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

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

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| F 0578<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .<br><br>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.<br><br>* 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].<br><br>* R24 completed paperwork to request a Do Not Resituate (DNR) status and the facility did not honor this request and performed Cardiopulmonary Resuscitation (CPR).<br><br>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].<br><br>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.<br><br>1.) R102 was admitted to the facility on [DATE] with diagnoses of cellulitis of left lower limb, dementia, and anxiety.<br><br>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.<br><br>R102's medical record documents R102 was deemed incapacitated at the hospital on [DATE].<br><br>R102's Power of Attorney for Health Care (POAHC) document dated [DATE] documents R102's<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0578<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>Emergency provider will not: Perform chest compressions, insert advanced airways, administer cardiac resuscitation drugs provide ventilator assistance and defibrillate.<br><br>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.).<br><br>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].<br><br>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<br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>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.<br><br>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.<br><br>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].<br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>On [DATE], R24's Advance Directive for Emergency Care DNR form was signed by R24's Medical Doctor (MD) – X.<br><br>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 agreed to go to the hospital. LPN-Y left the room to complete paperwork (for the hospital transfer)<br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | 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).<br><br>Surveyor notes 911 was called by the facility staff and facility staff started CPR.<br><br>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).<br><br>Surveyor notes R24 was provided CPR against their Advance Directives requesting a DNR status.<br><br>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.<br><br>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.<br><br>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 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**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.<br><br>*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.<br><br>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.<br><br>*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.<br><br>Findings include:<br><br>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.<br><br>On 1/28/26 a Nutrition Assessment was completed by Registered Dietitian (RD) – AA which documents R24 has an allergy to fish.<br><br>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.<br><br>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<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>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).<br><br>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.<br><br>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.<br><br>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.<br><br>On 3/25/2026, at 1:37 PM, Surveyor interviewed Medical Doctor (MD)-X. MD-X stated they were with<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | R17's Diabetic Ulcer of the Right Plantar Foot care plan was initiated on 3/13/2026.<br><br>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.<br><br>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.<br><br>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.<br><br>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 0806<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.<br><br>**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<br>(continued on next page) |

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| F 0806<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>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 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure that residents at risk for pressure injuries received necessary treatment and services consistent with professional standards of practice to promote healing and prevent new pressure injuries from developing or worsening for 1 (R98) of 5 residents reviewed for pressure injuries.*R98 was assessed on admission to be at risk for the development of pressure injuries. R98 developed an avoidable, unstageable pressure injury to the coccyx. R98's admission wound assessment completed on 3/5/26 documented a Stage 1 wound to R98's coccyx. R98's baseline care plan documented a barrier cream intervention with no further instructions for use and no other interventions in place to prevent pressure injury decline. Wound MD-BB was not made aware of the stage 1 wound to R98's coccyx on admission. On 3/17/26, R98's coccyx was assessed, and facility staff noted a worsening pressure injury. Facility staff did not complete a thorough wound assessment with description of the wound bed or staging of the wound. Wound MD-BB assessed R98 on 3/18/26 and documented an unstageable wound of the coccyx that was 100% necrotic. Facility staff initiated a skin integrity and pressure injury care plan on 3/18/26, but the care plan did not include interventions for offloading, or pressure reducing/relieving devices in bed or chair. Surveyor observed R98 on 3/24/26 in a recliner without a pressure relieving cushion from 8:09 AM through 12:47 PM.Findings include: The facility policy with a last revision date of 7/10/23, and titled, Wound treatment guide for initial wound evaluation documents, in part: The facility strives to ensure that a resident entering the facility with pressure injuries does not develop further pressure injuries or that the worsening of the pressure injury occurs unless the individual's clinical condition demonstrates that they were unavoidable. A resident with altered skin integrity will receive the necessary treatment and services to promote healing, prevent infection, and prevent further impairments from developing. Procedure: Identify and assess the wound, measure, identify wound base tissue and determine amount of drainage. Choose the treatment protocol based on above assessment. Obtain Physician's order. Cleanse all wounds with normal saline or wound cleanser unless otherwise directed by physician. Apply skin protectant to wound edges as ordered. Change dressing every 1-7 days based on product. Re-evaluate weekly and change treatment as needed. Stage 1 or suspected Deep Tissue Injury (without blister formation): Apply house skin protectant twice daily and monitor each shift for changes until resolves. If area changes proceed to appropriate treatment based on clinical assessment. Put additional pressure relief measures in place as indicated.Surveyor noted facility policy documents that a stage 1 wound should have house skin protectant applied twice daily and the wound should be monitored each shift until it is resolved.The facility policy with a last revision date of 7/10/23, and titled, Evaluation and measurement of a wound documents, in part: Policy/purpose: to standardize and ensure consistent documentation among clinicians using anatomic structures when evaluation and documenting wound assessment and wound changes. Procedure: All licensed nurses are responsible to document any wound noted upon admission, readmission and/or changes in the status of resident skin or wounds as they occur in the Electronic Medical Record. Licensed staff should obtain and complete necessary evaluations, place on 24-hour board for monitoring, implement interventions, ensure appropriate treatment in place, submit referrals, and update the Physician and Responsible Party of any changes. Initial documentation to include: Document the type of wound and location of wound. Describe the stage (refer to staging of pressure ulcers) OR wound base type/color. Document the size. Measure in centimeters- ALWAYS= length x width x depth. Describe the drainage (exudates)- type, amount, color, odor. Surveyor noted facility policy documents if a wound is found, it should be evaluated, interventions should be implemented, and a treatment should be put in place. The facility's policy documents an initial wound assessment should include type, location, stage and measurements.The facility policy with a last revision date of 7/10/23, and titled, Pressure injury prevention, assessment<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | and treatment documents, in part: The facility will ensure that a resident who enters the facility without pressure injuries does not develop pressure injuries unless the individual's clinical condition demonstrates that they are unavoidable. A resident with pressure injuries will receive the necessary treatment and services that promote healing, prevents infection, promotes comfort, ensures dignity and attempts to prevent further pressure related injuries from developing. A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. On admission, residents will have their skin assessed and any skin issues documented in the medical record. Interventions will be put into place, and the wound team or designee will review the wounds and the interventions used to promote healing at least weekly. Potential for skin break down and actual break down in integument system will be assessed and care planned. Residents assessed at risk for skin break down will have interventions in place while in bed and when up in a wheelchair. If a resident refuses intervention, this will be documented, and care planned.*R98 was admitted to the facility on [DATE] with diagnoses including Chronic Congestive Heart Failure (CHF) (Condition where the heart muscle cannot pump blood efficiently causing fluid buildup in the lungs and body), Stage 3 chronic kidney disease (Chronic kidney damage), and Protein-calorie malnutrition. R98's admission Minimum Data Set (MDS) assessment dated [DATE] documents R98 is cognitively intact. R98 requires supervision or touching assistance for bathing, toileting, bed mobility and transfers. R98 is occasionally incontinent of bowel and bladder. R98 is at risk for developing pressure injuries. R98's Pressure Injury Care Area Assessment (CAA) dated 3/11/26 documents, in part: [R98 is] at risk for skin break down related to need for [activity of daily living (ADL)] assistance for bed mobility. Extrinsic risk factors: Pressure: [R98] needs special mattress or seat cushion to reduce or relieve pressure. [R98] had a decline in ADL function and transfers [status post] hospitalization for bilateral pleural effusions, acute/chronic CHF, . [stage 3 chronic kidney disease], moderate calorie malnutrition . R98's admission Braden scale assessment (an assessment tool used to predict a patient's risk of developing pressure injuries) completed on 3/5/26 documents a score 17, indicating R98 is at risk for developing pressure injuries. R98's admission skin assessment dated [DATE] documents, in part: Coccyx. Other-Redness. Stage 1. R98's progress note dated 3/5/26 at 8:34 PM, documents, in part: Skin warm, dry, and intact. Has drain site on the left rib cage covered with a pressure dressing, puncture site [related to] thoracentesis on the right rib cage [open to air], multiple bruises on the right forearm from IVs and blood draws, and redness of the coccyx area. Surveyor noted staff documented a stage 1 area of redness on R98's coccyx on admission. Surveyor noted a thorough assessment was not completed on R98's wound. Facility staff did not measure or describe the wound further than redness. R98's Individual Resident Care Plan form dated 3/5/26, documents in part: (Develop within 48 hours of admission) . Skin Risk: High or greater risk (implement intervention)- blank. Special Mattress-blank. Barrier cream- checked off. [Wheelchair] cushion- blank. Repositioning- blank. Incision- left side pleurex [drain]. Wound location: blank. Surveyor noted the paper baseline care plan had an intervention of only barrier cream listed. Surveyor noted there were no instructions as to how often, where and when the barrier cream should be used. Surveyor noted there were no other interventions for offloading of coccyx implemented on the baseline care plan even though a stage 1 area of redness was identified on admission to the facility. Surveyor reviewed R98's comprehensive care plan and noted facility staff did not initiate an at risk for skin integrity impairment care plan or an at risk for pressure injury care plan for R98 upon admission. Surveyor reviewed R98's medical record and noted facility staff did not document R98's MD or Wound MD-BB was made aware of R98's stage 1 area of redness to the coccyx. Surveyor reviewed R98's MD orders. Surveyor noted a treatment order for R98's stage 1 wound was not initiated when found on admission. On 3/25/26 at 9:42 AM, Surveyor interviewed Assistant Director of Nursing (ADON)-C. Surveyor asked how the admission skin assessment is completed. ADON-C stated 2 nurses will assess the resident's skin. If there is a concern, the wound nurse should be informed, the wound MD should be made aware, (continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | a treatment should be put in place, and an intervention should be placed. Surveyor asked if ADON-C was aware facility staff documented a stage 1 area of redness for R98 on admission. ADON-C stated ADON-C was not aware. ADON-C stated the nurse should have notified the wound nurse, obtained consent for the wound team to see R98, obtained a treatment order and started care planning. Typically, after an area is identified, facility staff will talk about it in a stand-up meeting, but ADON-C stated R98 was not one that was discussed on stand up after R98's admission. On 3/25/26 at 10:33 AM, Surveyor interviewed Director of Nursing (DON)-B. Surveyor asked what the expectation is for an initial skin assessment. DON-B stated 2 nurses should complete the assessment. If the facility wound nurse is working, they will be the second nurse. Any skin impairment is documented within the first 24 hours. Surveyor asked what should be completed if a stage 1 wound is documented on an initial skin assessment. DON-B stated the facility wound nurse should lay eyes on the concern and follow it. Wound MD -BB would follow it as well. Surveyor asked if a stage 1 wound is found on admission if that should be addressed in a care plan. DON-B stated it should be care planned. Initially, staff use the paper baseline care plan to place interventions. Surveyor asked if a stage 1 wound requires a treatment order to be in place. DON-B stated it should have a treatment in place. Surveyor noted facility staff did not follow the process explained by ADON-C and DON-B. Surveyor noted ADON-C and DON-B stated with a stage 1 wound, the wound nurse and Wound MD-BB should have been notified, care planning should have been completed, and a treatment should have been ordered. R98's progress note dated 3/17/26 at 9:12 PM, documents, in part: . Resident was seen by Unit Manager, noted 1 x 1.5 wound to coccyx. Wound nurse will see on 3/18/26. R98's skilled charting note dated 3/17/26 at 9:12 PM, documents, in part: . Wound care: Resident has treatable wounds. Pressure, coccyx 1 x 1.5. Dressing changed as per treatment orders . Wound doctor will see 3/18/26. Surveyor noted R98's coccyx wound was not thoroughly assessed on 3/17/26 when the Unit Manager identified a 1 x 1.5 wound to the coccyx. Facility staff did not stage or provide a description of the wound bed including any eschar (black tissue), granulation (pink tissue) or slough (white tissue). On 3/25/26 at 10:15 AM, Surveyor interviewed Registered Nurse Manager (RN)-O. Surveyor asked what process nurses follow if a skin concern is identified on assessment. RN-O stated the nurse would assess the concern by measuring it, describing the wound bed or staging it, informing the MD and entering care plan interventions. RN-O stated if it were on a resident's buttocks, we would enter repositioning intervention, cushion in chair, or offloading in the afternoon. Surveyor reviewed R98's care plan and noted a pressure injury care plan was not initiated when R98's wound was identified on 3/17/26. R98's Wound MD-BB evaluation dated 3/18/26 documents, in part: Unstageable (due to necrosis) coccyx, full thickness. Etiology: Pressure . 1.5 x 1 x 0.1 . 100% thick adherent devitalized necrotic tissue . Dressing treatment plan: Xeroform gauze apply once daily and as needed . Gauze Island [with border] apply once daily and as needed . The importance of side to side in bed, elevate legs, off load heels, limit time up in chair, high protein diet, keeping wounds clean [and] dry, looking for signs of infections, air bed were (sic) discussed . The patient's plan of care was discussed with Patient, Nursing staff member . R98's MD order with a start date of 3/18/26, documents, in part: Cleanse wound to coccyx with normal saline and pat dry. Apply skin prep to peri wound. Apply Xeroform cut to wound base size and cover with gauze island border dressing once daily and [as needed]. R98's progress note dated 3/18/26 at 11:40 AM, documents: Resident seen by wound MD and nurse for unstageable [due to] necrosis pressure ulcer to coccyx. Initial assessment for wound MD. Treatment in place. Wound MD recommends air mattress and new cushion for resident. MD updated. Will treat as ordered. Surveyor noted Wound MD-BB documented in R98's wound notes on 3/18/26 the importance of an air mattress. Surveyor noted that facility staff documented Wound MD-BB recommended an air mattress. Surveyor notes an air mattress was implemented on 3/20/26. R98's unstageable [due to] necrosis pressure ulcer to coccyx care plan initiated on 3/18/26, documents the following interventions: Administer treatments as ordered and monitor effectiveness. Complete Braden with any admission, readmission, quarterly assessment, change of condition assessments, new pressure injury (continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | and as needed. Follow facility policies/protocols for the prevention/treatment of skin breakdown. Monitor/document/report [as needed] any changes in skin status: appearance, color, wound healing, [signs/symptoms] of infection, wound size (length x width x depth), stage. R98's potential for skin impairment to skin integrity care plan initiated on 3/18/26, documents the following interventions: Encourage good nutrition and hydration in order to promote healthier skin. Identify/document potential causative factors and eliminate/resolve where possible. Keep skin clean and dry. Use lotion on dry skin. Surveyor noted facility-staff initiated skin integrity and pressure injury care plans 13 days after the initial skin assessment documented a stage 1 coccyx wound and a day after the coccyx wound developed into an unstageable pressure ulcer. Surveyor noted that the interventions documented as important by the Wound MD were not all initiated on R98's skin integrity or pressure injury care plan. Interventions not included in R98's care plan were the importance of side to side in bed, elevating legs, off-load heels, limit time up in chair, and air mattress. R98's Care Card dated 3/24/26, documents, in part: Turn and reposition while awake [every] 2-3 [hours]. On 3/24/26 at 8:09 AM, Surveyor interviewed R98. R98 stated R98 developed a wound while at the facility. R98 informed Surveyor R98's mattress is hard and causes R98 to be uncomfortable at times. R98 stated a new mattress is supposed to be coming today. R98 stated R98 has limited movement because any movement causes shortness of breath. R98 stated R98 does not float heels or wear boots on heels while in bed. R98 stated R98 does not have a seat cushion in recliner. Surveyor noted a seat cushion in R98's wheelchair. Surveyor asked if R98 uses the wheelchair. R98 stated R98 does not use the wheelchair much. Surveyor did not observe air mattress machine at end of R98's bed. On 3/25/26 at 7:21 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-E. Surveyor asked what interventions have been implemented for R98's pressure injury. LPN-E stated staff reposition R98 every 2 hours. LPN-E stated R98 sits in recliner during the day. LPN-E stated pain medications are used as needed to control pain. Staff make sure R98 is always dry and change R98's brief as needed. Surveyor asked if R98 has an air mattress. LPN-E stated LPN-E was not sure. LPN-E stated maintenance told LPN-E the facility is low on-air mattresses and they are waiting for 3 new air mattresses to place on resident beds that need it. On 3/25/26 at 8:18 AM, Surveyor interviewed Director of Plant Operations (DOPO)-F. Surveyor asked how residents are able to get an air mattress. DOPO-F stated nursing staff will put a work order in and then it will be assigned to a maintenance employee to take care of replacing the mattress. Surveyor asked how long it typically takes to get an air mattress placed after a work order is placed. DOPO-F stated it varies, but typically, no longer than a business day. Surveyor asked if there was a shortage of air mattresses at the facility. DOPO-F stated all of the facility's air mattresses are in use and there is an order placed for more air mattresses. Surveyor asked if DOPO-F had received a work order for R98 to receive an air mattress. DOPO-F stated DOPO-F would check and get back to Surveyor. On 3/25/26, at 8:42 AM, DOPO-F returned to Surveyor and stated the first work order for an air mattress for R98 was placed on 3/20/26. The air mattress was placed on the same day on 3/20/26. DOPO-F provided the work order to Surveyor. On 3/25/26, at 10:29 AM, DOPO-F walked Surveyor to R98's room. DOPO-F stated typically the air mattress machine is placed hanging off the end of a resident's bed. In R98's case, the machine is hanging under the bed on the bed frame. Surveyor observed the air mattress on and functioning. DOPO-F confirmed the air mattress has been in place since 3/20/26. R98's work order dated 3/20/26, documents: Comments- Hi, Resident in [R98's room] will need an air mattress. Can someone replace [R98's] mattress with an air mattress? Thank you! (assigned on 3/20/26 at 10:03 AM). Notes- [R98's room number] The regular mattress was placed in the wheelchair room. The air mattress was installed on to the bed frame. 3/20/26 at 2:34 PM. Surveyor noted R98's initial skin assessment revealing a stage 1 wound on R98's coccyx, R98 received a regular facility mattress. Surveyor noted R98's coccyx wound worsened on 3/17/26 and R98 continued using the initial mattresses assigned upon admission. Surveyor noted on 3/18/26, Wound MD recommended an air mattress, and the air mattress was not promptly placed. Surveyor noted that an air mattress was placed 3 days after R98's coccyx wound<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | worsened and 2 days after it was ordered by Wound MD-BB. On 3/24/26 at 8:09 AM, Surveyor observed R98 in R98's recliner chair. R98's feet were in slipper socks and resting on the floor. Surveyor noted R98 does not have a pressure-relieving seat cushion in recliner. On 3/24/26 at 10:39 AM, Surveyor observed R98 in R98's recliner chair. R98's feet were in slipper socks and resting on the floor. Surveyor noted R98 does not have a seat cushion in recliner. On 3/24/26 at 12:47 AM, Surveyor observed R98 in R98's recliner chair. R98's feet were in slipper socks and resting on the floor. Surveyor noted R98 does not have a seat cushion in recliner. Surveyor noted that from 8:09 AM through 12:47AM, R98 was observed in the same position in R98's recliner without a seat cushion. Surveyor noted on 3/18/26, Wound MD-BB recommended that R98 should limit time up in chair. On 3/24/26, R98 was observed to be sitting in chair for over 4 hours. On 3/24/26 at 3:56 PM, Surveyor observed R98 lying in bed on R98's back. R98's heels are resting directly on the bed. On 3/25/26 at 7:05 AM, Surveyor observed R98 lying in bed on R98's back. R98's heels are resting directly on the bed. Surveyor noted on 3/18/26 Wound MD-BB recommended elevating legs and offloading heels. These interventions were not in place on Surveyor's observations. R98's Wound MD-BB evaluation dated 3/25/26, documents, in part: Unstageable (due to necrosis) coccyx full thickness. Etiology: pressure. 1.3 x 0.8 x 0.1. 70% necrotic. 30% granulation. Treatment plan [remains the same]. On 3/25/26 at 9:42 AM, Surveyor interviewed Assistant Director of Nursing (ADON)-C. Surveyor asked what interventions are in place for R98's pressure injury. ADON-C stated R98 is on a turning schedule every 2-3 hours while in bed. Surveyor asked where staff document the repositioning has taken place. ADON-C stated it should be in the Treatment Administration Record (TAR). ADON-C stated it is an order, and the nurses can answer yes or no if the repositioning was completed or not. ADON-C stated R98 is not to be in the recliner longer than 2 hours. Surveyor asked where that is documented. ADON-C stated ADON-C believes that it was part of R98's preference discussed at R98's care conference. ADON-C stated R98's family present at the care conference stated R98's buttocks hurt when R98 was in recliner. Surveyor asked if R98 has a pressure relieving cushion for R98's recliner. ADON-C stated, not to my knowledge. Surveyor asked when an air mattress is put in place for residents. ADON-C stated it is put in place if the Braden score indicates the resident is at risk for developing pressure injury. Surveyor asked if a Stage 1 is considered a wound. ADON-C stated yes. Surveyor asked when R98's air mattress was placed on R98's bed. ADON-C stated R98 was placed on an air mattress fairly quick. ADON-C confirmed the air mattress was placed on 3/20/26. Surveyor asked if it takes 3 days after a wound worsens for an air mattress to be placed. ADON-C stated it was placed fairly quick. Surveyor reviewed R98's MD orders and noted R98 does not have an active order for turning and repositioning. Surveyor did not locate documentation indicating that it is being completed. Surveyor reviewed R98's EMR and did not locate facility staff documentation about R98's recliner use and limiting time in the recliner. On 3/25/2026 at 8:05 AM, Surveyor interviewed Wound MD-BB. Surveyor asked what caused R98's coccyx wound to develop into an unstageable pressure injury. Wound MD-BB stated R98's wound was caused by pressure. Wound MD-BB stated R98 has multiple comorbidities and an overall decline. Surveyor asked if Wound MD-BB was made aware of R98's stage 1 wound on admission. Wound MD-BB stated Wound MD-BB was not aware. Wound MD-BB was brought on R98's case when the coccyx wound was unstageable. Surveyor asked what interventions should be in place for R98. Wound MD-BB stated facility staff should be offloading R98's coccyx, R98 should limit time in R98's chair. R98 should have an air mattress and a cushion for R98's chair. On 3/25/26 at 10:38 AM, Surveyor informed DON-B and Nursing Home Administrator (NHA)-A of the concern R98 was assessed to be at risk for developing pressure injuries on admission. R98's admission skin assessment included documentation of a stage one area of redness on R98's coccyx. The only intervention put in place was barrier cream, but there was no documentation of where, when and how often the barrier cream was to be used. Facility did not put a treatment order in place for the stage 1 wound. R98 did not have an air mattress after finding a stage 1 wound and after being assessed by facility staff to be at risk for developing pressure injuries. On 3/17/26, less than 2<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | weeks after admission, R98's coccyx wound worsened. A thorough wound assessment including staging or description of the wound bed was not completed. On 3/18/26, Wound MD diagnosed R98 with an unstageable 100% necrotic pressure injury. Wound MD recommended an air mattress be placed. Facility staff placed an air mattress on 3/20/26, 3 days after R98's coccyx wound deteriorated. On 3/18/26, facility staff initiated a skin integrity care plan and pressure injury care plan but did not include all the recommended interventions made by Wound MD on 3/18/26. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>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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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, and record review, the facility did not ensure food was prepared and served in accordance with professional standards for food service safety potentially affecting the residents on the third floor and 7 residents who are on a pureed diet. Cook-L served residents on the third floor and was observed to touch with gloved hands food as it was being plated after touching other unclean surfaces. The food served from the steam table was not temped prior to serving to ensure the food was held at an appropriate temperature. Cook-L pureed the lunch meal without following the guidelines for the correct consistency of having a smooth texture; the pureed taco meat was the consistency of thin, watery gravy and the pureed mixed vegetables were thick and clumpy. Findings include: The facility policy and procedure titled Puree (PU4) from the MealSuite Diet Manual p. 48, undated, documents: Definition/Indication: The standards for the International Dysphagia Diet Standardization Initiative (IDDSI) Level 4 Puree (PU4) are used for this texture. The puree texture is designed for individuals with dysphagia or those who have moderate to severe chewing and/or swallowing difficulties. The foods on this texture are blended until smooth, cohesive, and homogenous requiring no chewing or manipulation for swallowing. Additional liquid may be used to moisten foods to achieve the necessary and desired consistency. Coarsely textured and sticky foods are avoided. All foods on this diet should be smooth and free of lumps. On 3/23/2026 at 12:47 PM, Surveyor observed the lunch service on the third floor dining room. The steam table with the menu items already in place in metal bins was brought up from the kitchen and placed in the kitchenette area of the dining room for meal service. The meal consisted of cold soup and taco salad in a tortilla shell with mixed vegetables on the side or grilled cheese sandwiches. Cook-L began plating food for the residents in the dining room. Surveyor did not observe Cook-L temp any of the items on the steam table and the steam table was not plugged into an outlet or turned on. Cook-L ladled soup into bowls from the steam table. Cook-L informed residents that the soup was gazpacho, a cold soup. Cook-L had gloves on and touched resident meal tickets, cabinet doors to get divided plates out, the outside of the metal bins in the steam table, the top of the steam table where the tickets and outgoing food was placed, and the microwave handle and buttons. Cook-L picked up the grilled cheese sandwiches with the same gloved hands, separated the sandwiches into halves and placed the sandwiches on the plate. Cook-L touched the mixed vegetables with the gloved hands to keep the vegetables on the plate. Cook-L touched the taco salad shell with the gloved hands to center it on the plate. No hand hygiene was observed. Cook-L changed gloves twice during service with no hand hygiene performed before putting on clean gloves. Partway through lunch service, Cook-L began using tongs to plate the grilled cheese sandwiches. Cook-L served pureed taco meat and pureed mixed vegetables on a divided plate. The pureed taco meat was the consistency of runny gravy and was contained by the rim of the divided plate. The pureed mixed vegetables were thick and chunky, not smooth in consistency. Residents complained that all the food on the plate was cold. Cook-L placed the plate in the microwave to heat up the meal. Surveyor asked Cook-L if the food had been temped in the dining room prior to serving the food. Cook-L stated the food is temped in the kitchen when it is put in the steam table, but they do not re-temp the food on the floors. Surveyor asked Cook-L if the steam table was plugged in. Cook-L stated the steam table is normally plugged in when it gets to the dining room, but this was a brand-new steam table that had been delivered that morning and had never been plugged in. Cook-L stated that was why Cook-L was microwaving some of the food. Surveyor asked Cook-L what prompted Cook-L to use the tongs for the grilled cheese sandwiches. Cook-L stated Cook-L should have used the tongs to begin with and had just forgotten. Surveyor asked Cook-L how often Cook-L washes their hands during service. Cook-L stated Cook-L washes their hands at the end of the service and will change gloves a couple of times but does not wash hands between changing gloves. On 3/24/2026 at 3:00 PM, Surveyor shared with Nursing Home Administrator (NHA)-A and<br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Director of Nursing (DON)-B the observation of the lunch meal on 3/23/2026 with Cook-L serving ready to eat foods with contaminated gloves and hand hygiene was not performed between glove changes. Surveyor also shared the concern residents puree meat was served in a runny consistency and the puree vegetables were served with chunks observed and not smooth. In an interview on 3/26/2026 at 2:38 PM, Surveyor asked Kitchen Manager (KM)-H who prepares the pureed food and how is it made. KM-H stated the lunch cook purees the meal prior to lunch service and the dinner cook purees the meal prior to dinner service. KM-H stated there are recipes for each meal that is served and the recipe says to add flavored liquid and then the food to make it correctly. Surveyor asked KM-H who pureed the lunch meal on 3/23/2026. KM-H stated Cook-L pureed the food, but it should have been a pudding like consistency. KM-H stated KM-H had heard about the concerns with the lunch meal not having the pureed food at the right consistency. KM-H stated the recipe for pureed food should be followed every time because it is dangerous to give the wrong consistency to residents and there is a reason the resident is on that diet. KM-H stated the pureed food should be smooth with no lumps. KM-H stated Cook-L had been working at the facility for 2 months and they have in-service training monthly with a film showing the consistency the different textures of food should be and to use the recipe every time an altered diet is made. Surveyor shared with KM-H the concern the new steam tables had not been heated up prior to use. KM-H agreed the steam tables were new that morning, but the food should have been up to temp when served. |

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| | 525172 | A. Building<br>B. Wing | 04/06/2026 |

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| Jewish Home and Care Center | 1414 N Prospect Ave<br>Milwaukee, WI 53202 |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>**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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>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 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure PRN (as needed) orders for psychotropic medications had a documented rationale for extending the use beyond 14 days and indicate the duration of the PRN order for 1 (R17) of 5 residents reviewed for unnecessary medications. R17 had an order for clonazepam, an antianxiety medication, 0.25 mg every 12 hours as needed for anxiety initiated on 12/16/2025 with no stop date. The clonazepam was discontinued on 3/1/2026 and reordered on 3/2/2026 with no stop date. Findings include: The facility policy and procedure titled Use of Psychotropic Medication dated 7/12/2023 documents: . 9. PRN orders for all psychotropic drugs shall be used only when the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record, and for a limited duration (i.e. 14 days). a. If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she shall document their rationale in the resident's medical record and indicate the duration for the PRN order. R17 was admitted to the facility on [DATE] with the diagnosis of anxiety disorder. R17's Significant Change Minimum Data Set (MDS) assessment dated [DATE] documented R17 took antianxiety medications and the Psychotropic Medication Care Area Assessment (CAA) associated with that MDS assessment documented R17 takes antianxiety medications as needed. R17's Behavior Problem related to Anxiety Care Plan was initiated on 8/6/2025 and R17's Mood Problem related to Anxiety Care Plan was initiated on 12/14/2025. On 8/10/2025, R17 had an order for clonazepam 0.25 mg daily for anxiety. On 9/8/2025, R17's clonazepam increased to 0.5 mg twice daily for anxiety. R17 was hospitalized from [DATE] to 10/6/2025. On 10/7/2025, R17 had an order for clonazepam 0.25 mg daily for anxiety for three days, ending on 10/9/2025. On 10/16/2025, R17 had an order for clonazepam 0.25 mg daily for anxiety.On 10/22/2025, R17's clonazepam increased too twice daily. On 12/16/2025, R17 had an order for clonazepam 0.25 mg every 12 hours as needed (PRN) for anxiety in addition to the scheduled twice daily clonazepam. No stop date was documented for the PRN clonazepam. On 1/7/2026, the pharmacist monthly medication review documented R17 had a PRN order for clonazepam 0.25 mg every 12 hours PRN which had been in place for greater than 14 days without a stop date. The pharmacist recommended discontinuing the PRN clonazepam. The pharmacist documented: If the medication cannot be discontinued at this time, please document the indication for use, the intended duration of therapy, and the rationale for the extended time period. Rationale for Recommendation: CMS (Centers for Medicare and Medicaid Services) requires that PRN orders for non-antipsychotic psychotropic drugs be limited to 14 days unless the prescriber documents the diagnosed specific condition being treated, the rationale for the extended time period, and the duration for the PRN order. No follow up on the recommendation was documented. On 2/4/2026, the pharmacist monthly medication review documented R17's clonazepam PRN is mandated to a 14-day trial by CMS and then evaluated to continue and it is beyond the 14 days at this time. The pharmacist recommended discontinuing the PRN clonazepam. No follow up on the recommendation was documented. On 3/1/2026, R17's scheduled clonazepam and PRN clonazepam were discontinued and reordered on 3/2/2026 with no stop date for the PRN clonazepam. On 3/4/2026, the pharmacist monthly medication review documented R17 had a PRN order for clonazepam 0.25 mg every 12 hours PRN which had been in place for greater than 14 days without a stop date. The pharmacist recommended discontinuing the PRN clonazepam. The pharmacist documented: If the medication cannot be discontinued at this time, please document the indication for use, the intended duration of therapy, and the rationale for the extended time period. Rationale for Recommendation: CMS requires that PRN orders for non-antipsychotic psychotropic drugs be limited to 14 days unless the prescriber documents the diagnosed specific condition being treated, the rationale for the extended time period, (continued on next page) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | and the duration for the PRN order. No follow up on the recommendation was documented. On 3/24/2026 at 8:19 AM, Surveyor observed R17 being assisted by staff members to go to the dining room for breakfast. R17 was adamant that Director of Nursing (DON)-B does not put the foot pedals on the wheelchair because the wheelchair would not fit under the table in the dining room with the foot pedals on. DON-B tried to explain the safety reasons for putting the foot pedals on the wheelchair for transport so R17's feet would not get stuck under the wheelchair. R17 finally compromised and allowed the foot pedals to go on the chair when DON-B agreed to remove the foot pedals once in the dining room. R17 was very vocal with their wishes. Surveyor asked R17 if R17 had any concerns with the care R17 was receiving. R17 stated R17 has a lot of medical issues and has been admitted to the hospital many times which causes anxiety. R17 talked at a rapid pace and had many other concerns that were brought forward. In an interview on 3/24/2026 at 1:06 PM, Surveyor asked DON-B how physicians are notified of pharmacy monthly medication reviews and recommendations. DON-B stated each physician has a folder on each unit where pharmacy recommendations are put, along with other communications for the physician. DON-B stated the Registered Nurse Unit Managers also get the recommendations if changes are needed. On 3/25/2026 at 3:17 PM, Surveyor shared with Nursing Home Administrator (NHA)-A, DON-B, and Medical Director (MD)-X the concern R17 has an order for PRN clonazepam with no stop date and has been on the medication for greater than 14 days. In an interview on 3/25/2026 at 3:42 PM, MD-X stated R17 has very severe anxiety and a lot of reasons to be scared and anxious with all R17's medical comorbidities. MD-X stated personality wise, R17 had been on those medications for a long time and had discussions with the pharmacist. MD-X stated R17 is in and out of the hospital a lot, for nephrostomy tubes coming out and requiring dialysis. MD-X stated R17 needs the schedule and PRN clonazepam. MD-X stated the pharmacist said if it was documented with risk and benefits, that would cover it. MD-X stated MD-X orders a 30-day supply with five refills and did not know there had to be a stop date even though that was how it was ordered. MD-X stated MD-X did a risk benefit for R17 and then MD-X sends it to be scanned into the medical record. MD-X stated MD-X would look for a copy to provide to Surveyor. No copy was provided and the PRN clonazepam continued with no stop date as of 3/30/2026. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**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.<br><br>*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.<br><br>*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.<br><br>Findings include:<br><br>The facility's policy titled Freedom of Abuse, Neglect and Exploitation, last reviewed 6/12/25, documents:<br><br>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.<br><br>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.<br><br>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.<br><br>R107 was admitted to the facility on [DATE].<br><br>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.<br><br>On 3/24/26, Surveyor reviewed a facility self-report dated 1/25/26 which documents the following:<br><br>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.<br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>2.) R82 was admitted to the facility on [DATE].<br><br>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.<br><br>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.<br><br>Surveyor conducted further review of the facility's investigation and noted that they did not contact law enforcement of the suspected abuse, per policy.<br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>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.<br><br>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 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>Based on interview and record review the facility did not ensure 1 (R107) of 1 residents reviewed for discharge had the discharge summary documented in the resident's medical record. R107 was discharged from the facility on 1/25/26, and the facility did not have a discharge summary for R107's facility stay. Findings include: The facility's policy titled Transfer and Discharge Policy, dated 7/2017, last revised on 7/22/24 documents the following:Anticipated Transfers or Discharges - resident-initiated discharges:A member of the interdisciplinary team completes relevant sections of the discharge summary. The nurse caring for the resident at the time of discharge is responsible for ensuring a discharge summary is complete and includes, but not limited to, the following:A recap of the resident's stay that includes diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology in consultation results.A final summary of the resident's status. On 3/25/26, Surveyor reviewed R107's Electronic Medical Record (EMR) which documents R107 discharged from the facility on 1/25/26. Surveyor notes, R107's medical record did not include a discharge summary including a summary of R107's stay and course of treatment in the facility. On 3/25/26, at 10:05 AM, interviewed Director of Nursing (DON)-B and asked if a discharge summary was completed for R107's stay at the facility. DON-B stated she will look to see if there is a discharge summary for R107. On 3/25/26, at 3:18 PM, Surveyor notified Nursing Home Administrator (NHA)-A and DON-B of concern with R107 having no discharge summary. NHA-A and DON-B acknowledged these concerns. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure the Minimum Data Set (MDS) assessment was accurate for 3 (R17, R7, and R13) of 18 sampled residents.<br><br>*R17's Quarterly MDS assessment dated [DATE] did not document the need for dialysis or antiplatelet; anticoagulant was documented when R17 did not receive an anticoagulant.<br><br>*R7's Annual MDS assessment dated [DATE] did not document R7 was a current tobacco user; R7 regularly smoked.<br><br>*R13's Quarterly MDS assessment dated [DATE] documented R13 used a restraint in a chair less than daily, a motion sensor alarm less than daily, and a wander/elopement alarm less than daily; R13 did not use any restraints.<br><br>Findings include:<br><br>1.) R17 was admitted to the facility on [DATE] with diagnoses of end stage renal disease requiring dialysis, congestive heart failure, diabetes, and atrial fibrillation.<br><br>R17 attended dialysis three times a week for end stage renal disease. R17 was taking the medication Plavix, an antiplatelet.<br><br>R17's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented R17 was not receiving dialysis and was receiving an anticoagulant. The MDS assessment did not document R17 was receiving an antiplatelet medication.<br><br>In an interview on 3/24/2026 at 10:35 AM, Surveyor asked MDS Coordinator-K if R17 had attended dialysis since admission. MDS Coordinator-K stated yes, R17 was a dialysis patient and would maybe miss appointments if R17 was in the hospital. Surveyor shared with MDS Coordinator-K the documentation on R17's Quarterly MDS assessment dated [DATE] did not document R17 as going to dialysis. MDS Coordinator-K did not know why dialysis was not coded. Surveyor shared with MDS Coordinator-K R17 was taking Plavix, an antiplatelet, and anticoagulant was coded rather than antiplatelet. MDS Coordinator-K stated MDS-Coordinator-K would look into why that MDS assessment was coded that way.<br><br>On 3/24/26 at 10:56 AM, MDS Coordinator-K informed Surveyor a correction to R17's MDS was completed to capture the dialysis and the antiplatelet medication. MDS Coordinator-K stated the previous MDS assessments for R17 would be reviewed to make sure they were coded accurately.<br><br>On 3/24/2026 at 3:00 PM, Surveyor shared with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B the concern R17's Quarterly MDS assessment dated [DATE] was not coded accurately to capture dialysis and antiplatelet and inaccurately documented R17 was given an anticoagulant.<br><br>2) R7 was admitted to the facility on [DATE] with diagnosis including anxiety disorder, and Major Depressive Disorder.<br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The annual MDS (Minimum Data Set), assessment dated [DATE] documents R7 currently does not use tobacco.<br><br>On 12/7/2025, the facility completed a Smoking Safety Screen which indicated R7 does smoke and is safe to smoke without supervision.<br><br>Surveyor notes the annual MDS was coded inaccurately as R7 does smoke cigarettes, although R7 has discussed quitting and using nicotine replacement therapy.<br><br>The facility was not able to provide additional information as to why the 2/28/26 annual MDS was coded inaccurately for the use of tobacco for R7.<br><br>3.) R13 was admitted to the facility on [DATE].<br><br>A review of R13's Quarterly MDS (Minimum Data Set), dated 2/16/26 documents R13 has a restraint used in a chair or out of bed, used less than daily; motion sensor alarm-used less than daily; wander elopement alarm-used less than daily.<br><br>Surveyor made observation of R13 on 3/24/26 at 11:55 AM, asleep in her wheelchair in her room. At this time there was no observation of a restraint used in the chair or a motion sensor alarm.<br><br>On 03/26/2026 at 2:56 PM, Surveyor interviewed MDS Coordinator-K regarding the use of a restraint and motion alarm use being marked on the quarterly MDS. MDS-Coordinator-K stated R13 does not use a restraint or motion alarm, and this was documented in error. |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure a baseline care plan was developed and implemented within 48 hours of a resident's admission for 3 (R10, R98, and R35) of 4 residents.<br><br>*R10's baseline care plan for post-traumatic stress disorder was not completed within the required 48-hour timeframe.<br><br>*R98's baseline care plan for risk for pressure injury/skin integrity was not thoroughly completed within the required 48-hour time frame.<br><br>*R35's baseline care plan for anticoagulant, antidepressant, diuretic, and antipsychotic was not completed within the required 48 hours timeframe.<br><br>Findings include:<br><br>On 3/25/26, Assistant Director of Nursing (ADON)-C informed Surveyor the facility does not have a policy regarding baseline care plans.<br><br>1.) R10 was admitted to the facility on [DATE] with diagnosis that included post-traumatic stress disorder (PTSD).<br><br>R10's admission Minimum Data Set (MDS) assessment dated [DATE], documents R10 has a moderate cognitive impairment. R10 has PTSD.<br><br>R10's Hospital Discharge summary dated [DATE], documents the following pertinent discharge diagnosis: Chronic PTSD.<br><br>Surveyor reviewed R10's medical record for evidence the facility staff completed a baseline care plan related to R10's diagnosis of PTSD.<br><br>R10's Paper charting form dated 2/25/26 and titled, Individual Resident Care Plan which is a document that has check boxes that facility staff can check to mark a certain intervention to be carried out for residents. R10's paper form documents, in part: (Develop within 48 hours of admission). Behavior/Mood/Safety. Mood issues: blank. Behaviors. blank. Environmental risks. blank.<br><br>Surveyor noted R10's Baseline care plan was blank for Behavior/Mood/Safety. Surveyor noted R10 did not have a baseline PTSD care plan with individualized interventions to identify ways to decrease the resident's exposure to triggers or identify ways to mitigate or decrease the effect of triggers on the resident.<br><br>On 3/24/2026 at 12:37 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-T. Surveyor asked if R10 had a diagnosis of PTSD and if so, is there a care plan for PTSD. CNA-T stated that CNA-T did not know much about that. On 3/24/2026 at 12:44 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-U. Surveyor asked what is completed upon admission if a resident has a diagnosis of PTSD. LPN-U stated that Surveyor should talk to the facility psych nurse. Surveyor asked if residents with PTSD should have a care plan. LPN-U informed Surveyor to talk to<br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | management to get more information about the psych nurse.<br><br>On 3/24/26 at 1:03 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-C. Surveyor asked how the initial care plan works. ADON-C stated the referral from the hospital is uploaded to the resident's chart. From there, we look to see what needs to be added to the care plan. We will also use the behavior notes from hospital. In the actual referral that is sent to us, there is a section for behavioral/psych diagnosis. In that section it will say if there is a goal or intervention that works. The MDS coordinator and social worker is the first staff to put interventions in the electronic care plan, but the nurse will initiate the initial paper care plan (Baseline care plan). Surveyor asked what section PTSD would be under in the paper baseline care plan. ADON-C stated that it would be under the Behavior/mood/safety section. Surveyor asked if PTSD should be care planned in the baseline care plan. ADON-C indicated that PTSD should be in the care plan. Surveyor asked if R10 had a baseline care plan for R10's PTSD diagnosis. ADON-C indicated that ADON-C does not see that in R10's care plan.<br><br>On 3/25/2026 at 9:04 AM, Surveyor interviewed Director of Social Services (DOSS)-G. Surveyor asked about the baseline care planning process. DOSS-G stated that facility social workers do not use the paper baseline care plan. DOSS-G stated they enter the care plans directly to the electronic care plan. DOSS-G stated that the care plans will start to be entered the day of or the day after admission. Social workers will update them as needed.<br><br>Surveyor reviewed R10's electronic Comprehensive Care Plan and noted that R10 did not have a care plan that was started within 48 hours for PTSD.<br><br>On 3/24/26 at 3:01 PM, Surveyor informed Director of Nursing (DON)-B and Nursing Home Administrator (NHA)-A of the concern that R10 was admitted to the facility with a diagnosis of PTSD and a baseline care plan was not initiated by facility staff.<br><br>No further information was provided.<br><br>2.) R98 was admitted to the facility on [DATE].<br><br>R98's admission Minimum Data Set (MDS) assessment dated [DATE] documents R98 is cognitively intact. R98 requires supervision or touching assistance for bathing, toileting, bed mobility and transfers. R98 is occasionally incontinent of bowel and bladder. R98 is at risk for developing pressure injuries.<br><br>R98's Pressure Injury Care Area Assessment (CAA) dated 3/11/26 documents, in part: [R98 is] at risk for skin break down related to need for [activity of daily living (ADL)] assistance for bed mobility. Extrinsic risk factors: Pressure: [R98] needs special mattress or seat cushion to reduce or relieve pressure. [R98] had a decline in ADL function and transfers [status post] hospitalization for bilateral pleural effusions, acute/chronic CHF, . [stage 3 chronic kidney disease], moderate calorie malnutrition.<br><br>R98's admission Braden scale assessment (an assessment tool used to predict a patient's risk of developing pressure injuries) completed on 3/5/26 documents a score 17, indicating R98 is at risk for developing pressure injuries.<br><br>R98's admission skin assessment dated [DATE] documents, in part: Coccyx. Other-Redness. Stage 1.<br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Surveyor noted facility staff documented a stage 1 area of redness on R98's coccyx.<br><br>R98's progress note dated 3/5/26 at 8:34 PM, documents, in part: Skin warm, dry, and intact. Has drain site on the left rib cage covered with a pressure dressing, puncture site [related to] thoracentesis on the right rib cage [open to air], multiple bruises on the right forearm from IVs and blood draws, and redness of the coccyx area.<br><br>Surveyor reviewed R98's medical record for evidence the facility staff completed a baseline care plan related to R98's pressure injury risk or skin integrity impairment.<br><br>R98's paper charting form dated 3/5/26 and titled, Individual Resident Care Plan which is a document has check boxes that facility staff can check to mark a certain intervention to be carried out for residents. R98's paper form documents, in part: (Develop within 48 hours of admission) . Skin Risk: High or greater risk (implement intervention)- blank. Special Mattress-blank. Barrier cream- checked off. [Wheelchair] cushion- blank. Repositioning- blank. Incision- left side pleurex [drain]. Wound location: blank.<br><br>Surveyor noted the baseline care plan had an intervention of barrier cream listed. Surveyor noted that there were no instructions as to how often and when the barrier cream should be used. Surveyor noted that there were no other interventions like a specialized mattress, cushion for wheelchair, or offloading of coccyx implemented on the baseline care plan even though a stage 1 area of redness was identified on admission to the facility.<br><br>On 3/25/26 at 10:15 AM, Surveyor interviewed Registered Nurse Manager (RN)-O. Surveyor asked about care planning after a resident is admitted with skin concern. RN-O stated the nurse will complete a thorough skin assessment. If something is found, the concern is measured, described, MD is made aware, treatment is put in place and interventions placed. RN-O indicated examples of interventions would include things like offloading in the afternoon, a cushion for the chair, prompt toileting care, possible air mattress and house barrier cream application. The baseline care plan is started on paper within the first 2 days of admission. The manager will review the baseline care plan and make sure all necessary topics and interventions are in place.<br><br>On 3/25/26 at 10:33 AM, Surveyor interviewed Director of Nursing (DON)-B. Surveyor asked what should be done on admission if facility staff document stage 1 redness on the coccyx. DON-B indicated the wound nurse should be made aware and would follow up, a treatment should be put in place, and a care plan should be started.<br><br>On 3/25/26 at 10:38 AM, Surveyor informed DON-B and Nursing Home Administrator (NHA)-A of the concern R98 was assessed by facility staff to have stage 1 redness on the coccyx. R98's baseline care plan documented house barrier cream but did not include how often and when the cream should be used and did not include other resident specific interventions to promote healing and prevent new pressure injuries from developing. R98 then developed an unstageable pressure injury to R98's coccyx within 2 weeks of admission to the facility.<br><br>3.) R35 was admitted to the facility on [DATE]. R35's diagnoses include altered mental status (AMS) (change in person's baseline cognitive function), acute kidney failure (AKF) (sudden loss of kidney function), atrial fibrillation (A-fib) (irregular heart rhythm), dementia (progressive decline in memory), heart failure (HF) (heart muscle is too week to pump), major depressive disorder (a serious mental health condition characterized by persistent, intense feelings of sadness, worthlessness, and a loss<br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | of interest in activities), delusional disorders (serious psychotic disorder with one or more fixed, false beliefs), anxiety disorders (excessive, persistent and uncontrollable fear that interferes with daily life), and muscle weakness.<br><br>R35's admission Minimum Data Set (MDS) completed on 1/11/26, documents R35 is independent with sitting to lying and lying to sitting. R35 requires supervision with eating, toileting hygiene, dressing, transfers and walking 150 feet. R35 is taking an antipsychotic, antidepressant, anticoagulant, diuretic and antiplatelet. R35 was documented as having a Brief Interview for Mental Status (BIMS) score of 13, indicating R35 is cognitively intact.<br><br>R35's Care Area Assessment (CAA) dated 1/11/26 documents the following:<br><br>-Cognitive Loss/Dementia CAA – R35 is alert and has some memory deficits noted. R35's recent BIMS score was 13 with rejection of care noted. Proceed to plan of care at this time.<br><br>Behavioral Symptoms CAA – R35 is a new admission to the facility. R35 frequently attempts to go on the elevator to go home. R35's recent BIMS score was 13 and is easily redirected. Rejection of care is noted for R35 and proceed to plan of care at this time.<br><br>Psychotropic Drug Use CAA – R35 is at risk for complications associated with psychotropic medication use. R35 had decline in Activities of Daily Living (ADL) function and transfers post hospitalization for Urinary Tract Infection (UTI), AKF, AMS and encephalopathy. R35 has a diagnosis of A-fib, Chronic Obstructive Pulmonary Disorder (COPD), dementia, HF and mixed anxiety with depressive disorder. R35 is alert and oriented. R35 is able to make needs known. R35 receives therapy services for strengthening, gait training, neuro reeducation, ADLs and self-care management. R35 had bladder incontinence during a look back period. R35 requires assistance of staff for toileting needs. R35 had no recent falls and skin is intact. R35 takes an antidepressant and antipsychotic medication daily. R35 receives a diuretic and anticoagulation therapy. R35 reported no pain during a look back period and has scheduled and as needed (PRN) analgesics ordered.<br><br>R35's care plan dated 1/5/26, documents the following:<br><br>R35 uses an antidepressant medication related to insomnia, anxiety and mixed mood disorder (date initiated 1/16/26).<br><br>Interventions include:<br><br>Administer antidepressant medications as ordered by physician. Monitor/document side effects and effectiveness every shift (date initiated 1/16/26).<br><br>Monitor/document/report as needed (PRN) adverse reactions to antidepressant therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in Activities of Daily Living (ADL) ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance problems, movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia, appetite loss, weight loss, nausea/vomiting, dry mouth and dry eyes (date initiated 1/16/26).<br><br>R35 has potential fluid deficit related to diuretic use (date initiated 1/16/26).<br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interventions include:<br><br>Administer medications as ordered. Monitor/document for side effects and effectiveness (date initiated 1/16/26).<br><br>Monitor/document/report PRN any side effects of dehydration: decreased or no urine output, concentrated urine, strong odor, tenting skin, cracked lips, furrowed tongue, new onset confusion, dizziness on sitting/standing, increased pulse, headache, fatigue/weakness, dizziness, fever, thirst, recent/sudden weight loss, dry/sunken eyes (date initiated 1/16/26).<br><br>Obtain and monitor lab/diagnostic work as ordered. Report results to Medical Director (MD) and follow up as indicated (date initiated 1/16/26).<br><br>R35 uses psychotropic medications. Antipsychotic medication use due to delusions and hallucinations (date initiated 1/16/26).<br><br>Interventions include:<br><br>Administer psychotropic medications as ordered by Physician. Monitor for side effects and effectiveness every shift (date initiated 1/16/26).<br><br>Monitor/document/report PRN any adverse reactions of psychotropic medications: unsteady gait, tardive dyskinesia, shuffling gait, rigid muscles, shaking, frequent falls refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss and appetite, weight loss, muscle cramps, nausea, vomiting, behavioral symptoms not usual to R35 (date initiated 1/16/26).<br><br>Referral to psychiatric services (date initiated 3/24/26).<br><br>R35 is on diuretic therapy (date initiated 1/16/26).<br><br>Interventions include:<br><br>Administer diuretic medications as ordered by Physician. Monitor for side effects and effectiveness every shift (date initiated 1/16/26).<br><br>Monitor/document/report PRN adverse reactions to diuretic therapy: dizziness, postural hypotension, fatigue and increased risk for falls (date initiated 1/16/26).<br><br>R35 is on anticoagulant therapy (date initiated 1/16/26).<br><br>Interventions include:<br><br>Administer anticoagulant medications as ordered by Physician. Monitor for side effects and effectiveness every shift (date initiated 1/16/26).<br><br>Monitor/document/report PRN adverse reactions of anticoagulant therapy: blood tinged or red blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, shortness of breath, loss of<br>(continued on next page) |

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| | 525172 | A. Building<br>B. Wing | 04/06/2026 |

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| Jewish Home and Care Center | 1414 N Prospect Ave<br>Milwaukee, WI 53202 |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | appetite, sudden changes in mental status, significant or sudden changes in vital signs (date initiated 1/16/26).<br><br>R35 is on sleep aid/antidepressant to promote sleep (Trazadone) (date initiated 1/16/26).<br><br>Interventions include:<br><br>Administer sleep medications as ordered by Physician. Monitor/document side effects and effectiveness PRN (date initiated 1/16/26).<br><br>Monitor/document/report PRN the following adverse effects of sleep therapy: daytime drowsiness, confusion, loss and appetite in the morning, increased risk of falls and fractures, dizziness (date initiated 1/16/26).<br><br>Surveyor reviewed R35's orders which documents the following:<br><br>Melatonin oral tablet 3 mg. Give 3 mg by mouth at bedtime for insomnia (start date 1/5/26).<br><br>Quetiapine Fumarate oral tablet. Give 12.5 mg by mouth in the evening for anxiety (start date 1/5/26, discontinued on 1/8/26).<br><br>Quetiapine Fumarate oral tablet. Give 12.5 mg by mouth in the evening for delusional thoughts and hallucinations (start date 1/8/26).<br><br>Spironolactone oral tablet. Give 25 mg by mouth one time a day (start date 1/6/26).<br><br>Trazadone oral tablet. Give 25 mg by mouth at bedtime for insomnia (start date 1/5/26, discontinued on 1/12/26).<br><br>Trazadone oral tablet. Give 50 mg by mouth at bedtime for insomnia related to other specified anxiety disorders (start date 1/12/26).<br><br>Apixaban 2.5 mg. Give 2.5 mg by mouth two times a day for thrombolytic (start date 1/5/26).<br><br>On 3/24/26, at 1:03 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-C who stated the referral is uploaded in the resident's chart upon admission. ADON-C stated from there, we look to see what needs to be added to the care plan. ADON-C stated facility staff will also use behavior notes from the hospital. The Minimum Data Set (MDS) coordinator is the first staff member to put interventions in the resident's care plan. The nurse will initiate the paper care plan (Baseline care plan). ADON-C stated a manager can review and add additional information if needed. The facility utilizes the paper base line care plan for 3 days, which is then uploaded into the system after 3 days. The care plan is then started in the residents' Electronic Medical Record (EMR).<br><br>On 3/25/26, at 9:04 AM, Surveyor interviewed Director of Social Services (DOSS)-G who stated social services does not use the paper base line care plan. DOSS-G stated the social services department enters their care plans directly into the resident's EMR. Social Services care plans will start to be entered the day of admission or the following day. Surveyor asked DOSS-G if psychiatric, anti-anxiety, antidepressant and diuretic medications are included in care planning and DOSS-G stated social services will enter a relocation stress care plan and behavior care plan, but nursing staff will (continued on next page) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | take care of the individual medications in the resident's care plan. Surveyor asked DOSS-G when the baseline care plan is discussed with the resident and/or Power of Attorney (POA) and DOSS-G stated that it is completed within the first couple of days on admission and documented in a progress note. Surveyor asked DOSS-G to review R35's care plan. DOSS-G stated social services entered the behavioral care plan on 1/5/26 and nursing would enter in the medication specific care plans.<br><br>On 3/25/26, at 3:18 PM, Surveyor notified Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B of concerns with R35 taking an anti-depressant, antipsychotic, diuretic, anticoagulant and medication for sleep that was not entered on R35's baseline care plan until 1/16/26 (11 days after admission). NHA-A and DON-B acknowledged these concerns. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**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.<br><br>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.<br><br>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.<br><br>Evidenced by:<br><br>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.<br><br>1.) R7 was admitted to the facility on [DATE] with diagnosis including anxiety disorder, major depressive disorder, mild intermittent asthma and rheumatoid arthritis.<br><br>R7's admission MDS (minimum data set), dated 2/27/25 documents R7 does not smoke.<br><br>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.<br><br>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<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>R7's nursing note dated 3/12/2026 at 11:52 PM, documents R7 returned from having a smoke outside.<br><br>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.<br><br>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.<br><br>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.<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | SW-P stated all residents are to sign out anytime they leave the unit, although staff are not always aware if a resident has signed out or not. SW-P confirmed R7 can propel herself in the wheelchair. During the quarterly care conference on 3/5/26, smoking was discussed with R7. Staff were aware R7 had started to smoke again and then stopped. After the care conference, R7 gave her cigarettes to nurse. R7 stated she was accepting of the nicotine replacement therapy, and it was ordered for her on 3/6/26. SW-P stated we asked for physical therapy to do another assessment on 3/6/26 to include going off campus. R7 could not complete the task of going from building to sidewalk safely, not independently. SW-P stated Nursing Home Administrator- A wanted to maintain a non-smoking environment on campus and R7 would have to get herself off campus to smoke. Surveyor asked SW-P if R7's plan of care addressed her desire to smoke and if she was safe to do so independently. SW-P stated Social Services and Nursing would write this plan of care, but she is not sure why R7 doesn't have one regarding her smoking.<br><br>On 3/26/26 at 3:00 PM, Surveyor shared concerns with Nursing Home Administrator (NHA)- A and Director of Nursing- B regarding R7 not having a care plan that addressed smoking cigarettes while residing at the facility. Surveyor shared concerns the only smoking assessment that was completed was dated 12/7/25 and gave contradicting information as to whether R7 was safe to smoke independently or not. Surveyor shared concerns once the facility staff became aware R7 was smoking again, a comprehensive assessment was not completed regarding R7's abilities to be safe while smoking. In addition, the care plan was still not updated as of 3/25/26 even though staff are aware R7 is smoking outside of the facility and had access to her own smoking materials without staff knowledge.<br><br>As of the time of exit, no additional information had been provided.<br><br>2.) R106 was admitted to the facility on [DATE] with diagnoses of senile degeneration of the brain, congestive heart failure, chronic respiratory failure with hypoxia, diabetes, vascular dementia, and depression. R106's Significant Change Minimum Data Set (MDS) assessment dated [DATE] documented R106 had moderate cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 10 and was dependent for activities of daily living (ADLs). The ADL Care Area Assessment (CAA) documented R106 required total assistance with ADLs related to impaired mobility and impaired cognition related to dementia. The Falls CAA documented R106 was at risk for fall related to incontinence, a history of falls, psychotropic medication usage, impaired mobility, and impaired cognition.<br><br>R106's ADL Care Plan was initiated on 10/26/2024 and had the revised intervention for bathing/showering on 12/6/2024 documented: R106 required maximum assistance by one staff with bathing/showering and utilize two people to transfer from the wheelchair to the shower chair. This intervention was also added to R106's High Risk for Fall Care Plan on 12/6/2024.<br><br>On 10/17/2025 at 4:26 PM, in the progress notes, Licensed Practical Nurse (LPN)-S documented a nurse reported to LPN-S R106 was lowered to the floor in the shower room by a Certified Nursing Assistant (CNA) during a shower. During R106 being transferred from the shower chair to the wheelchair, R106 became unsteady, and the CNA lowered R106 to the floor. No injuries were noted at the time of the assessment. R106 was lifted from the floor with a full body mechanical lift and the assistance of three staff members.<br><br>On 10/17/2025 at 4:32 PM, in the progress notes, an LPN documented an SBAR (Situation, Background, Assessment, Recommendation) summary. The LPN documented R106 was lowered to<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | the floor in the shower room. R106 was noted to be leaning up against the wall with no apparent injuries.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interviews, the facility did not ensure they provided services to help maintain acceptable nutritional parameters for 1 (R6) of 3 residents reviewed for significant weight loss.R6 experienced a significant weight loss in January 2026. The facility's response was to obtain weekly weights so they could closely monitor R6's nutritional status. The facility did not obtain weekly weights, therefore could not comprehensively assess R6's weights and implement interventions to address R6's weight concerns. Evidenced by:Policy review: Weight Monitoring; revision date 11/20/23.Policy: Based on a resident's comprehensive assessment, the facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise.7. Documentationa. The resident's weight will be obtained by nursing staff as ordered and documented in the medical record.1. The nurse will compare previous weights and request reweigh if warranted.b. The Dietician, Physician and resident/resident representative will be notified of any significant weight changes by the licensed nurse. c. The Registered Dietician/designees will be consulted to assist with interventions; actions are recorded in the nutrition progress notes. R6 was admitted to the facility on [DATE] with diagnosis that included Dementia, anxiety, peptic ulcer, esophageal reflux disease, and Parkinson's disease. Surveyor conducted a review of R6's care plan and noted R6 has a history of unplanned/unexpected weight loss due to insufficient energy/protein intakes. R6 has a history of skin breakdown and significant weight loss; initiated 4/9/25. Significant for weight loss 1/14/26.Interventions included: The resident will consume 76% or greater most meals Date Initiated: 04/09/2025. Revision on: 02/06/2026. Will maintain to within +/-5 lbs. (pounds) of CBW (current body weight). Gradual weight gain acceptable. Intake at most meals increase 51-75; Initiated: 04/09/2025; Revision on: 02/06/2026. Cut food up into bite sized pcs (pieces). Provide a divided plate, Date Initiated: 05/05/2025; Revision on: 01/16/2026. General diet w/ (with)Thin liquids. Date Initiated: 04/14/2025. Med Pass 2.0 4oz (ounces) after meals and at bedtime. Date Initiated: 01/14/2026. Monitor and evaluate any weight loss. Determine percentage lost and follow facility protocol for weight loss; Date Initiated: 04/09/2025. Monitor and record food intake at each meal; Date Initiated: 04/09/2025. Offer substitutes as requested or indicated. The resident prefers/ .; Date Initiated: 04/09/2025. Revision on: 08/04/2025. Weigh every week. Date Initiated: 08/07/2025. Revision on: 01/14/2026.R6's Nutrition progress note dated 11/5/2025, at 3:34 PM; RD (Registered Dietician) Weight/Wound Note: Per Wound MD (Medical Doctor) 11/5/25: US PI (unstageable pressure injury) to R (right) heel exacerbated. CBW (current body weight) 109# (pounds) BMI (body mass index) 21.3, Underweight for age. IBW (Ideal Body Weight) 118 # for minimum BMI 23 for age. Weight history: 109# (11/4),111# (10/3), 113.5# (8/4), 112.5# (5/1). Stable weight pattern. Intakes are variable with an avg of 75% (~1575 kcal 61 g pro) of a general diet. Receives Med Pass 2.0 120 mL TID (three times per day) (720 kcal 30 g (grams) pro (protein)) with intakes of 60% of full dose, 32% half dose and 5.4% refusal which provides ~664 kcal/day, 28 g protein. Receives Active Liquid Protein 30 mL BID (200 kcal 30 g pro) with intakes of 68% of a full dose, 24% half dose and 8% refusal which provides ~174 kcal and 26 g protein. Total intakes are ~ 838 kcal 54 g protein. Estimated Nutrition Needs:1620-1890 kcal (30-35 kcal/kg/IBW) 68-81 protein (1.25-1.5 g/kg/IBW).Estimated Intakes: 2413 kcal, 115 g protein. PO (by mouth) intakes and supplements meet/exceed estimated needs for wound healing, however, wound is still not healing. RD (Registered Dietitian) recommends Juven BID (twice a day) (180 kcal, 14g arginine, 14g glutamine, Vit C, Vit E, B12, Zinc) to promote healing as medically feasible. RD to monitor weight trend, intakes and wound healing progress and follow up as needed.R6's Significant Change MDS (Minimum Data Set), dated 1/14/26, documents R6 has a BIMS (brief interview for mental status) moderate cognitive impairment. The MDS documents R6 weighs<br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 100 pounds and has had weight loss of 5% or greater that is not a physician prescribed weight loss regimen. R6 has a stage #4 pressure ulcer that was present on admission. R6's Nutrition/Dietary Note dated 1/14/2026, at 9:12AM; R6's CBW (current body weight) 99.5lbs and is significant for weight loss. This equates to a loss of -8.7%, or -9.5Lbs x (times) 60days, and -10.8%, or -12.0lbs x180 days. PO (per oral/by mouth)/Fluid intake at most meals: variable. Increased nutritional supplement: 4oz (120mL) of Med Pass 2.0 QID (four times per day). Monitor weekly weights.A review of the Full Nutrition Assessment dated 1/16/26 documents the following regarding R6. Nutrition Assessment Change of Condition: [AGE] year-old on the long-term care unit. R6 is tolerating a general diet w/ intake at most meals 25-50% and her intake has decreased in the past quarter. CBW: 99.5lbs BMI: 19.4, underweight for age. Weight history: 111.0 lbs. on 12/2/25 and weight on 7/28/25 was 111.5 lbs. Is prescribed Mirtazapine 7.5 mg (milligrams) to help stimulant appetite. R6 has had a significant weight loss x 30days and 180 days. Provided 4 oz Med pass 2.O QID increased from TID and 30 mL Active liquid protein BID (200 kcal 20 g pro) for weight gain and wound healing, Zinc and MVI (multivitamin) w/ minerals in place as well as Juven BID. Nutrition Diagnosis: Increased Nutrient Needs r/t increased demand in wound healing aeb (as evidenced by) Stage 4 PI (pressure injury) Right heel. Weight loss is significant x30 days and 180 days. Nutrition Interventions: Continue diet order, document intakes of food/fluids, weights per MD order. Monitoring/Evaluation: monitor po intake, weight trend and wound healing progression. Monitor supplement acceptance. Follow up as needed.Surveyor conducted further record review and noted the following Physician orders were obtained on 1/14/26:*House Nutritional Supplement after meals and at bedtime for appetite/poor intakes Med Pass 2.0 120 mL QID (4 times daily) Supplement Active 1/14/2026.*Weigh resident every week and notify physician of significant weight changes. No directions specified for order. Active1/14/2026.Nutrition/ Dietary note dated 2/6/2026, at 10:49AM, documents R6's wound area on right heel is healed, (per wound report on 2/4/26) d/c (discontinue) Juven protein supplement, Continue w/ Med Pass 2.0 nutritional supplement for weight gain/maintenance.Nutrition/ Dietary note dated 2/6/2026, at 10:59 AM; Will also d/c actine liquid protein supplement d/t (due to) wound area on right heel is healed. Will update nutritional care plan.Nutrition/ Dietary note dated 2/11/2026, at 5:19 PM, Triggers for significant desirable weight gain x 1-month (6%/6#) CBW 106# BMI 20.7, Underweight for age. IBW 118 # for minimum BMI 23 for age Wt (weight) Hx (history): 106# (2/11),100# (1/13), 109# (11/4), 113.5# (8/4). Intakes are variable with an avg of 75% of a general diet. Receives Med Pass 2.0 120 mL TID (960 kcal 40 g pro). RD to monitor weight trend, intakes and follow up as needed.Surveyor reviewed weights in R6's medical record which documented:-1/13/26--100.0 lbs.-1/28/26 - 108 lbs.-2/11/26 - 106 lbs.-2/25/26 - 105 lbs.-3/11/26 - 102 lbs.The facility nursing staff were not following the physician order to weigh R6 weekly. Weekly weights were to be obtained to closely monitor if any further significant weight loss was occurring.On 03/25/2026, at 11:41 AM, Surveyor interviewed Registered Dietician (RD)- AA regarding R6 being at risk for further significant weight loss and why the facility staff was not following the physician order to weigh R6 weekly. RD- AA stated the process for obtaining weights has changed. The facility used to have it where they would get an initial weight on a resident, then weekly for a couple of weeks and then monthly weights unless the resident had a diagnosis of Congestive Heart Failure, then it was weekly. RD- AA stated the Dietary Tech will send out a sheet with the names of residents that need to be weighed or in need of a re-weight to be taken. RD- AA stated if a resident is being followed for weight loss, she will put out a request and put an order into the electronic medical record. RD- AA stated she will look at the weights weekly and prepare a report for the clinical meeting that happens on Wednesdays. RD-AA stated she will give a list of weight variances to nursing. Surveyor asked RD- AA about R6 and her weights not being documented weekly per Physician order. RD- AA stated she is aware R6 has a history of significant weight loss and she was also following her because she had a pressure ulcer. RD- AA stated she was not alerted that staff were not obtaining weekly weights for R6 and she had no further insight as to why the weights were not being taken. RD- AA stated that she (continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | can't monitor a resident's weights if they are not there. RD- AA stated she had discontinued the liquid protein for R6 because the pressure ulcer did heal. Surveyor explained R6 is at high risk for PI development and has a history of significant weight loss. RD - AA again stated she can't assess if the information is not there. RD- AA stated she will follow-up and see why weights were not obtained and if they can get a current weight on her. On 3/26/26 at 12:05 PM, Surveyor made observations of R6 seated in her wheelchair in the dining room. R6 remained asleep for much of the lunch meal. Her food was served on a divided plate but there was not encouragement from staff for her to awaken and eat the lunch meal. As of the time of exit, there was no additional information provided as to why they were not taking weekly weights on R6 so they could continue to comprehensively assess R6's nutritional needs. |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**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<br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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<br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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<br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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 0699<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care or services that was trauma informed and/or culturally competent.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 1 (R10) of 3 residents reviewed for post-traumatic stress disorder (PTSD) received trauma informed care in accordance with professional stands of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization.R10 was admitted to the facility with a diagnosis of PTSD. The facility did not complete a trauma assessment or develop a person-centered care plan identifying triggers, interventions, or monitoring for R10's PTSD.Findings include: The facility policy, with a last revision date of 8/21/25, and titled Trauma Informed Care documents, in part: It is the policy of this facility to provide care and services which, in addition to meeting professional standards, are delivered using approaches which are culturally competent account for experiences and preferences and address the needs of trauma survivors by minimizing triggers and/or re-traumatization. The facility will work to facilitate the principles of trauma informed care which include: . Ensuring residents have a sense of emotional and physical safety . Collaboration- an emphasis on partnering between residents and/or his or her representative, an all staff and disciplines involved in resident's care in developing the plan of care. The facility will use a multi-pronged approach to identifying a resident's history of trauma. This will include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event, as well as screening and assessment tools such as the Resident Assessment Instrument (RAI), admission Assessment, the history and physical, the social history/assessment and others. The facility will collaborate with resident trauma survivors, and as appropriate, the resident's family, friends, the primary care physician, and any other health care professionals. to develop and implement individualized care plan interventions . The facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger-specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident and will be added to the resident's care plan. Trauma-specific care plan interventions will recognize the interrelation between trauma and symptoms of trauma. The facility will evaluate whether the interventions have been able to mitigate (or reduce) the impact of identified triggers on the resident that may cause re-traumatization.R10 was admitted to the facility on [DATE] with diagnosis that includes post-traumatic stress disorder (PTSD). R10's admission Minimum Data Set (MDS) assessment dated [DATE], documents R10 has moderate cognitive impairment. R10 has PTSD. R10's Hospital Discharge summary dated [DATE] documents the following pertinent discharge diagnosis: Chronic PTSD. Surveyor reviewed R10's electronic medical record (EMR) for evidence that facility staff completed a trauma-informed care assessment and initiated a care plan related to R10's PTSD. Surveyor did not locate an assessment that identified triggers which may re-traumatize R10. Surveyor did not locate a care plan that included individualized interventions to identify ways to decrease the resident's exposure to triggers or identify ways to mitigate or decrease the effect of triggers on the resident. On 3/24/2026 at 12:37 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-T. Surveyor asked if R10 had a diagnosis of PTSD and if so, is there a care plan for PTSD. CNA-T stated CNA-T did not know much about that. On 3/24/2026 at 12:44 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-U. Surveyor asked what is completed upon admission if a resident has a diagnosis of PTSD. LPN-U stated Surveyor should talk to the facility psych nurse. Surveyor asked if residents with PTSD should have a care plan. LPN-U informed Surveyor to talk to management to get more information about the psych nurse. On 3/24/26 at 1:03 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-C. Surveyor asked if R10 has PTSD. ADON-C found the diagnosis of PTSD on R10 hospital discharge Summary. Surveyor asked if R10 should have a care plan related to R10's diagnosis of PTSD. ADON-C indicated that PTSD should be in the care plan. Surveyor asked if R10 had a baseline or comprehensive care plan for R10's<br>(continued on next page) |

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| F 0699<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | PTSD diagnosis. ADON-C indicated ADON-C does not see that in R10's care plan. On 3/24/26 at 12:49 PM, Surveyor interviewed Social Worker (SW)-EE. Surveyor asked what is done for a resident with a diagnosis of PTSD. SW-EE stated that the social worker will ask the resident if they would like [psych visits] while at the facility. Social work will complete a social history assessment. A trauma informed care assessment and care plan will be triggered based on the social history assessment answers. The social history assessment is completed on admission for every resident. Surveyor asked if R10 has a social history assessment, trauma informed care assessment or care plan related to PTSD. SW-EE stated that SW-EE did not see any of that in R10's medical record for this admission. SW-EE stated that SW-EE was not employed at the facility at the time that R10 was admitted to the facility. Surveyor reviewed R10's EMR for R10's admission social history assessment. Surveyor noted the last social history and psychosocial assessment completed for R10 was dated 8/14/24. Surveyor noted that R10 did not have a social history assessment completed for this admission. On 3/25/26 at 9:04 AM, Surveyor interviewed Social Services Director (SSD)-G. Surveyor asked what is done for a resident with a diagnosis of PTSD. SSD-G stated PTSD is identified through the social history assessment. If identified on that assessment, additional assessments and care planning will be triggered. Surveyor asked what is done if a social history assessment is not completed on admission. SSD-G stated everyone has a social history assessment completed. Surveyor asked if R10 had a social history assessment completed on admission. SSD-G stated SSD-G completed the history. SSD-G stated that SSD-G did not complete a new social history assessment in the EMR but instead reviewed the social history assessment completed in 2024. SSD-G stated nothing had changed. Surveyor asked if SSD-G had documented that the 2024 social history assessment was reviewed with R10. SSD-G stated SSD-G did not document that. Surveyor asked if the facility has a trauma informed care assessment. SSD-G stated yes, it is a screening tool. Surveyor asked when that assessment is supposed to be completed. SSD-G stated when indicated. Surveyor asked if a trauma informed care assessment should be completed on a resident with PTSD. SSD-G stated that SSD-G knows R10 very well and R10 has been in the facility for previous admissions. SSD-G stated SSD-G asked about R10's trauma but R10 did not want to talk about it. SSD-G did not want to trigger R10 so did not proceed with questioning. SSD-G stated SSD-G did not proceed with a plan of care for PTSD because there were no changes in R10's social history. Surveyor noted R10 has an active diagnosis of PTSD that was not assessed or care-planned on the current admission to the facility. On 3/24/26 at 3:01 PM, Surveyor informed Director of Nursing (DON)-B and Nursing Home Administrator (NHA)-A of the concern R10 was admitted to the facility with a diagnosis of PTSD. A trauma informed care assessment and a person-centered care plan identifying triggers, interventions, or monitoring for R10's PTSD was not developed. |

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

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Jewish Home and Care Center | 1414 N Prospect Ave<br>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.

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>Based on observation, interview, and record review, the facility did not ensure food served was palatable, attractive, and at a safe and appetizing temperature for 1 (R8) of 1 resident reviewed for pureed diet. R8 was served a pureed meal consisting of taco meat and mixed vegetables. The pureed taco meat was a tan liquid, and the pureed mixed vegetables were green and chunky. R8 complained of the food being cold and after the plate was microwaved, R8 spit out the food and refused to eat it due to the taste. No other foods were offered to R8 after the refusal of the main course. Findings include: The facility policy and procedure titled Puree (PU4) from the MealSuite Diet Manual p. 48, undated, documents: Definition/Indication: The standards for the International Dysphagia Diet Standardization Initiative (IDDSI) Level 4 Puree (PU4) are used for this texture. The puree texture is designed for individuals with dysphagia or those who have moderate to severe chewing and/or swallowing difficulties. The foods on this texture are blended until smooth, cohesive, and homogenous requiring no chewing or manipulation for swallowing. Additional liquid may be used to moisten foods to achieve the necessary and desired consistency. Coarsely textured and sticky foods are avoided. All foods on this diet should be smooth and free of lumps. On 3/23/2026 at 12:47 PM, Surveyor observed the lunch service on the third floor dining room. The steam table with the menu items already in place in metal bins was brought up from the kitchen and placed in the kitchenette area of the dining room for meal service. Cook-L began plating food for the residents in the dining room. The meal consisted of cold soup and taco salad in a tortilla shell with mixed vegetables on the side or grilled cheese sandwiches. R8 had a visitor present and was assisting R8 with the lunch meal. R8 was on a physician prescribed pureed diet. R8 complained the soup was cold and staff explained that the soup was a cold soup but warmed it to R8's liking in the microwave. At 1:14 PM, R8 was served pureed taco meat and pureed mixed vegetables on a divided plate. The pureed taco meat was the consistency of runny gravy and was contained on the plate by the rim of the divided plate. The pureed mixed vegetables were thick and chunky, not smooth in consistency. R8 complained all the food on the plate was cold. Cook-L placed the plate in the microwave to heat up the meal. The plate was returned to R8 and when R8's visitor attempted to feed R8, R8 took a sip of the pureed meat and spit it out, refusing to eat anymore because R8 did not like the taste. R8 took a bite of the pureed mixed vegetables and refused to eat any more due to the taste. No other foods were offered to R8 at that time. Surveyor asked Cook-L if the food had been temped in the dining room prior to serving the food. Cook-L stated the food is temped in the kitchen when it is put in the steam table, but they do not re-temp the food on the floors. Surveyor asked Cook-L if the steam table was plugged in. Cook-L stated the steam table is normally plugged in when it gets to the dining room, but this was a brand-new steam table that had been delivered that morning and had never been plugged in. Cook-L stated that was why Cook-L was microwaving some of the food. On 3/24/2026 at 3:00 PM, Surveyor shared with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B the observation of the lunch meal on 3/23/2026 and the concern R8 was given unpalatable pureed food. Surveyor shared the pureed taco meat was a light brown liquid, and the pureed mixed vegetables were a mix of yellow and green/brown clumpy food and R8 refused to eat it even after it was microwaved. In an interview on 3/26/2026 at 2:38 PM, Surveyor asked Kitchen Manager (KM)-H who prepares the pureed food and how is it made. KM-H stated the lunch cook purees the meal prior to lunch service and the dinner cook purees the meal prior to dinner service. KM-H stated there are recipes for each meal that is served. Surveyor asked KM-H who pureed the lunch meal on 3/23/2026. KM-H stated Cook-L pureed the food, but it should have been a pudding like consistency. KM-H stated the recipe says to add flavored liquid and then the food to make it correctly. KM-H stated KM-H had heard about the concerns with the lunch meal and agreed the steam tables were new that morning, but the food should have been up to temp when served. |

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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**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. |