication or refusal.1.) R35 was admitted to the facility on [DATE]. R35's medical record does not contain documentation the COVID vaccine was offered, or documented as receiving, along with risks and benefits, upon admission.On 3/26/2026, at 11:31 AM, Surveyor interviewed Assistant Director of Nurses (ADON)-C. ADON-C stated the immunization process is admissions are reviewed on WIR (Wisconsin Immunization Registry), then the residents are screened for vaccine history and offered the required vaccines. They also obtain consents and review the risks and benefits. On 3/26/2026, at 3:21 PM, at the facility exit meeting with Nursing Home Administrator (NHA) -A, Director of Nurses (DON) -B and ADON-C. Surveyor shared the concerns R35 was not offered or did not receive a COVID vaccination. 2. R7 was admitted to the facility on [DATE]. R7's medical record does not contain documentation the COVID vaccine was offered, documented as receiving, along with risks and benefits, upon admission.On 3/26/2026, at 11:31 AM, Surveyor interviewed Assistant Director of Nurses (ADON)-C. ADON-C stated the immunization process is admissions are reviewed on WIR (Wisconsin Immunization Registry), then the residents are screened for vaccine history and offered the required vaccines. They also obtain consents and review the risks and benefits. On 3/26/2026, at 3:21 PM, at the facility exit meeting with Nursing Home Administrator (NHA) -A, Director of Nurses (DON) -B and ADON-C. Surveyor shared the concern R7 was not offered or did not receive a COVID vaccination. 3.) R6 was admitted to the facility on [DATE]. R6's medical record does not contain documentation the COVID vaccine was offered, or documented as receiving, along as risks and benefits, upon admission.On 3/26/2026, at 11:31 AM, Surveyor interviewed Assistant Director of Nurses (ADON)-C. ADON-C stated the immunization process is admissions are reviewed on WIR (Wisconsin Immunization Registry), then the residents are screened for vaccine history and offered the required vaccines. They also obtain consents and review the risks and benefits. On 3/26/2026, at 3:21 PM, at the facility exit meeting with Nursing Home Administrator (NHA) -A, Director of Nurses (DON) -B and ADON-C. Surveyor shared the concern R6 was not offered or did not receive a COVID vaccination.