STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525241	A. Building B. Wing	03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgerton Care Center, Inc	313 Stoughton Rd Edgerton, WI 53534

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50285 Based on interview and record review, the facility failed to ensure a copy of a resident's advance directive was included in the resident's medical record, for 3 of 17 sampled residents (R25, R33, and R146) reviewed for advance directives. The facility did not have advanced directives on file in R25, R33, or R146's medical record. Evidenced by: The facility policy, entitled Advance Directives, dated 2001 with a Revision Date of [DATE], states, in part: . Policy Statement: The resident has the right to formulate an advance directive . Advance directives are honored in accordance with state law and facility policy . Definitions: 1.b. Advance Directive - a written instruction, such as a living will or durable power of attorney for health care, recognized by state law . relating to the provisions of health care when the individual is incapacitated . 1.b.(3) Do Not Resuscitate (DNR) - indicates that, in case of respiratory or cardiac failure, the resident, legal guardian, health care proxy, or representative (sponsor) has directed that no cardiopulmonary resuscitation (CPR) or other life-sustaining treatments or methods are to be used . Determining Existence of Advance Directive: 1. Prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives . If the Resident Has an Advance Directive: 1. If the resident or the resident's representative has executed one or more advance directive(s), or executes one upon admission, copies of these documents are obtained and maintained in the same section of the residents medical record and are readily retrievable by any facility staff. 2. The director of nursing services (DNS) or designee notifies the attending physician of advance directives (or changes in advance directives) so that appropriate orders can be documented in the resident's medical record and plan of care . Example 1: R25 was admitted to the facility on [DATE], with diagnoses that include, in part: Syncope (fainting/passing out) and collapse, Unspecified dementia, Muscle wasting (wasting of muscle mass) and atrophy (reabsorption/break down of tissue), Essential hypertension, and Heart failure. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R25's Admission Minimum Data Set (MDS) Assessment, with Assessment Reference Date (ARD) of [DATE], shows R25 had a Brief Interview of Mental Status (BIMS) score of 11 out of 15, indicating R25 has moderate cognitive impairment. On [DATE], the banner listed at the top of R25's EHR (Electronic Health Record) states DNR (Do Not Resuscitate). R25 did not have a copy of a signed Emergency Care Do Not Resuscitate Order (DNR) on file, nor was there a physician's order for DNR in R25's medical record. (of note: R25's wishes were to be a DNR.) Example 2: R33 was admitted to the facility on [DATE], with diagnoses that include, in part: Heart disease, Unspecified dementia, [NAME] insufficiency chronic, peripheral (a condition where the veins in the legs fail to return blood effectively to the heart), Adult failure to thrive, Acute respiratory disease, Cerebrovascular disease (a condition affecting the brain's blood vessels, potentially leading to reduced blood flow and oxygen to the brain), and Type 2 diabetes mellitus. R33's Admission MDS (minimum data set) Assessment, with an ARD (assessment reference date) of [DATE], shows R33 had a BIMS score of 8 out of 15, indicating R33 has moderate cognitive impairment. On [DATE], the banner listed at the top of R33's EHR (Electronic Health Record) states DNR (Do Not Resuscitate). R33 did not have a copy of a signed Emergency Care Do Not Resuscitate Order (DNR) on file, nor was there a physician's order for DNR in R33's medical record. (of note: R33's wishes were to be a DNR.) On [DATE] at 4:37 PM, Surveyor requested any copy of DNR paperwork that the facility had for R25 and R33 from NHA A (Nursing Home Administrator). On [DATE] at 8:52 AM, Surveyor interviewed NHA A who stated that she did not have any DNR paperwork for R25 or R33. NHA A indicated that she had called both R25 and R33's family to bring in copies, and that R33's daughter would be bringing in a copy of her DNR. NHA A stated that R25's DNR was supposed to have been completed in the hospital but that they couldn't find it in their medical records either, so she reached out to the MD (Medical Director). NHA A stated that the social worker and medical records were all working on pieces of the admissions process, but that they were both new in their roles. NHA A stated that ultimately the admissions nurse should have obtained the DNR forms at the time of admission. NHA A indicated that she would be completing a full audit on Advanced Directives, and that she just implemented a check list with medical records to ensure they are getting all the appropriate paperwork for the admissions process to be complete. NHA A stated that it is her expectation that residents who wish to be a DNR would have the state DNR forms signed and in their charts. On [DATE] at 8:07 AM, NHA A supplied a copy of R33's Emergency Care Do Not Resuscitate Order (DNR) form, signed by R33's POA (Power of Attorney) and the MD, dated [DATE]. 39849 (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Example 3: On [DATE] at 3:19 PM Surveyors reviewed R146's Electronic Health Record (EHR) and noted, in part: R146's banner indicates DNR. R146's Facility Informed Consent and Provision of Resuscitation form, indicating: No, I do not want CPR, was signed by the resident's responsible party/POA (Power of Attorney) and two witnesses. There was no physician or advanced level practitioner signature on this form. Surveyors could not locate a physician order for DNR. On [DATE] at 8:54 AM, Surveyor interviewed NHA A (Nursing Home Administrator) and asked what the process is for obtaining a resident's code status. NHA A indicated, admissions should be gathering this information and checking it off on a box. NHA A indicated when a resident comes into the facility, that day, medical records checks off that we have received everything and if we haven't, they reach out to the hospital. Medical records checks the face sheets to make sure everything is there. NHA A indicated admissions is responsible for going in and asking the resident what they want for code status. If the resident wanted to be a DNR, admissions should have obtained the signed form from the hospital and if they didn't, then admissions should have coordinated with the doctor to get the state DNR form signed. NHA A indicated that the admission role is currently filled by a nurse. Surveyor asked NHA A if the facility should have had the state DNR forms completed for residents on admission that wanted to be DNR. NHA A indicated, yes. On [DATE] at 8:05 AM, NHA A (Nursing Home Administrator) provided a signed DHS (Department of Health Services) Emergency Care Do Not Resuscitate Order (DNR) form for R146 to surveyors that was dated [DATE] and signed by the physician and R146's Power of Attorney. Surveyor asked NHA A if they had any documentation prior to [DATE] of a physician signed DNR form or order. NHA A indicated they did not.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49434 Based on interview and record review, the facility did not make prompt efforts to document, investigate, and resolve grievances a resident may have for 2 of 17 residents reviewed for grievances (R28 and R6). R28 voiced a grievance to the facility and the facility did not complete appropriate interviews, audits, education, or provide follow up with R28 after the conclusion of the investigation. R6 and his family voiced grievances to the facility. The facility did not complete appropriate interviews, audits, education, or provide follow up with R6 or his family after the conclusion of the investigation. Evidenced by: Surveyor requested a Grievance Policy from the facility; however, one was not provided. Example 1: R28 was admitted to the facility on [DATE], with diagnosis that include, in part: heart failure, epilepsy (seizure disorder), generalized anxiety disorder, hypertension (high blood pressure), history of cardiac arrest (heart stops beating), and presence of other cardiac implants and grafts. R28's most recent Minimum Data Set (MDS), with Assessment Reference Date of 2/7/25, states that R28 has a BIMS (Brief Interview for Mental Status) of 15 out of 15, indicating that R28 is cognitively intact. On 12/8/25 at 2:48 PM, a Progress Note is written by LPN S that states, in part: .She informed writer that she didn't sleep well last night and was tired this AM (morning) . On 1/2/25, a Progress Note that states, in part: .Resident c/o (complained) roommate was[sic] being loud all night, said she was unable to get to sleep until early morning, then was awakened[sic] again when nursing staff came to help her roommate get up . On 1/6/25, a Progress Note is written by LPN R, that states, in part: .Tired[sic] this am (morning) and states roommate kept her up most of the[sic] night so all she wants to do today is sleep . On 3/19/25, a Progress Note is written by a Nurse Practitioner, that states, in part: .Intermittently she does not get along with her roommate which also leads to troubles with sleep . (Of note: Surveyor reviewed the Grievance Log for the past year and no grievance was logged or investigated related to R28's concern). Example 2: (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R6 was admitted to the facility on [DATE], with diagnosis that include, in part: hereditary spastic paraplegia (group of disorders causing progressive spinal leg paralysis), MELAS syndrome (rare inherited mitochondrial disease that affects the nervous syndrome, muscles, and energy production), epilepsy, and neurogenic bowel (loss of normal bowel function due to a nerve problem). R6's Minimum Data Set (MDS), with Assessment Reference Date of 3/12/25, states that R6 has a BIMS (Brief Interview for Mental Status) of 15 out of 15, indicating that R6 is cognitively intact. (Of note: R6 has an activated healthcare power of attorney meaning he cannot make his own medical decisions). Surveyor requested and was provided with R6's care conference notes from the past year. These notes contain multiple grievances, raised by R6's family, that were not investigated, including conducting interviews, audits, education, or providing follow up to R6's family after the conclusion of the investigation. A care conference note was written on 9/30/24, that states, in part: . -family concerns w/ (with) safety with using bed as recliner .feels some negativity w/ others at [Facility Name] . nobody called to let family know that chair was not working . (Of note: Chair is noted to have been provided by R6's family.) A care conference note was written on 10/14/24, that states, in part: . -Call light -last night -> 3 (great than 3) hrs (hours) -had to flag down [Staff Name] got help -on going c (with) Agency -[Resident Name] went out of room to find her -Wanted to get into chair . A care conference note was written on 11/15/24, that states, in part: . Input seems to be tracked inaccurately - input/output does not align - below 3000 mL for wk (week) w/o (without) call . Surveyor reviewed the facility's grievance log and found no indication of these grievances being listed, what investigation took place, and the resolution or outcome provided by the facility. On 3/31/25 at 2:53 PM, Surveyor interviewed MT JJ (MedTech). Surveyor asked MT JJ what she does if a resident reports a grievance to her. MT JJ indicates she fills out a grievance form and gives it to the social worker. Surveyor asked MT JJ if she would consider a resident reporting she can't sleep because her roommate keeps waking her up at night a grievance. MT JJ states, yes. On 3/31/25 at 3:23 PM, Surveyor interviewed RN Y. Surveyor asked RN Y what she does if a resident reports a grievance to her. RN Y indicates she is agency and usually texts NHA A or DON B (Director of Nursing). Surveyor asked RN Y if she would consider a resident reporting she can't sleep because her roommate keeps waking her up at night a grievance. RN Y indicates yes, she would bring it up to DON B to potentially change the resident's room. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/31/25 at 4:06 PM, Surveyor interviewed DSS C (Director of Social Services/Social worker). Surveyor asked DSS C what her process is when someone reports a grievance. DSS C indicates she always fills out a grievance sheet, starts the investigation, which includes initially talking to the resident, then talking to staff working the floor, check schedules to ensure all staff members are interviewed, then I follow up with the status of the grievance, the grievance resolution, and the complainant's opinion of the resolution. Surveyor asked DSS C if she would consider a resident reporting being unable to sleep because of a roommate a grievance. DSS C indicates that it could be and that the facility could potentially look for a different room. Surveyor asked DSS C if R6's concerns raised by the family during his care conferences are considered grievances. DSS C indicated that she does not write a grievance for every single complaint raised by the family as some complaints are related to the hospital care, but she guesses that she could. On 3/31/25 at 11:36 AM, Surveyor interviewed NHA A (Nursing Home Administrator). Surveyor asked NHA A if she is aware of R28's grievance concerning not being able to sleep due to her roommate. NHA A states she is not aware of this grievance. Surveyor asked NHA A what she would expect staff to do when they were told about R28's concern. NHA A indicates she would expect staff to inform her that R28 was raising these concerns. NHA A indicated she is aware of R6's concerns.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30992 Based on interview and record review, the facility failed to protect a Residents right to be free from physical abuse by a CNA (Certified Nursing Assistant) and LPN (Licensed Practical Nurse) for 1 of 17 residents (R46). During a NOC (night) shift CNA H (Certified Nursing Assistant) heard R46 calling for help. CNA H (Certified Nursing Assistant) observed R46 to be bright red and shaking with fresh blood on his right forearm (from a skin tear) and bedding. CNA H also observed fresh blood on R46's sheets. R46 stated, CNA F (Certified Nursing Assistant) and LPN G (Licensed Practical Nurse), both agency staff, wouldn't let him get up and held his hands down. The police officer documents, he observed significant bruising to R46's right hand and thumb print bruise to his left hand. As evidenced by The State Operations Manual under F600 states in part; S483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. S483.12(a) The facility must-S483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. R46 was admitted to the facility on [DATE] with diagnoses including, but not limited to, as follows: dementia (a group of thinking and social symptoms that interferes with daily functioning), generalized anxiety disorder (severe, ongoing anxiety that interferes with daily activities), major depressive disorder (persistent low mood, loss of interest or pleasure that significantly interferes with daily functioning) and low back pain. R46 discharged from the facility 12/10/24 and has since passed away. R46's Minimum Data Set (MDS) dated [DATE], indicates R46 scored 11 out of 15 on his Brief Interview for Mental Status (BIMS) indicating he is moderately cognitively impaired. R46 requires extensive assist of 2 for transferring, dressing, toileting, and hygiene. R46's comprehensive care plan documents, in part, as follows: (Date Initiated: 10/4/24) Problem: Behavioral Symptoms R46 is combative with cares. Goal: R46 will accept cares e/b (evidenced by) cares being completed on first attempt or reapproach. Approach: .If R46 becomes combative, stop cares, ensure resident is safe, leave the room, and reapproach at a later time. R46's comprehensive care plan documents, in part, as follows: (Date Initiated: 9/12/24) Problem: R46 has hallucinations. R46 had a diagnosis of cerebral infarction, cognitive communication deficit. Goal: R46 will interact appropriately with staff, other residents, and family members. Approach: .(Date Initiated: 11/3/22) Provide safe, quiet, low-stimuli environment (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R46's comprehensive care plan documents, in part, as follows: (Date Initiated: 9/12/24) Problem: R46 resists ADL (Activities of Daily Living) assistance at times and can become verbally/physically aggressive towards staff. Frequent refusals to get out of bed for any length of time. Goal: R46 will accept assistance for ADL's w/o (without) exhibiting resistance to care. Resistance to care pattern: verbal/physical aggression towards staff. Approach .(Date Initiated: 10/19/22) Offer resident to play game of solitaire when awake at night. On 11/28/24 the following three (3) people were working together on the floor: CNA H (Certified Nursing Assistant), CNA F (Certified Nursing Assistant-Agency) and LPN G (Licensed Practical Nurse-Agency). For clarification purposes, in the statements below, CNA H is Caucasian; CNA F and LPN G are African American. The police officer did record weights of all staff involved. CNA F is smaller in stature than LPN G. The facility's Self Report documents the following: 11/29/24 - Around 7:30 AM, NHA A (Nursing Home Administrator) received a call from DON B (Director of Nursing), who was contacted by the AM shift regarding an injury of unknown origin regarding R46. DON B advised NHA A that R46 had some bruising on his right hand and a smaller bruise on his left hand. DON was asked by NHA A to confirm that R46 felt safe and the two staff, being investigated and identified are no longer in the facility until investigation is complete. NOC (night) shift employees were out of the facility. After this phone call NHA A reviewed cellphone log and noticed a voicemail from 1:54 AM advising that R46 had a skin tear and blood on the bed. For clarification, this voicemail was not received until after NHA A was notified of the incident by DON B. The clinic, Medical Director, [sic] alerted of the incident by DON B. Family updated and alerted of incident by NHA A. Of note, CNA H (Certified Nursing Assistant) left NHA A a voicemail message regarding the incident. NHA A onsite at facility spoke with the resident regarding the incident and questioned resident with police officer. NHA A and officer stood near R46's bed to reenact the incident with resident direction during interview. Questioned roommate and asked if he heard anything during the night last night. R46's roommate stated he did not hear anything and slept well. R46 states he feels safe in his room and at facility. DON B and NHA A made call to all night shift employees that worked on 11/28/24 on the third floor and all 1st shift staff noted in statements to confirm and acknowledge that statements are to be sent to NHA A as soon as possible. Like-minded residents at facility were questioned 1-Have you been abused or witnessed other residents being abused? 2-Have you heard of other residents being abused? 3-Do you feel safe here? 4-Is there anything that you need to report to me that has not already been reported and/or resolved? Skin Assessments completed on all 3rd floor residents to confirm this injury of unknown origin was an isolated incident. No new or unknown bruising, skin tears or injuries were found. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Email sent to agency Account Manager to advise her of the ongoing investigation and the incident in question. Account manager informed per facility policy, neither of these two employees will be able to be on our facility scheduled until the investigation has been completed to ensure resident safety and wellbeing. Account Manager confirmed email receipt and advised that both employees were DNR (Do Not Return) as the investigation is ongoing. Account Manager will reach out to their Trust & Safety team as part of their internal investigation. It was identified that [sic] care plan had behavioral care plans in place from October 2024 as R46 could be combative with care. If the resident becomes combative with care, stop care, ensure resident safety, leave the room, and reapproach later. Care plan updated on 12/4/24 Ongoing dementia training for staff on how to respond to R46's needs with reassurance and reapproach being most effective for R46. and again on 2/6/24 If R46 is wanting to get out of bed at night, offered to assist resident out of bed and play solitaire. As care plans were not followed the facility Disciplinary Action Form was completed for LPN G (Licensed Practical Nurse) and CNA F (Certified Nursing Assistant) over phone and forwarded to staffing agency Manager. As investigation proved that neither LPN G nor CNA F followed facility care plan, agency alerted that neither agency staff will be allowed [sic] returning to facility as agency staff. Sign added to R46's wall, near the bed, assist R46 out of bed when requested to recliner or wheelchair per preference, regardless of time of day. Interview Questions with R46: NHA A and police officer: Do you want to tell me anything that happened recently? Two nurses came in here hurt my hand and made me stay in bed. When did this occur? Last night Can you identify who did this? Two nurses, they were black, one bigger nurse and one smaller nurse. Do you know what time of night this occurred? During the night last night. Did they provide care to you? No, they just wouldn't let me get up. Can you explain what happened? I was trying to get out of bed to go see mom (his wife), they lifted my legs back in bed and the nurses told me that I couldn't get out of bed. The two nurses held my hands down and would not let me get up. Were you looking for your mom or (wife's name)? They are both the same. Do you remember where the nurses were standing? The small nurse was (Identified as CNA F) on the right and the bigger girl (Identified as LPN G) was on the left. R46 pointed at his right and left sides of the bed. NHA A moved the bedside table, stood at the resident left hand bedside, and asked R46 if this is where the bigger nurse was standing. R46 replied, Yes, and the smaller nurse was right there. R46 pointed near the bathroom door (R46's right side). Do you remember if you were on your back or side? I was on my back. I was not laying on my side. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Do you remember if you pinched one of the nurses? No, I did not pinch either of the nurses but I was swatting at their hands because I wanted to get up and they wouldn't let me. Are you in any pain? No no pain but look at the bruises on my hands and this dressing. R46 pointed to his right forearm. Do you know the head nurse's name? No, she is the darker nurse. Do you feel safe in your room and this facility? Yes, I do feel safer now that you are here. Has this ever happened before? No, I would have told you because I came here to be taken care of not get hurt. On 11/29/24 the police report documents, in part, as follows: .NHA A (Nursing Home Administrator) informed me (police officer) that the two employees (agency staff) that were involved in this incident are LPN G (Licensed Practical Nurse) and CNA F (Certified Nursing Assistant) . NHA A (Nursing Home Administrator) and I spoke with DON B (Director of Nursing), who advised that around 6:51 AM this morning, she received a phone call from LPN G, who is employed by (agency name) and is a travel nurse. LPN G informed DON B that earlier in the night R46 was in his room, and was screaming. LPN G and CNA F went to check on him and noticed that R46 had his legs off of the bed and his bedding was soiled. LPN G and CNA F provided care to R46, and R46 became combative with them. LPN G informed DON B that R46 grabbed onto her back and dug his nails into her back. LPN G removed R46's hand from her back and they finished their care. LPN G then left the room about 30 minutes later, R46 was screaming from his room again. A CNA (CNA H) went into the room and observed that R46 was bleeding and had a skin tear to his arm and had bruising to his arm. LPN G completed a written statement; a copy is included in this case file. NHA A provided me with a Grievance Form that was completed by HM O (Housekeeping Manager), who is an employee at the facility. HM O grievance form is dated 11/29/24 with an approximate time of 1:45-2:00 AM. The form indicates that HM O is filing a grievance about CNA F and LPN G. The grievance said the following: R46 stated that he wanted to get out of bed and the 2 ladies did not want him to get out of bed. He stated that they grabbed his wrist to force him to lay down. He stated that they grabbed his wrist so hard they started bleeding. He stated he yelled for them to leave his alone. The bottom half of the Grievance Form asks if there were any witnesses to his incident. HM O wrote CNA H as an employee witness and wrote the following: CNA H (Certified Nursing Assistant) is a CNA that was working the floor when the event occurred. She stated she heard R46 yelling for help. She (CNA H) said R46 was bleeding. CNA H stated the nurse and CNA ran in after she did. CNA H said R46 pointed to the nurse and CNA and said You both did this to me. You both abused me and you need to get out. CNA H stated, R46 told her that those 2 women hurt him. NHA A (Nursing Home Administrator) stated that she contacted CNA H (Certified Nursing Assistant) about this incident. CNA H sent her a text message with what she witnessed. This text message said: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At approximately 1:45, 2:00 AM, I was near R46's room and heard, help. I ran to R46's room and found fresh blood on his bedding and arm. The nurse was right behind me when I asked him what happened, soon as he seen that nurse he became extremely upset and ordered her to get out of his room. I asked the CNA to come and look at R46's arm and hand. As soon as R46 seen the CNA, he became upset and kicked her out of his room as well. CNA H stated, I repeatedly told the nurse that she needed to completed [sic] and IR (Injury Report). I'm certain nothing would have been said, if I did not hear R46 yelling help. Statement from R46 NHA A (Nursing Home Administrator) and I went to R46's room and obtained a statement from R46. It should be noted that R46 is (age) and has dementia, but he was still willing and able to give a statement. R46 stated that he was trying to get out of bed to talk with his wife (name) and the nurse and CNA were trying to keep him in bed. R46 stated that the nurse grabbed one of his arms and the CNA grabbed the other arm and gripped his arms tight. R46 stated this cause [sic] him pain and that he would rate the pain a 9/10, but he was no longer in pain during my contact with him. R46 stated that he asked them to stop but they kept telling him that he couldn't get out of bed. R46 did state that he tried to push their hands away when they grabbed onto him, but stated that he never pinched the nurse. *I (police officer) observed significant bruising to R46's right hand and thumb print bruise to his left hand. It should be noted that R46 is on blood thinners and bruises and bleeds very easily. I took 7 photos of R46's injuries and tagged them into digital evidence. This case can remain active. Further follow up needed. Statements: MT/CNA I (Medication Technician/Certified Nursing Assistant) documented when she arrived on the floor, another employee, clarified as CNA H (Certified Nursing Assistant), found her to tell her R46 was upset and that his hand was bruised/bleeding. MT/CNA I instantly went to the NOC (night) nurse LPN G (Licensed Practical Nurse) to report this and ask what happened. LPN G explained the situation, and MT/CNA I called DON B (Director of Nursing). DON B (Director of Nursing) received a call from the NOC nurse, LPN G (Licensed Practical Nurse) regard R46 and the situation that occurred. LPN G explained that she and CNA F were providing care, and R46 began screaming and swatting at LPN G and CNA F. LPN G stated R46 grabbed her. LPN G then explained she removed the residents hands off her and was later called to the room for bruising on R46's hand. LPN G explained how R46 is on Eliquis that caused the bruising . DON B asked LPN to write a statement. DON B later rounded with DPT J (Director of Physical therapy) and asked R46 questions about the incident. R46 stated, They hurt me and were fighting me. R46 described workers as black girls one big and one small to DON B and DPT J. DON B provided active listening and reassured the resident that he is safe, and this will be investigated. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA H (Certified Nursing Assistant) documented the following statement: Around 1:45-2:00 AM, I was in the 1st dining room, and I heard help, help, help from R46's room. I went to check on R46 to see what he needed. Once I entered the room, I noticed fresh blood on his right forearm and bedding. I asked R46, What happened? LPN G (Licensed Practical Nurse) followed me into the room, and R46 stated, Get out of my room. LPN G left the room, and I went to find the other CNA, CNA F (Certified Nursing Assistant). who was in the hallway walking towards me. I said to CNA F, Did you see R46's arm? Come here. We both entered the room, and R46 kicked her out. Once CNA F left the room, I wiped his arm with a cold washcloth. The bleeding had stopped, and he said, Thank you for helping me. I phoned the NHA A (Nursing Home Administrator) and left a voicemail at 1:54 AM advising her of the incident. The next time I entered the room was around 3:00 AM, 4:00 AM, 5:00 AM and 6:00 AM. We checked, changed, and repositioned him at 4:30 AM. R46 had no other comments that night. CNA F (Certified Nursing Assistant) documented the following statement: CNA F started rounds at 12:00 AM and around 1:30 AM R46 was yelling for help I was unable to to get to him in time so the nurse, LPN G (Licensed Practical Nurse), went in because I was still helping a client next door to him and was unable to get him at that [sic] so she went in for me after I got done with the neighbor I went into R46's room and R46 was upset and trying to hit the nurse so I told her I'll get him a snack and we can come back later when he calms down after about 20-30 minutes go by I asked LPN G if she could come help me with R46 because I couldn't find the other CNA, CNA H (Certified Nursing Assistant), LPN G agreed we went into R46's room and changed him there were no bruises or bleeding when we got done with him around 2:00 AM I told LPN G I was going on break and she could inform the other CNA, CNA H, I get back at 2:36 AM. CNA H waited for me outside the bathroom and stated that R46 has a bruise on his hand and it was bleeding. I went to observe it and he was extremely upset with CNA H and kept yelling for her to get out of his room and once I left his room with her I came back and asked what happened to his hand he said that women squeezed it. LPN G (Licensed Practical Nurse) documented the following statement: Writer heard patient yelling out and writer went to R46's room he had his legs hanging off the bed. Writer assisted legs back into bed when agency CNA, CNA F (Certified Nursing Assistant), came into the room because she found R46 yelling as well. CNA F checked R46 and asked writer to help her change R46's brief due to it being soiled and writer agreed while being changed R46 started yelling out and being combative with staff. R46 grabbed writer's back fat roll and dug nails into writer's skin. Writer asked R46 to please stop and remove his hand which patient then stated I'll punch you [sic] tits next. Writer removed R46's hand from back area as patient continued to dig his nails into writer's back roll area. R46 was finished cleaned and covered with bed low. About 30 minutes later R46 began yelling out again . This time CNA H (Certified Nursing Assistant) went into R46's room and informed writer that R46 had a skin tear to his right hand with bruising and the skin tear was on the right arm area but writer could not tell due to R46 refusing treatment. R46 refused to let writer look at his right arm or hand patient told writer to get the hell away from me. (of note: LPN G and CNA F did not follow R46's care plan, by stopping cares, ensuring safety and reapproaching.) (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DPT J (Director of Physical Therapy) documented the following statement: I was approached by DON B in the morning about an injury that occurred to R46's hand and was asked to be involved in the investigation. I asked R46 if I could see his hand and then asked if he could tell me what happened. R46 replied, I wanted to get out of bed and I was being combative and skinny black nurse grabbed my hand did this. We then asked R46 if he felt safe here. R46 replied, No, you come to a place like this to get help and this is what happens. R46 also said he had no pain when asked. We assured R46 we were going to investigate this and that we were very sorry this happened to him. We asked if there was anything else we could do for him at this time and he said no. On 11/29/24 the facility documented the following Disciplinary Action Form for CNA F (Certified Nursing Assistant) and LPN G (Licensed Practical Nurse). Reason for disciplinary action: Not following care plan - when a resident is having combative behaviors we reapproach, we try a different staff member we are not to engage with a combative resident. Supervisor's expectations for the employee's improvement in work performance: Follow care plan - reapproach. Next course of action if the employee does not meet improvements as directed: Termination - Do not return to facility On 3/26/25 at 3:47 PM, Surveyor spoke with DPT J (Director of Physical Therapy). Surveyor showed DPT J her statement. DPT J stated, her statement is accurate. DPT J stated, she joined DON B (Director of Nursing) in R46's room to be the second person while they spoke with R46. DPT J stated, R46 stated the one (1) nurse grabbed him hard. DPT J stated, either R46 was trying to get up and they wouldn't let him or vice versa. DPT J stated, R46 wasn't doing what the (agency) staff wanted him to do. Surveyor asked DPT J, which staff members were involved. DPT J stated, she was not privy to know who was involved. Surveyor stated, your statement documents, that you and DON B asked R46 if he felt safe here. R46 replied, No . DPT J stated, That's accurate. Surveyor asked DPT J, what was R46's demeanor. DPT J stated, R46 seemed at baseline. Surveyor asked DPT J, if R46 a resident you work with. DPT J stated, no. Surveyor asked DPT J, if a staff member observes an injury and a resident voices that were abused, what should staff do. DPT J stated, report to NHA A (Nursing Home Administrator) immediately. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/26/25 at 4:40 PM. Surveyor spoke with CNA H (Certified Nursing Assistant). CNA H has worked at the facility for over one (1) year. CNA H stated, she heard R46 yelling help, help around 1:00-2:00AM. CNA H stated, LPN G came in R46's room behind her. CNA H stated, R46 kicked LPN G out of his room. CNA H stated, R46 told LPN G she was trying to hurt or kill him. CNA H stated, she has a good relationship with R46 and he knew he was safe with me. CNA H stated, she got CNA F and asked her did you see R46. CNA H stated, when R46 saw CNA F he also told her to get out of his room. CNA H stated, talking about this situation is very upsetting to her. CNA H stated, it's documented all over the facility that when a resident tells you stop you stop. CNA H stated, R46 was resisting and they (clarified CNA F and LPN G) manhandled him. CNA H stated this situation was very frightening to her. Surveyor asked CNA H, did R46 feel safe, CNA H stated, R46 knows when I was there he's safe. CNA H stated, if a resident states they want to get up we should let them up. CNA H stated, if R46 is upset and telling you no, ensure his safety, leave him and revisit it. CNA H stated, staff should have gone in with a different approach. CNA H stated, R46 had favorite foods like chocolate. CNA H stated, if R46 got ugly (combative) with me I just let it be. CNA H added, when R46 holds the blankets up in front of his face that's a sign he does not want to be changed at that time. CNA H stated, it's important to ensure R46 is safe and reapproach later. CNA H added, at other times he will will tell you no or say get out. CNA H stated, staff need to respect what he's telling them. CNA H stated, staff need to give R46 space and problem solve. CNA H added, R46 doesn't automatically start getting resistive like that. Surveyor asked CNA H, when he was calling out and you entered his room, what did you observe regarding R46's mood. CNA H stated, R46 was bright red and shaking. CNA H added, R46 was beyond fearful, he was mad. CNA H stated, when R46 gets mad you know it. CNA H stated, it was an uncomfortable night to start with. Surveyor asked CNA H to clarify. CNA H stated, agency doesn't know the residents they're working with and sometimes CNA H feels like the third wheel. CNA H stated, we need to get permanent staff in this facility. Surveyor asked CNA H if she worked with CNA F and LPN G prior to this shift. CNA H stated, she worked with CNA F once and had not worked with LPN G prior to this. Surveyor asked CNA H if there was an RN/LPN (Registered Nurse/Licensed Practical Nurse) working on a different floor during this night shift. CNA H stated, she is not sure. Surveyor asked CNA H, did you notice any change in R46's demeanor or daily routine following this incident. CNA H stated, no. CNA H added, it's a resident's right for R46 to refuse. CNA H added, for whatever reason, if your approach is right his response will change. CNA H stated, staff need to change their approach and rapport with R46. On 3/27/25 at 8:18 AM, Surveyor spoke with HM O (Housekeeping Manager). HM O stated, she is also a Certified Nursing Assistant. HM O stated, when she arrived at the facility CNA H (Certified Nursing Assistant) notified her of R46's injuries and that R46 is really upset. HM O stated, R46 told he there's two (2) women in there grabbing his wrists. HM O stated, she could see R46 had a wound on his arm or wrist. HM O stated, she wrote up the concern and immediately gave to the SW (Social Worker). HM O stated, both staff that were accused are agency. HM O stated, both CNA F and LPN G were in the building. HM O stated, normally she would give the concern to the charge nurse. HM O stated, she educated CNA H that this is something she should fill out. HM O stated, she knows CNA H called NHA A (Nursing Home Administrator) so she already knew. (Note, NHA A did not get the voice mail message and was not yet aware of the allegation of abuse.) (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/27/25 at 8:25 AM, Surveyor spoke with MT/CNA I (Medication Technician/Certified Nursing Assistant) who arrived to work the AM shift. Surveyor show MT/CNA I her statement. MT/CNA I stated, her statement is accurate. MT/CNA I stated, she was notified by CNA H (Certified Nursing Assistant). MT/CNA I was told their was an incident when CNA F (Certified Nursing Assistant) and LPN G (Licensed Practical Nurse) were doing cares on R46. MT/CNA I stated when staff rolled R46 over his bottom was sore and he tried to grab CNA F and LPN G and he grabbed on of their arms. MT/CNA I stated, she called DON B (Director of Nursing) and notified her of the allegation. Surveyor asked MT/CNA I, have you and other staff received education regarding abuse. MT/CNA I stated, a little bit of education and who to go to and inform. MT/CNA I stated, she learned she should call NHA A first. Surveyor asked MT/CNA I, if a resident is agitated or upset what should you do. MT/CNA I stated, she would give R46 or any agitated resident a few minutes and go back. MT/CNA I stated, that day she believes staff wiped his bottom too hard because it hurt and that's maybe when that altercation happened. MT/CNA I stated, she thinks R46 reacted because it hurt. MT/CNA I stated, normally R46 is not combative or aggressive. On 3/27/25 at 9:05 AM, Surveyor spoke with NHA A (Nursing Home Administrator). Surveyor asked NHA A, when a residents reports abuse and there is an injury (bruising, bleeding, skin tear) what should staff do. NHA A stated, staff should immediately call me. Surveyor asked NHA A, should residents be protected. NHA A stated, Oh, of course. Surveyor asked NHA A, what time did this incident occur. NHA A stated, around 2:00 AM. Surveyor asked NHA A, how soon should staff report this to you. NHA A stated, immediately. NHA A stated, she found out about it when DON B (Director of Nursing) called me around shift change. NHA A stated, CNA H (Certified Nursing Assistant) called me and left a voicemail message during the night. NHA A stated, she reached out to DON B at 8:15 AM. NHA A stated, staff are not to just just leave me a voicemail and carry on. NHA A stated, she should have called NHA A back again and tried DON B as well. NHA A stated, staff need to keep calling NHA A and DON B until they reach one of them and NHA A and DON B will notify each other. NHA A stated, CNA H is thinking she reported it (by leaving a voicemail message). NHA A stated, CNA F and LPN G should have left the facility immediately. NHA A stated, if CNA H had reached her directly this is what she would have told CNA F and LPN G. Surveyor asked NHA A, is it the facility's responsibility to protect R46 as well as all other residents. NHA A stated, Yes. NHA A stated, CNA H was the only other staff member working on the 3rd floor besides CNA F and LPN G. Surveyor asked NHA A to describe what occurred. NHA A stated 1st shift came in and noticed R46 had bruising. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Tell me about what happened: MT/CNA I (Medication Technician/Certified Nursing Assistant) came in to work the AM shift and noted R46 had markings (bruises) on him. MT/CNA I notified DON B (Director of Nursing). Staff alerted their concerns to LPN G (Licensed Practical Nurse) who was leaving. LPN G then called DON B to report. NHA A stated, she doesn't know if CNA F or LPN G would have said anything which is very shameful. NHA A stated, she thinks the only reason LPN G reached out to DON B was because our regular staff came in and started questioning. NHA A stated, DON B and DPT J went to speak with R46. NHA A stated, she was on PTO (Paid Time Off), however, she came into the facility. NHA A stated, she immediately spoke with R46. NHA A stated, R46's family member had just left the facility but she did not connect with her. NHA A stated, she notified the police and they started their investigation. NHA A stated, she notified staff to do skin assessments. NHA A stated, R46 has dementia, however, when he's with it, he's with it. NHA A stated, when she spoke with R46's family member she discovered R46 had been notified by his family that his spouse was declining. The facility started the process for R46 to transfer facilities to be close to her. NHA A stated, the wheels were in motion at this point but he was not officially accepted to the other facility. NHA A stated, R46's statements regarding him coming here for help and then this happens hurt her. NHA A stated, she asked R46 do you feel safe now. NHA A stated, he said yes, now that you're here I feel safe. Surveyor asked NHA A, did you note any long term effects. NHA A stated, no. NHA A stated, no changes were noted in R46's daily routine or mood. NHA A stated, care plans were in place to address situations, such as, if R46 gets combative ensure safety and reapproach. NHA A stated she notified the agency and neither staff member will be returning to this facility or any of their sister facilities. NHA A stated, police took photos and there is a visible thumb print on R46's arm that is referenced in the police report. NHA A clarified that CNA F was on R46's right side and LPN G was on R46's left side. Surveyor asked NHA A, have any concerns been reported regarding CNA F or LPN G. NHA A stated, it may have been LPN G's first time at the facility and she thinks CNA F has worked here before. Surveyor asked NHA A, what training has been provided to staff following this incident. NHA A stated, we did dementia education including reapproaching and notifying regarding abuse. Surveyor asked NHA A, is it ever acceptable for staff to hold a resident's arms down. NHA A, stated, no, we are a restraint free building. R46 was not free from physical abuse by CNA F and LPN G. Cross Reference: F609, F610

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39849 Based on observation, interview and record review, the facility failed to ensure that each resident is free from physical restraints that are not required to treat the resident's medical symptoms for 1 of 2 residents reviewed for restraints (R146). R146 was observed in an power lift recliner with the remote not in reach and thus restricting R146's movement. Evidenced by: The facility policy, Use of Restraints, revision date, April 2017, indicates, in part: Policy Statement: Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls . Policy Interpretation and Implementation: 1. Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. 2. The definition of a restraint is based on the functional status of the resident and not the device. If the resident cannot remove a device in the same manner in which the staff applied it given that the resident's physical condition .and this restricts his/her typical ability to change position or place, the device is considered a restraint . 4. Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted, including: .c. placing a resident in a chair that prevents the resident from rising . 9. Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative (sponsor) . R146 was admitted to the facility on [DATE] with diagnoses that include, in part: Parkinsonism (A group of symptoms, including tremor, bradykinesia (slowed movement), rigidity, and postural instability), Other lack of coordination, Difficulty in walking, and Weakness. R146's most recent Minimum Data Set (MDS), target date 3/17/25, indicates a Brief Interview of Mental Status (BIMS) of 5. Indicating that R146 has a severe cognitive impairment. Section GG indicates R146 is dependent in Sit to Stand and Chair/bed-to-chair transfer. Section P indicates R146 does not have any restraints. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/25/25 at 10:16 AM Surveyors interviewed R146 during the initial screening process. R146 was observed in a power recliner in a reclined position. R146 indicated that this morning one of the nurses came in and said to give her the controller and that she was going to use it today instead of R146. Surveyors clarified with R146 which controller and he indicated the controller for the recliner. Surveyors observed the controller on the floor on the back right side of the recliner (of note, this position is if you're facing the recliner, the remote was out of R146's reach). On 3/25/25 at 10:31 AM, Surveyors interviewed LPN K (Licensed Practical Nurse) asked if R146 is supposed to have the remote for the recliner. LPN K indicated they don't want R146 to have it because he has been falling and he will put the recliner up and try to stand up. LPN K indicated today was the first time she put the remote on the floor so he couldn't use it and fall. LPN K indicated they have tried a low bed and fall mat, have offered to have him lie down, or go in the wheelchair but he refused. LPN K indicated, We have tried everything and this is what we're doing right now. On 3/26/25 at 4:59 PM, Surveyors interviewed CNA L (Certified Nursing Assistant). CNA L indicated when she assists R146 to the recliner she will lay him out, elevate his legs, give him his call light, his table. CNA L indicated R146 really slides and this was the first time she took care of him and he was in the bed a lot so she said let's try the recliner. CNA L indicates as she was checking on him she noticed R146 sliding and so she was worried and put him back into bed. Surveyors asked CNA L if R146 is able to use the recliner remote. CNA L indicated R146 did not try but that she had given it to him. Surveyors asked CNA L if R146 is able to get out of his recliner alone. CNA L indicated R146 tries but isn't able to without going on the floor. Surveyors asked CNA L if she feels R146 is strong enough to get out of the recliner alone. CNA L indicated on some days she thinks he could, but on other days, no. On 3/31/25 at 9:01 AM Surveyors interviewed DON B (Director of Nursing) and asked if the facility completes an assessment to see if residents are safe to use power recliners. DON B indicated she believed therapy does an assessment. Surveyors requested a copy of this assessment. (Of note, therapy notes provided did not include a recliner assessment.) Surveyor asked DON B if it is ok for staff to move the remote where the resident cannot reach it. DON B indicated, no. Surveyors asked DON B if this could be considered a restraint. DON B indicated that it could be. Surveyors asked DON B if R146 is able to get out of the recliner himself. DON B indicated R146 has been moving all over the place and that she doesn't know how safe it is. Surveyor reviewed the interview with LPN K with DON B. Surveyors asked if it could be considered a restraint if the remote for the recliner was purposefully put out of reach. DON B indicated it would be considered a restraint. R146 was observed in an power lift recliner with the remote not in reach and thus restricting R146's movement.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30992 Based on record review and interview, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment are reported immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse to the appropriate agencies for 5 of 5 allegations involving residents (R46, R146, R6, and R3) and 2 of 3 supplemental residents (R18, R19) and failed to implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime. During a NOC (night) shift on 11/28/24 to 11/29/24, CNA H (Certified Nursing Assistant) heard R46 calling for help. CNA H (Certified Nursing Assistant) observed R46 to be bright red and shaking with fresh blood on his right forearm (from a skin tear) and bedding. R46 stated, CNA F (Certified Nursing Assistant) and LPN G (Licensed Practical Nurse), both agency staff, wouldn't let him get up and held his hands down. On 11/29/24 at 1:54 AM, CNA H called NHA A (Nursing Home Administrator) and left a a voicemail message regarding the incident. NHA A did not hear the phone ring or get the message until after the NOC shift was done and AM shift came on duty. CNA H did not continue trying to reach NHA A directly to immediately report the allegation of abuse. Therefore, the allegation of abuse was not reported timely. R146 reported an allegation of abuse that was not reported to the NHA, and other officials within two hours of discovery. Facility was aware of family member threatening to take R6's art supplies away, and did not report this allegation to the state agency or law enforcement. R18, R19, R6, and R3 reported neglect allegations to staff, including the former Social Worker and NHA A (Nursing Home Administrator), but was not reported to the state agency or law enforcement. Evidenced by: The facility's policy, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, states, in part, as follows: Reporting Allegations to the Administrator and Authorities: If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. Immediately is defined as: within two hours of an allegation involving abuse or result in serious bodily injury . The State Operations Manual under F600 states in part; S483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. S483.12(a) The facility must-S483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Example 1 R46's Minimum Data Set (MDS) dated [DATE], indicates R46 scored 11 out of 15 on his Brief Interview for Mental Status (BIMS) indicating he is moderately cognitively impaired. R46 requires extensive assist of 2 for transferring, dressing, toileting, and hygiene. R46 was admitted to the facility 10/4/21 with diagnoses including, but not limited to, as follows: dementia (a group of thinking and social symptoms that interferes with daily functioning), generalized anxiety disorder (severe, ongoing anxiety that interferes with daily activities), major depressive disorder (persistent low mood, loss of interest or pleasure that significantly interferes with daily functioning) and low back pain. R46 discharged from the facility 12/10/24 and has since passed away. R46's comprehensive care plan documents, in part, as follows: (Date Initiated: 10/4/24) Problem: Behavioral Symptoms R46 is combative with cares. Goal: R46 will accept cares e/b (evidenced by) cares being completed on first attempt or reapproach. Approach: .If R46 becomes combative, stop cares, ensure resident is safe, leave the room, and reapproach at a later time. R46's comprehensive care plan documents, in part, as follows: (Date Initiated: 9/12/24) Problem: R46 has hallucinations. R46 had a diagnosis of cerebral infarction, cognitive communication deficit. Goal: R46 will interact appropriately with staff, other residents, and family members. Approach: .(Date Initiated: 11/3/22) Provide safe, quiet, low-stimuli environment. R46's comprehensive care plan documents, in part, as follows: (Date Initiated: 9/12/24) Problem: R46 resists ADL (Activities of Daily Living) assistance at times and can become verbally/physically aggressive towards staff. Frequent refusals to get out of bed for any length of time. Goal: R46 will accept assistance for ADL's w/o (without) exhibiting resistance to care. Resistance to care pattern: verbal/physical aggression towards staff. Approach .(Date Initiated: 10/19/22) Offer resident to play game of solitaire when awake at night. On 11/28/24 NOC shift, the following three (3) people were working together on the floor: CNA H (Certified Nursing Assistant), CNA F (Certified Nursing Assistant-Agency) and LPN G (Licensed Practical Nurse-Agency). For clarification purposes, in the statements below, CNA H is Caucasian; CNA F and LPN G are African American. The police officer did record weights of all staff involved. CNA F is smaller in stature than LPN G. CNA H (Certified Nursing Assistant) documented the following statement: Around 1:45-2:00 AM, I was in the 1st dining room, and I heard help, help, help from R46's room. I went to check on R46 to see what he needed. Once I entered the room, I noticed fresh blood on his right forearm and bedding. I asked R46, What happened? LPN G (Licensed Practical Nurse) followed me into the room, and R46 stated, Get out of my room. LPN G left the room, and I went to find the other CNA, CNA F (Certified Nursing Assistant) who was in the hallway walking towards me. I said to CNA F, Did you see R46's arm? Come here. We both entered the room, and R46 kicked her out. Once CNA F left the room, I wiped his arm with a cold washcloth. The bleeding had stopped, and he said, Thank you for helping me. I phoned the NHA A (Nursing Home Administrator) and left a voicemail at 1:54 AM advising her of the incident. The next time I entered the room was around 3:00 AM, 4:00 AM, 5:00 AM and 6:00 AM. We (meaning CNA H and the accused staff) checked, changed, and repositioned him at 4:30 AM. R46 had no other comments that night. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/27/25 at 9:05 AM, Surveyor spoke with NHA A (Nursing Home Administrator). Surveyor asked NHA A, when a residents reports abuse and there is an injury (bruising, bleeding, skin tear) what should staff do. NHA A stated, staff should immediately call me. Surveyor asked NHA A, should residents be protected. NHA A stated, Oh, of course. Surveyor asked NHA A, what time did this incident occur. NHA A stated, around 2:00 AM. Surveyor asked NHA A, how soon should staff report this to you. NHA A stated, immediately. NHA A stated, she found out about it when DON B (Director of Nursing) called her around shift change. NHA A stated, CNA H (Certified Nursing Assistant) called me and left a voicemail message during the night. NHA A stated, staff are not to just just leave me a voicemail and carry on. NHA A stated, CNA H should have called NHA A back again and tried DON B as well. NHA A stated, staff need to keep calling NHA A and DON B until they reach one of them and NHA A and DON B will notify each other. NHA A stated, CNA H is thinking she reported it (by leaving a voicemail message). CNA H was the only other staff member working on the 3rd floor besides CNA F and LPN G. The facility failed to immediately report an allegation of abuse, protect their residents, and immediately educate CNA H and all staff regarding reporting and restraints (physically holding a resident's hands down.) Cross Reference: F600, F610 39849 Example 2 R146 was admitted to the facility on [DATE] with diagnoses that include, in part: Parkinsonism (A group of symptoms, including tremor, bradykinesia (slowed movement), rigidity, and postural instability), Bipolar disease (Brain disorder that causes significant shifts in a person's mood, energy, and activity levels), chronic pain, Muscle wasting and atrophy, Unspecified abnormalities of gait and mobility, and weakness. R146's most recent Minimum Data Set (MDS), target date 3/17/25, indicates a Brief Interview of Mental Status (BIMS) of 5. Indicating that R146 has a severe cognitive impairment. On 3/25/25 at 10:16 AM during the initial screening process, surveyors interviewed R146 who reported that two nurses are horrible. R146 indicated that one of the nurses picked him up and threw him in bed, she just slammed me. R146 indicated it made him feel horrible. R146 also indicated, you should have seen how she was changing my clothes, she just ripped them off. R146 did not remember the name of the person he told, but states he pointed her out to a staff member in the dining room this morning. R146 indicated that he did not feel safe. On 3/25/25 at 11:28 AM surveyor interviewed SW C (Social Worker) and asked if she was assisting residents with eating this morning in the dining room? SW C indicated she assisted R146. Surveyor asked SW C if R146 brought up any concerns to her? SW C indicated R146 didn't initially, but towards the end he mentioned that he thought the girls were being kind of rough with him. SW C indicated she asked R146 how they were rough and R146 said when they were getting him out of bed. SW C indicated that R146 pointed to a CNA that was walking through. Surveyors asked SW C if she reported this to anyone. I didn't report it to NHA A (Nursing Home Administrator) at that time. Surveyor asked SW C if a resident comes to you and says someone was rough with them should that be reported to the NHA when it was brought to your attention. SW C stated yes. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/25/25 at 11:37 AM surveyor interviewed NHA A and asked if any concerns had been brought to her today regarding R146. NHA A reported when she was in the conference room downstairs, she heard rumblings that R146 said a staff member was rough with him. Surveyor asked NHA A when she first was made aware of this allegation. NHA A indicated around 11:00 am. Surveyor asked NHA A what time R146 would have been eating breakfast and she indicated 8:15 AM. Surveyor reviewed interviews obtained from R146 and SW C with NHA A. Surveyor asked NHA A if SW C should have come to her immediately when R146 brought the concern to her. NHA A replied yes. 49434 Example 3: R6 was admitted to the facility on [DATE], with diagnosis that include, in part: heart failure, epilepsy (seizure disorder), generalized anxiety disorder, cerebral infarction (stroke), hypertension (high blood pressure), history of cardiac arrest (heart stops beating), presence of other cardiac implants and grafts. hereditary spastic paraplegia (group of hereditary disorders causing progressive, spinal, spastic leg muscle weakness), MELAS syndrome (genetic disorder causing muscle weakness, seizures and stroke-like episodes), neurogenic bowel (loss of normal bowel function due to a nerve problem), and constipation. R6's Minimum Data Set (MDS), with Assessment Reference Date of 3/12/25, states that R6 has a BIMS (Brief Interview for Mental Status) of 15 out of 15, indicating that R6 is cognitively intact. Section GG indicates R6 utilizes a manual wheelchair and mechanical lift for mobility. GG0115 indicates R6 has impairment on both his right and left lower extremities. GG0130 indicates he is independent for eating, and dependent on staff for toileting hygiene, showering and bathing, and lower body dressing. GG0170 indicates R6 is dependent on staff for rolling left and right, transferring between a chair and a bed, and transferring to a toilet is marked not applicable. Problem: [Resident Name], a former sport reporter and illustrator, requires support to continue pursing his passion for drawing and staying connected to his love of sports. He needs assistance with accessing materials and staying up-to-date on local sports teams' schedules. Problem Start Date: 1/29/25. Approach: To support [Resident's Name]'s passion for sports and art, Activity Aides will check in with him daily to ensure he has all the necessary materials for his drawings. The Activity Director will work with [Resident Name] to create prints of his artwork, using a list of names provided by [Resident Name]. Additionally, the Activity Director will print schedules for [Resident Name]'s favorite local Wisconsin teams, including the Badgers. Packers, and Bucks, to keep him informed about upcoming games. [Resident Name] will also continue to be involved in BINGO activities, serving as the caller twice a week, which brings him joy and fulfillment. By providing [Resident Name] with the support and resources he needs, we aim to foster his continued engagement in his passion for sports and art. Approach Start Date: 1/29/25. On 11/25/24, a Care Conference Note was written that notes FM II (Family member), R6's Daughter, as a participant via phone. This note states, in part: . -issues c (with) refusing to drink -wanted to draw -foot down won't be coming if not getting fluid intake -getting away c (with) it . -Water intake has increased after argument - assuming has[sic] helped c (with) regulated bowels -Will take all drawing stuff away if not drinking water . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/31/25 at 11:41 AM, Surveyor was interviewing NHA A and DON B about R6's poor fluid intake. During the interview, NHA A commented that the facility encourages R6 to drink, but R6's family is very concerned about R6's fluid intake and has threatened to take away his art supplies if he doesn't drink more, telling R6 that his art supplies were a privilege. The facility became aware of an allegation of abuse on 11/25/24 during R6's care conference and this allegation was not reported to the State Survey Agency or law enforcement. 50285 Example 4: R18 was admitted to the facility on [DATE]. R18's most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/22/25, indicates R18 has a Brief Interview of Mental Status (BIMS) score of 13 out of 15, indicating R18 is cognitively intact. On 10/8/24 the facility became aware that R18 had been left in her wheelchair all night without being changed or assisted to bed. The facility completed a grievance form but did not report it to the state agency. On 3/31/25 at 2:49 PM, Surveyor interviewed R18 about the incident that happened on 10/28/24. R18 remembered the incident and stated that nobody put her into bed, and nobody checked on her all night. R18 stated she was tired and scared because she never saw a CNA all night. Example 5: R19 was admitted to the facility on [DATE]. R19's most recent MDS, with an ARD of 1/3/25, indicates R19 has a BIMS score of 10 out of 15, indicating R19 has mild cognitive impairment. On 12/15/24 the facility became aware that R19 had her call light on all night, but that staff had shut her door and not assisted her to get changed from her wet brief. The facility completed a grievance form but did not report it to the state agency. On 3/31/25 at 2:40 PM, Surveyor interviewed R19 about the incident that happened on 12/15/24. R19 remembered the incident and stated that she had her call light on all night and was left in pee all night. R19 stated the CNA closed the door and she felt afraid. R19 said it made her feel terrible, that she was crying, and that she was overwhelmed and angry that they weren't taking care of her, and she had to lay in pee like that all night. Example 6: R6 was admitted to the facility on [DATE]. R6's most recent MDS, with an ARD of 3/12/25, indicates R6 has a BIMS of 15 out of 15, indicating R6 is cognitively intact. On 12/16/24 the facility became aware that R6 had received an enema then was left in his stool for hours without being changed and cleaned up by staff. The facility completed a grievance form but did not report it to the state agency. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/31/25 at 2:33 PM, Surveyor interviewed R6 about the incident that happened on 12/16/24. R6 remembered the incident and stated that he had an enema and no one came back in to check or change him. R6 stated that he had a BM (bowel movement) and stayed in it all night, and that he wasn't cleaned up for several hours until the next morning. Example 7: R3 was admitted to the facility on [DATE]. R3's most recent MDS, with an ARD of 1/2/25, indicates R3 has a BIMS of 11 out of 15, indicating R3 has a mild cognitive impairment. On 11/13/24 the facility became aware that R3 stated he had not been changed and then a CNA (Certified Nursing Assistant) entered his room and waved his wet brief in his face. The facility completed a grievance form but did not complete report it to the state agency. On 3/31/25 at 4:24 PM, Surveyor interviewed NHA A about these grievance forms and these incidents. Surveyor asked NHA to read the grievance forms and if they would be considered allegations of abuse. NHA A replied yes, they would be potential neglect allegations. Surveyor asked NHA A if they were reports of potential abuse, had they been thoroughly investigated and reported. NHA A replied that for most of them they followed through on them, but they didn't have a file or documentation on them. NHA A stated that they should have been reported and investigated. NHA A stated that she has learned the hard way to take ownership of abuse allegations and ensure that everything gets done properly. The Facility treated these incidents for R18, R19, R6 and R3 as grievances instead of as abuse allegation; therefore, they did not follow their policy and did not report this accusation of abuse to the state agency. Cross Reference F610.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50285 Based on interview and record review, the facility did not ensure that in response to allegations of abuse, neglect, exploitation, or mistreatment, all alleged violations were thoroughly investigated for 3 of 3 sampled residents (R3, R6, R46) and 2 of 3 supplemental residents (R19, R18) reviewed for abuse investigations. On 10/8/24 the facility became aware that R18 had been left in her wheelchair all night without being changed or assisted to bed. The facility completed a grievance form but did not complete a thorough investigation. On 12/15/24 the facility became aware that R19 had her call light on all night, but that staff had shut her door and not assisted her to get changed from her wet brief. The facility completed a grievance form but did not complete a thorough investigation. On 12/16/24 the facility became aware that R6 had received an enema then was left in his stool for hours without being changed and cleaned up by staff. The facility completed a grievance form but did not complete a thorough investigation. On 11/13/24 the facility became aware that R3 stated he had not been changed and then a CNA (Certified Nursing Assistant) entered his room and waved his wet brief in his face. The facility completed a grievance form but did not complete a thorough investigation. The facility became aware of an allegation of abuse on 11/25/24 during R6's care conference by FM II and the facility did not investigate the allegation. During a NOC (night) shift on 11/28/24 to 11/29/24, CNA H (Certified Nursing Assistant) heard R46 calling for help. CNA H (Certified Nursing Assistant) observed R46 to be bright red and shaking with fresh blood on his right forearm (from a skin tear) and bedding. R46 stated, CNA F (Certified Nursing Assistant) and LPN G (Licensed Practical Nurse), both agency staff, wouldn't let him get up and held his hands down. This allegation was not thoroughly investigated and the facility did not provide training to staff regarding physically restraining residents to ensure this does not occur again. Evidenced by: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility policy entitled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, dated 2001, with Revision Date of September 2023, states, in part: Policy Statement: All reports of resident abuse . neglect, exploitation, or theft . are to be reported to local, state, and federal agencies . and thoroughly investigated by facility management. Findings of all investigations are documented and reported . Reporting Allegations to the Administrator and Authorities: . 6. Upon receiving any allegations of abuse, neglect . the administrator is responsible for determining what actions (if any) are needed for the protection of the residents . Investigating Allegations: 1. All allegations are thoroughly investigated. The administrator initiates investigations . 7. The individual conduction the investigation as a minimum: a. reviews the documentation and evidence; reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident; c. observes the alleged victim, including his or her interactions with staff and other residents' d. interviews the person(s) reporting the incident; e. interviews any witnesses to the incident; f. interviews the resident (as medically appropriate) or the resident's representative; g. interviews the resident's attending physician as needed to determine the resident's condition; h. interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; i. interviews the resident's roommate, family members and visitors; j. interviews other residents to whom the accused employee provides care or services; k. reviews all events leading up to the alleged incident; and l. documents the investigation completely and thoroughly . Example 1: R18 was admitted to the facility on [DATE]. R18's most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/22/25, indicates R18 has a Brief Interview of Mental Status (BIMS) score of 13 out of 15, indicating R18 is cognitively intact. R18's Basic CNA (Certified Nursing Assistant) Care Plan, dated 7/5/24 states, in part: Transfers: EZ Stand (a stand assist device) with assist of 2, use Hoyer (a mobile lift service) with 2 assist on PM (evening) shift. Mobility: WC (wheelchair) for mobility. Encourage to propel short distances. Staff to assist as needed. Dressing: Extensive assist of 1 with UB (upper body) dressing and hygiene. Assist of 1 to complete LB (lower body) dressing and hygiene . Prompted toileting with AM/PM (morning/evening) cares, rounds and PRN (as needed). On 10/28/24, the facility became aware of an allegation of abuse involving R18. A Grievance Form was completed that indicates the following, Nature of the Concern: [Resident Name] states that nobody came to check on her all night. She said that nobody put her in her bed. [Resident Name] was very distraught, tired, wet and wanted to get in bed. Witness account by HM O (Housekeeping Manager) states: I arrived on the 3rd floor at approximately 4:10 AM. [Resident Name] was in her wheelchair in the doorway of her room and she was crying. She told me that nobody put her to bed or checked on her all night. She was very distraught and asked what she did wrong because they wouldn't help her. She said she was tired and sitting in her pee and needed to get to bed. I found the nurse, she said she was too busy to notice she was never put to bed. I got the 2 CNA's and they said they had never seen [Resident Name] before. I told the CNA's to get her cleaned up and in bed. Investigation: Resident stated she was not put into bed until very early this morning. Resident upset that she was left up late, missed breakfast, and missed some activities. Resident was happy that HM O helped her and got staff to get her into bed. Resolution: Education and more frequent rounds. Review and update care plans. Follow-up: No further concerns. The Grievance Form was signed by NHA A (Nursing Home Administrator). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgerton Care Center, Inc	313 Stoughton Rd Edgerton, WI 53534

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/31/25 at 2:49 PM, Surveyor interviewed R18 about the incident that happened on 10/28/24. R18 remembered the incident and stated that nobody put her into bed, and nobody checked on her all night. R18 stated she was tired and scared because she never saw a CNA all night. The facility did not follow their abuse policy to complete a thorough investigation, as no other residents or staff members were interviewed to identify any further abuse or neglect. Example 2: R19 was admitted to the facility on [DATE]. R19's most recent MDS, with an ARD of 1/3/25, indicates R19 has a BIMS score of 10 out of 15, indicating R19 has mild cognitive impairment. R19's Basic CNA Care Plan, dated 1/15/25 states, in part: Transfers: 1 assist and 2 WW (wheeled walker). Mobility: Ambulates with 1 assist and 2WW. Dressing: Assist of 1 for UB/LB (upper body/lower body) cares. Toileting: Prompted toileting assist every 2-3 hours. On 12/15/24, the facility became aware of an allegation of abuse involving R19. A Grievance Form was completed that indicates the following, Nature of the Concern: Resident states that she had her call light on all night. She states when the CNA came in, she told her that she was soaked in pee all the way up her back. Resident states that the CNA left the room and shut the door without changing her. Resident states she was scared because the door was shut, and she was angry because she was left to lay in her pee all night. Investigation: Resident upset her needs were not met and her door was shut. Resident did not know the name of the staff member involved and could only tell this writer it was a female staff member. Resolution: Education to staff on rounding and all resident doors are to be open unless cares are being completed. Follow-up: No further concerns expressed by the resident at this time. The Grievance Form was signed by NHA A on 12/17/24. On 3/31/25 at 2:40 PM, Surveyor interviewed R19 about the incident that happened on 12/15/24. R19 remembered the incident and stated that she had her call light on all night and was left in pee all night. R19 stated the CNA closed the door and she felt afraid. R19 said it made her feel terrible, that she was crying, and that she was overwhelmed and angry that they weren't taking care of her, and she had to lay in pee like that all night. The facility did not follow their abuse policy to complete a thorough investigation, as no other residents or staff members were interviewed to identify any further abuse or neglect. Example 3: R6 was admitted to the facility on [DATE]. R6's most recent MDS, with an ARD of 3/12/25, indicates R6 has a BIMS of 15 out of 15, indicating R6 is cognitively intact. R6's Basic CNA Care Plan, dated 9/13/24 states, in part: Transfers: 2 assist and Hoyer. Mobility: Propels self in WC. Dressing and Toileting: Extensive assist with hygiene and dressing. Supra pubic catheter. Incontinent of bowel. Provide incontinence care after each incontinent episode. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/16/24 the facility became aware of an allegation of abuse involving R6. A Grievance Form was completed that indicated the following, Nature of the Concern: Resident was given a suppository or enema and no one came back in to check on him. Resident states he had a BM (bowel movement) and was not changed until the AM shift when the aide came in to get him ready for breakfast. Investigation: Resident states after receiving an enema he was not checked on or changed until AM shift came in to get him ready for breakfast. Resolution: Resident care plan updated. Follow-up: No further concerns from resident at this time. The Grievance Form was signed by NHA A on 12/20/24. On 3/31/25 at 2:33 PM, Surveyor interviewed R6 about the incident that happened on 12/16/24. R6 remembered the incident and stated that he had an enema and no one came back in to check or change him. R6 stated that he had a BM and stayed in it all night, and that he wasn't cleaned up for several hours until the next morning. The facility did not follow their abuse policy to complete a thorough investigation, as no other residents or staff members were interviewed to identify any further abuse or neglect. Example 4: R3 was admitted to the facility on [DATE]. R3's most recent MDS, with an ARD of 1/2/25, indicates R3 has a BIMS of 11 out of 15, indicating R3 has a mild cognitive impairment. R3's diagnoses include, in part: Type 2 diabetes mellitus with diabetic chronic kidney disease, Chronic Obstructive Pulmonary Disease (COPD), Constipation, Essential hypertension, Pain unspecified, Generalized anxiety disorder, Unspecified dementia with anxiety, Depression unspecified, Low back pain, Personal history of neoplasm of the skin, Chronic kidney disease stage 3, Functional urinary incontinence, Chronic instability of left knee, Pain in left knee, Unspecified congestive heart failure. R3's Basic CNA Care Plan, dated 3/16/25 states, in part: Transfers: Hoyer transfer with 2 assist. Mobility: WC for mobility staff to assist. Toileting: Has agreed to use bedpan/urinal for toileting needs. Offer assistance every 2-3 hours and PRN providing peri-care and assist with clothing management. Dressing: Minimum assist of 1 for UB (upper body) and Max assist for LB (lower body) and with toileting cares. On 11/13/24 the facility became aware of an allegation of abuse involving R3. A Grievance Form was completed that indicated the following, Nature of the Concern: Resident states a group of 3 girls turned him in bed but did not change his brief. Resident states that he called a nurse down to his room and told the nurse he had not been changed. A CNA came back to his room and put the wet brief in his face, per resident. Investigation: Resident states he was helped in bed by 3 girls but his brief was not changed. Resident called the nurse down to his room and told her he had not been changed, per resident. A CNA came in and put the wet brief in his face and said, Look! I wouldn't not change you. Resident was asked to describe the CNA. Resident stated she ha a lot of hair on top of her head. Resolution: Agency CNA DNR (Do Not Return). Follow-up: No further concerns from resident. The Grievance Form was signed by NHA A on 11/15/24. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/31/25 at 3:56 PM, Surveyor interviewed SW C (Social Worker) who is the facility Grievance Officer. SW C stated that she had only been working at the facility since January and had no knowledge of the events involving R18, R19, R6, or R3. Surveyor asked SW C to read the grievance forms for these incidents. SW C read the forms and stated that in her opinion she would consider these incidents as allegations of potential abuse, and she would have wanted to investigate them if she was the Grievance Officer at that time. SW C states that if a resident reports a grievance of any kind, she starts an investigation by speaking to the resident, the staff on the floor, and the previous shift. Surveyor asked SW C if she follows up with the resident after the investigation. SW C stated yes, she follows up with the resident after she completes her investigation and gives them a status update as well as what the resolution is. SW C ensures that the resident is satisfied with that solution. On 3/31/25 at 4:24 PM, Surveyor interviewed NHA A about these grievance forms and these incidents. Surveyor asked NHA to read the grievance forms and if they would be considered allegations of abuse. NHA A replied yes, they would be potential neglect allegations. Surveyor asked NHA A if they were reports of potential abuse, had they been thoroughly investigated. NHA A replied that for most of them they followed through on them, but they didn't have a file or documentation on them. NHA A stated that they should have been reported and investigated. NHA A stated that she has learned the hard way to take ownership of abuse allegations and ensure that everything gets done properly. The facility did not follow their abuse policy to complete a thorough investigation, as no other residents or staff members were interviewed to identify any further abuse or neglect. Cross Reference F609. 49434 Example 5 The facility became aware of an allegation of abuse on 11/25/24 during R6's care conference by FM II and the facility did not assess residents, interview residents, take statements, conduct a facility audit, or report this incident to law enforcement. R6 was admitted to the facility on [DATE], with diagnosis that include, in part: heart failure, epilepsy (seizure disorder), generalized anxiety disorder, cerebral infarction (stroke), hypertension (high blood pressure), history of cardiac arrest (heart stops beating), presence of other cardiac implants and grafts. hereditary spastic paraplegia (group of hereditary disorders causing progressive, spinal, spastic leg muscle weakness), MELAS syndrome (genetic disorder causing muscle weakness, seizures and stroke-like episodes), neurogenic bowel (loss of normal bowel function due to a nerve problem), and constipation. R6's Minimum Data Set (MDS), with Assessment Reference Date of 3/12/25, states that R6 has a BIMS (Brief Interview for Mental Status) of 15 out of 15, indicating that R6 is cognitively intact. Section GG indicates R6 utilizes a manual wheelchair and mechanical lift for mobility. GG0115 indicates R6 has impairment on both his right and left lower extremities. GG0130 indicates he is independent for eating, and dependent on staff for toileting hygiene, showering and bathing, and lower body dressing. GG0170 indicates R6 is dependent on staff for rolling left and right, transferring between a chair and a bed, and transferring to a toilet is marked not applicable. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/25/24, a Care Conference Note was written that notes FM II, R6's Daughter, as a participant via phone. This note states, in part: . -issues c (with) refusing to drink -wanted to draw -foot down won't be coming if not getting fluid intake -getting away c (with) it . -Water intake has increased after argument -assuming has[sic] helped c (with) regulated bowels -Will take all drawing stuff away if not drinking water . On 3/31/25 at 11:41 AM, Surveyor was interviewing NHA A and DON B about R6's poor fluid intake. During the interview, NHA A commented that the facility encourages R6 to drink, but R6's family is very concerned about R6's fluid intake and has threatened to take away his art supplies if he doesn't drink more, telling R6 that his art supplies were a privilege. No further information was provided regarding an investigation into this incident. 30992 Example 6 R46's Minimum Data Set (MDS) dated [DATE], indicates R46 scored 11/15 on his Brief Interview for Mental Status (BIMS) indicating he is moderately cognitively impaired. R46 requires extensive assist of 2 for transferring, dressing, toileting, and hygiene. R46 was admitted to the facility 10/4/21 with diagnoses including, but not limited to, as follows: dementia (a group of thinking and social symptoms that interferes with daily functioning), generalized anxiety disorder (severe, ongoing anxiety that interferes with daily activities), major depressive disorder (persistent low mood, loss of interest or pleasure that significantly interferes with daily functioning) and low back pain. R46 discharged from the facility 12/10/24 and has since passed away. R46's comprehensive care plan documents, in part, as follows: (Date Initiated: 10/4/24) Problem: Behavioral Symptoms R46 is combative with cares. Goal: R46 will accept cares e/b (evidenced by) cares being completed on first attempt or reapproach. Approach: .If R46 becomes combative, stop cares, ensure resident is safe, leave the room, and reapproach at a later time. R46's comprehensive care plan documents, in part, as follows: (Date Initiated: 9/12/24) Problem: R46 has hallucinations. R46 had a diagnosis of cerebral infarction, cognitive communication deficit. Goal: R46 will interact appropriately with staff, other residents, and family members. Approach: .(Date Initiated: 11/3/22) Provide safe, quiet, low-stimuli environment R46's comprehensive care plan documents, in part, as follows: (Date Initiated: 9/12/24) Problem: R46 resists ADL (Activities of Daily Living) assistance at times and can become verbally/physically aggressive towards staff. Frequent refusals to get out of bed for any length of time. Goal: R46 will accept assistance for ADL's w/o (without) exhibiting resistance to care. Resistance to care pattern: verbal/physical aggression towards staff. Approach .(Date Initiated: 10/19/22) Offer resident to play game of solitaire when awake at night. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/28/24 NOC shift, the following three (3) people were working together on the floor: CNA H (Certified Nursing Assistant), CNA F (Certified Nursing Assistant-Agency) and LPN G (Licensed Practical Nurse-Agency). For clarification purposes, in the statements below, CNA H is Caucasian; CNA F and LPN G are African American. The police officer did record weights of all staff involved. CNA F is smaller in stature than LPN G. CNA H (Certified Nursing Assistant) documented the following statement: Around 1:45-2:00 AM, I was in the 1st dining room, and I heard help, help, help from R46's room. I went to check on R46 to see what he needed. Once I entered the room, I noticed fresh blood on his right forearm and bedding. I asked R46, What happened? LPN G (Licensed Practical Nurse) followed me into the room, and R46 stated, Get out of my room. LPN G left the room, and I went to find the other CNA, CNA F (Certified Nursing Assistant) who was in the hallway walking towards me. I said to CNA F, Did you see R46's arm? Come here. We both entered the room, and R46 kicked her out. Once CNA F left the room, I wiped his arm with a cold washcloth. The bleeding had stopped, and he said, Thank you for helping me. I phoned the NHA A (Nursing Home Administrator) and left a voicemail at 1:54 AM advising her of the incident. The next time I entered the room was around 3:00 AM, 4:00 AM, 5:00 AM and 6:00 AM. We (meaning CNA H and the accused staff) checked, changed, and repositioned him at 4:30 AM. R46 had no other comments that night. Note, CNA F (Certified Nursing Assistant) and LPN G (Licensed Practical Nurse), the accused staff, continued working with R46 as well as other residents for over 5 hours after R46 made an allegation of abuse. On 3/27/25 at 9:05 AM, Surveyor spoke with NHA A (Nursing Home Administrator). Surveyor asked NHA A, when a residents reports abuse and there is an injury (bruising, bleeding, skin tear) what should staff do. NHA A stated, staff should immediately call me. Surveyor asked NHA A, should residents be protected. NHA A stated, Oh, of course. Surveyor asked NHA A, what time did this incident occur. NHA A stated, around 2:00 AM. Surveyor asked NHA A, how soon should staff report this to you. NHA A stated, immediately. NHA A stated, she found out about it when DON B (Director of Nursing) called me around shift change. NHA A stated, CNA H (Certified Nursing Assistant) called me and left a voicemail message during the night. NHA A stated, she reached out to DON B at 8:15 AM. NHA A stated, staff are not to just just leave me a voicemail and carry on. NHA A stated, she should have called NHA A back again and tried DON B as well. NHA A stated, staff need to keep calling NHA A and DON B until they reach one of them and NHA A and DON B will notify each other. NHA A stated, CNA H is thinking she reported it (by leaving a voicemail message). NHA A stated, CNA F and LPN G should have left the facility immediately. NHA A stated, if CNA H had reached her directly this is what she would have told CNA F and LPN G. Surveyor asked NHA A, is it the facility's responsibility to protect R46 as well as all other residents. NHA A stated, Yes. NHA A stated, CNA H was the only other staff member working on the 3rd floor besides CNA F and LPN G. Surveyor asked NHA A to describe the what occurred. NHA A stated 1st shift came in and noticed R46 had bruising. Surveyor asked NHA A, did you educate staff regarding restraining residents. NHA A stated, no. Surveyor asked NHA A, should you have educated staff regarding not physically restraining residents. NHA A stated, yes. The facility failed to immediately report an allegation of abuse, protect their residents, and immediately educate CNA H and all staff regarding reporting and restraints (physically holding a resident's hands down.) Cross Reference: F600, F609

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49434 Based on observation, interview, and record review, the facility did not ensure that residents received treatment and care in accordance with professional standards of practice (N6, Wisconsin Nurse Practice Act) for 4 of 17 sampled residents (R6, R2, R24, and R16). R6 and R16 are being cited at severity level 3 (actual harm). R2 and R24 are being cited at severity level 2 (potential for more than minimal harm). R6 has diagnoses of neurogenic bowel (loss of normal bowel function) and constipation. The facility failed to accurately assess and monitor R6 for constipation, decreased fluid intake and output as well as changes in R6's mental status, resulting in frequent visits to the emergency department. The facility failed to notify R6's primary care physician of his level of inadequate fluid intake and significant increases in urine output. Between 1/1/25 and 3/31/25, R6 has been send to the hospital several times requiring IV (intravenous) fluid administration. R16 experienced sudden onset of four (4) projectile coffee ground emesis (forceful vomiting of dark digested blood). The facility waited 2+ hours to send R16 to the ED (emergency department). R24 had a change of condition and focused assessments were not completed for continued monitoring of changes. R2 had a changes in her physical condition that were not addressed by the facility as a change in condition. This is evidenced by: The facility policy entitled, Bowel (Lower Gastrointestinal Tract) Disorders - Clinical Protocol, dated 9/2017, states, in part: . 1. As part of the initial assessment, the staff and physician will help identify individuals with previously identified lower gastrointestinal tract conditions and symptoms. This should include a review of gastrointestinal problems during any recent hospitalization s . 2. Examples of lower gastrointestinal tract conditions and symptoms include: . f. alteration in bowel movements; . h. Residents taking antidiarrheal medications or medications related to bowel mobility . 3. In addition, the nurse shall assess and document/report the following: . c. change in mental status or level of consciousness; . e. Signs of dehydration (altered level of consciousness, lethargy, dizziness, recent change in mental status, dry mucous membranes, decreased urine output); f. Abdominal assessment; . Treatment/Management . 3. The staff and physician will address significant complications due to bowel dysfunction . Monitoring and Follow-Up . 2. The physician will adjust interventions based on identification of causes, resident responses to treatment, and other relevant factors. 3. Before prescribing additional courses of medications, the physician should carefully evaluate and examine directly an individual who has not responded as expected to an initial course of treatment such as antidiarrheal medication, changes in the bowel regimen, etc. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The facility policy entitled, Bowel Management Protocol, undated, states, in part: 1) NOC (Night Shift) Nurse will run the Resident Bowel Management Report in [Name of Electronic Medical Record] each NOC shift . 2) Identify all residents who have not had a bowel movement in the last 2 or more days and add them to the Nurse's Daily Bowel Report. 3) Provide Dietary department a copy of the Nurse Daily Bowel Report by 6 AM . 4) Follow this procedure for residents with 2 or more days since last bowel movement. Day #2 No Bowel Movement -Dietary will provide a natural remedy (i.e. power pudding, prune juice, prunes, fiber cookie) with the AM (morning) meal. Day #3 No Bowel Movement - Dietary will provide a natural remedy (i.e. power pudding, prune juice, prunes, fiber cookie) with the AM meal. -AM Nurse will complete a full bowel assessment and document a progress note in [Name of Electronic Medical Record]. - If resident has not had a bowel movement by 12:00 PM, AM Nurse to administer 30 mL of Milk of Magnesia (Laxative that pulls water into the bowel) per Standing Orders. Day #4 No Bowel Movement -NOC Nurse will complete a full bowel assessment and administer Bisacodyl (Laxative that increases movement in the intestines) 10 mg (milligrams) suppository per Standing Orders on last rounds . then document a progress note in [Name of Electronic Medical Record]. -If a resident has not had a bowel movement by 11 AM: -Dietary will provide a natural remedy (i.e. power pudding, prune juice, prunes, fiber cookie) with the meal. -AM Nurse will complete a full bowel assessment and document a progress note in [Name of Electronic Medical Record] and update MD (Medical Doctor) as well as resident responsible party. The facility policy entitled, Resident Hydration and Prevention of Dehydration, dated 10/2017, states, in part: Policy Statement: This facility will strive to provide adequate hydration and to prevent and treat dehydration. Policy Interpretation and Implementation 1. The dietitian will assess all residents for hydration as part of the comprehensive assessment, at least quarterly, and more often as necessary per resident need. 2. Minimum fluid needs will be calculated and document on initial, annual, and significant change assessments, using current standards of practice .4. The dietitian and nursing staff will educate the resident and family regarding hyderation [sic] and preventing dehydration. 5. Nurses will assess for signs and symptoms of dehydration during daily care. 6. Nurses' aides will provide and encourage intake of bedside, snack and meal fluids, on a daily routine bases as part of daily care. a. Intake will be document in the medical records. b. Aides will report intake of less than 1200 ml (milliliters)/day to nursing staff . 8. Orders may be written for extra fluids to be encouraged between meals and/or with medication passes. a. A specific minimum amount should be included in the order . 9. The dietitian, nursing staff, and the physician will assess factors that may be contributing to inadequate fluid intake . 12. Nursing will monitor and document fluid intake and the dietitian will be kept informed of status. The interdisciplinary team will update the care plan and document resident response to interventions until the team agrees that fluid intake and relating factors are resolved. According to the Wisconsin Nurse Practice Act, N6.03(1), An R.N. (Registered Nurse) shall utilize the nursing process in the execution of general nursing procedures in the maintenance of health, prevention of illness or care of the ill. The nursing process consists of the steps of assessment, planning, intervention, and evaluation. This standard is met through performance of each of the following steps of the nursing process: (a) Assessment. Assessment is the systematic and continual collection and analysis of data about the health status of a patient culminating in the formulation of a nursing diagnosis. (b) Planning. Planning is developing a nursing plan of care for a patient which includes goals and priorities derived from the nursing diagnosis. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	(c) Intervention. Intervention is the nursing action to implement the plan of care by directly administering care or by directing and supervising nursing acts delegated to L.P.N.s (Licensed Practical Nurse) or less skilled assistants. (d) Evaluation. Evaluation is the determination of a patient's progress or lack of progress toward goal achievement which may lead to modification of the nursing diagnosis. According to N6.04(1), In the performance of acts in basic patient situations, the L.P.N. shall, under the general supervision of an R.N. or the direction of a provider . (b) Provide basic nursing care. (c) Record nursing care given and report to the appropriate person changes in the condition of a patient . (e) Perform the following other acts when applicable: 1. Assist with the collection of data. 2. Assist with the development and revision of a nursing care plan. 3. Reinforce the teaching provided by an R.N. provider and provide basic health care instruction. 4. Participate with other health team members in meeting basic patient needs. Example 1: R6 was admitted to the facility on [DATE], with diagnosis that include, in part: heart failure, epilepsy (seizure disorder), generalized anxiety disorder, cerebral infarction (stroke), hypertension (high blood pressure), history of cardiac arrest (heart stops beating), presence of other cardiac implants and grafts. hereditary spastic paraplegia (group of hereditary disorders causing progressive, spinal, spastic leg muscle weakness), MELAS syndrome (genetic disorder causing muscle weakness, seizures and stroke-like episodes), neurogenic bowel (loss of normal bowel function due to a nerve problem), and constipation. R6's Minimum Data Set (MDS), with Assessment Reference Date of 3/12/25, states that R6 has a BIMS (Brief Interview for Mental Status) of 15 out of 15, indicating that R6 is cognitively intact. Section GG indicates R6 utilizes a manual wheelchair and mechanical lift for mobility. GG0115 indicates R6 has impairment on both his right and left lower extremities. GG0130 indicates he is independent for eating, and dependent on staff for toileting hygiene, showering and bathing, and lower body dressing. GG0170 indicates R6 is dependent on staff for rolling left and right, transferring between a chair and a bed, and transferring to a toilet is marked not applicable. Section H indicates R6 has an indwelling catheter. H0400 indicates R6 is always incontinent of bowel. H0500 indicates that a toileting program is currently being used to manage R6's bowel continence. H0600, which asks if there is constipation present is not complete. Section K indicates R6 has no signs or symptoms of a swallowing disorder. R6's Comprehensive Care Plan states, in part: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Problem: Potential for dehydration r/t (related to) frequent episodes of N/V (nausea/vomiting), recurrent UTI's (urinary tract infections), periods of lethargy with refusals of meals/fluids. Problem Start Date: 12/10/24. Approach: Frequent oral cares d/t (due to) emesis (vomiting) and dehydration. Approach Start Date: 1/23/25. Approach: Assess for dehydration (dizziness on sitting/standing, change in mental status, decreased urine output, concentrated urine, poor skin turgor, dry, cracked lips, dry mucus membranes, sunken eyes, constipation, fever, infection, electrolyte imbalance). Approach Start Date: 12/10/24. Approach: Document any and all refusals for this resident. Approach Start Date: 12/10/24. Approach: Encourage fluids of choice. Keep iced water cup filled at bedside. Approach Start Date: 12/10/24. Approach: Record intake and output every shift. Approach Start Date: 12/10/24. Approach: Update wife every shift if resident has any nausea or vomiting, poor intake and any other changes. Approach Start Date: 12/10/24. (Of note: This problem was created on 12/10/24, with all approaches starting the same day except for frequent oral cares which started 1/23/25. No additional approaches or interventions were put in place to improve R6's fluid intake, even with multiple hospitalization s.) Problem: Resident has potential for constipation R/T (related to) decreased mobility. Problem Start Date: 11/18/16. Problem End Date: 7/11/23. Edited: 2/25/25. Goal: Resident will have a regular, soft-formed bowel movement at least every 3rd day. Long Term Goal Date: 5/25/25. Approach: Follow bowel protocol as needed. Approach Start Date: 3/1/23. Approach: Monitor unbilical for any changes in hernia type protruding area, pain or change in bowel movements. Update MD if changes. Approach Start Date: 6/28/18. Approach: Administer medications per MD order. Monitor effectiveness and side effects. Approach Start Date: 11/18/16. Approach: Document frequency and character of bowel movements. Approach Start Date: 11/18/16. Approach: Encourage fluids of choice. Approach Start Date: 11/18/16. Approach: Monitor for signs of constipation such as decreased bowel sounds/abdominal pain/distension/decreased appetite/fever, etc. Approach Start Date: 11/18/16. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	(Of note: This problem start date is indicated to be 11/18/16 and no approaches or interventions were put in place after 3/1/23. Also of note, this problem is indicated to have an end date of 7/11/23.) Problem: Resident requires supra pubic catheter R/T DX (Diagnosis): neurogenic bladder (bladder control is affect due to nerve damage). HX (History): chronic, frequent UTI's. Approach: Encourage fluids of choice. Water mug within reach and encouraged to drink every 2 hours. Family supplies [Brand Name] packages to flavor water. Approach Start Date: 3/12/25. Approach: Record catheter output amount. Change catheter per [Doctor's Name] orders only. Approach Start Date: 9/21/21 . Problem: Basic CNA (Certified Nurse Assistant) Care Plan. Problem Start Date: 9/13/24. Approach: . Transfers: Hoyer and assist of 2 . Grooming/Dressing/Toileting: . Extensive assist with hygiene and dressing. Supra pubic catheter. Incontinent of bowel. Provide incontinence care after each incontinence episode . Behavior and Cognition: Pleasant and cooperative . Approach Start Date: 9/13/24. (Of note, this care plan does not indicate Water mug within reach and encouraged to drink every 2 hours.) R6's Physician Orders state, in part: Benefiber (Fiber Supplement, Supports Digestive System) Clear SF (dextrin) (wheat dextrin) powder in packet; 3 gram/3.5 gram; amt (amount): 2 tsp (teaspoons); oral, Once a day, 12:00 PM. Start Date: 11/14/24. End Date: 1/30/25. Start Date: 1/30/25. End date: 3/24/25. Bisacodyl (Laxative that increases movement in the intestines) [OTC] (Over the Counter) suppository; 10 mg (milligrams); amt: 1 suppository (solid dosage form inserted into the rectum where it dissolves or melts to deliver medication); rectal. Special Instructions: Give at 8 pm and 5 am daily. Twice a day. 20:00 (8:00 PM), 04:00 (4:00 AM). Start Date: 11/16/24. End Date: 1/10/25. Bisacodyl [OTC] (Over the Counter) suppository; 10 mg (milligrams); amt: 1 suppository; rectal. Special Instructions: Give at 8 pm and 4 am daily (may be given at 3A (3:00 AM) if awake). Twice a day. 20:00 (8:00 PM), 04:00 (4:00 AM). Start Date: 1/10/25. End Date: 1/30/25. Bisacodyl [OTC] (Over the Counter) suppository; 10 mg (milligrams); amt: 1 suppository; rectal. Special Instructions: Insert 1 suppository to equal 10 mg per rectum BID (twice a day) at[sic] 8 pm and 4 am daily (may be given at 3A if awake). [NAME] a day. 20:00, 04:00. Start Date: 1/30/25. End Date: 3/24/25. Bisacodyl [OTC] tablet, delayed release (DR/EC); 5 mg; amt: 1 tab daily; oral. Special Instructions: Take one tablet daily. Once a day. 06:30-10:00. Start Date: 9/19/24. End Date: 1/30/25. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Bisacodyl [OTC] tablet, delayed release (DR/EC); 5 mg; amt: 1 tab daily; oral. Special Instructions: Take one tablet to equal 5 mg daily X 360 doses. Once a day. 06:30 - 10:00. Start Date: 1/30/25. End Date: 1/25/26. Docusate sodium (stool softener that increases the amount of water the stool absorbs in the gut to treat constipation) [OTC] tablet; 100 mg; amt: 200 mg; oral. Special Instructions: Give Docusate Sodium 200 mg BID (twice a day). Twice a day. 06:30 - 10:00, 18:30 - 22:30 (6:30 PM - 10:30 PM). Start Date: 12/5/24. End Date: 1/30/25. Start Date: 1/30/25. End Date: 3/24/25. Electrolyte (Electrolyte Supplement) Fast Chew tablet; 0.5 (3.3g); amt: 1; oral. Once a day. 06:30-10:30. Start Date: 6/22/24. End Date: 1/30/25. Electrolyte Fast Chew tablet; 0.5 (3.3g); amt: 1; oral. Special Instructions: Take 1 tab to equal 3.3 g daily. Once a day. 06:30-10:30. Start Date: 1/30/25. End Date: 3/24/25. Fleet Enema (sodium phosphates) (draws water into colon and rapidly produces a bowel movement) [OTC] enema (introduction of liquid through rectum into the large intestine to treat constipation); 19-7 gram/118 mL (milliliters); amt: 133 mL; rectal. Special Instructions: Insert 133 mL into rectum daily PRN (as needed) for constipation. As needed. PRN 1 (as needed once per day). Start Date: 1/30/25. End Date: 3/24/25. Milk of Magnesia (Laxative that pulls water into the bowel) (magnesium hydroxide) [OTC] suspension; 400 mg/5 mL; amt: 30 ml; oral. Special Instructions: daily prn for constipation. As needed. PRN 1. Start Date: 6/22/24. End Date: 1/30/25. Milk of Magnesia (Laxative that pulls water into the bowel) (magnesium hydroxide) [OTC] suspension; 400 mg/5 mL; amt: 30 ml; oral. Special Instructions: Take 30 mL daily PRN for constipation. As needed. PRN 1. Start Date: 1/30/25. End Date: 3/24/25. Miralax (Laxative that draws water into the bowels) (polyethylene glycol 3350) [OTC] powder; 17 gram/dose; amt: 17 grams; oral. Special Instructions: MIX IN ORANGE JUICE PER RESIDENT REQUEST. Once a Day on Mon (Monday). 11:00 - 13:00 (1:00 PM). Start Date: 6/22/24. End Date: 1/30/25. Miralax (polyethylene glycol 3350) [OTC] powder; 17 gram/dose; amt: 17 grams; oral. Special Instructions: RESIDENT WOULD LIKE MIRALAX MIXED WITH ORANGE JUICE. MIX WITH METAMUCIL AS WELL AND TELL RESIDENT WHAT HE IS RECEIVING PER FAMILY. Hold if having loose stools. Twice a day. 06:30 - 10:30, 18:00 - 22:30. Start Date: 6/22/24. End Date: 1/30/25. Start Date: 1/30/25. End Date: 3/24/25. Start Date: 3/25/25. Senna Plus (Keeps water in the intestines which increases movement in the intestines and treats constipation) (sennosides-docusate sodium) [OTC] tablet; 8.6-50 mg; amt: 17.2 - 100 mg; oral. Special Instructions: Give Senna Plus 2 tablets daily. Hold if having loose stools. Twice a day. 06:30 - 14:00 (2:00 PM), 18:30 - 22:00. Start Date: 6/22/24. End Date: 1/30/25. Senna Plus (sennosides-docusate sodium) [OTC] tablet; 8.6-50 mg; amt: 17.2 - 100 mg; oral. Special Instructions: Take 2 tabs to equal 17.2 - 100 mg daily. Hold for loose stools. Once a day. 06:30 - 14:00 (2:00 PM). Start Date: 1/30/25. End Date: 3/24/25. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Soap suds enema (Irritates the lining of the colon which stimulates bowel contractions and encourages person to release contents of their bowel) enema; warm soap suds; at least 500 ml; rectal. Special Instructions: if no results from scheduled bisacodyl suppositories given at HS (bedtime) and 0400 (4:00 AM), sign out and give warm soap suds enema if no results from suppositories. As needed. PRN 1. Start Date: 1/12/25. End Date: 2/3/25. Soap suds enema, enema; warm soap suds; amt: at least 500 ml; rectal. Once a day. 10:00 (10:00 AM). Start Date: 2/4/25. End Date: 2/10/25. Sodium chloride 0.9% (IV Fluid Replacement) parenteral (intravenous) solution - ; amt: 125 ml/hr (milliliters/hour) over 16 hours; intravenous. Special Instructions: Order updated since resident had a liter of fluids while at the ER (emergency room). Now run 0.9% sodium chloride at 125 ml/hr over 24 hours; intravenous. Once - One Time. 22:00 (10:00 PM). Start Date: 1/22/25. End Date: 1/22/25. Encourage fluids every shift. Every Shift; day, pm, noc. Start Date: 1/18/23. End Date: Open Ended. UPDATE WIFE EVERY SHIFT IF RESIDENT HAS ANY NAUSEA OR VOMITING, POOR INTAKE, AND ANY OTHER CHANGES. Special Instructions: call if output less than 3000 ml in 24 hrs, call if input is less than 64 oz. Every Shift; day, pm, noc. Start Date: 11/4/24. End Date: Open Ended. (Of note: This list contains 5 different medications that either draw water into the colon or prevent the body from absorbing water from the colon. On 12/10/24 at 21:57 (9:57 PM), a Progress Note is written that states, in part: Notes from [Physician's Name] visit today: Make sure he has 64 oz (ounces) (1,893 milliliters) of fluid daily . please keep track of urine output daily . chronic constipation, continue with current bowel regimen and fluid intake . On 12/11/24 at 14:39 (2:39 PM), a Progress Note is written by LPN S (Licensed practical Nurse), that states, in part: .He did not have a BM (bowel movement) from scheduled Bisacodyl suppository given on noc (night) shift. PM (Evening) nurse aware. Resident drank 480 ml at both meals and drank 360 ml water with med passes. He was drinking his flavored ice water in his personal water bottle. He drank approximately 16 oz (473 ml) by the end of this shift . (Of note, no bowel assessment is indicated as being done) On 12/27/24 at 12:32 PM, a Telephone Note is written by a clinic RN, that states, in part: .Note from 12/10/24 visit: 1. Constipation -Return to previous bowel regimen: bisacodyl suppository twice daily (morning and night) . -Encourage fluid intake goal of 64 ounces daily (two 32[sic]-ounce containers) . R6's Fluid Intake is care planned to be documented every shift. From 1/1/25 to 3/25/25, R6 had no fluid intake documented for 15 different days. In a physician's note to the facility, the physician reports R6 requires 64 oz (1,893 mL) every day to maintain hydration. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	From 1/1/25 to 3/25/25 R6 never reaches his fluid intake goal. The most fluid intake that R6 had in a single day, according to facility documentation, was 1,360 mL. On 1/1/25 at 13:43 (1:43 PM), a Progress Note is written by LPN S, that states, in part: Resident had large BM as a result of scheduled Bisacodyl suppository given by noc nurse . Resident offered no c/o pain, SOB (shortness of breath) or feeling ill . On 1/1/25, R6 consumed 480 mL of fluid, according to the fluid intake record. The resident is documented to have a large bowel movement at 14:43 (2:43 PM). On 1/2/25 at 13:34 (1:34 PM), a Progress Note is written that states: Resident was lethargic and hard to arouse all morning, writer entered room on 3 separate occasions to evaluate VS (vital signs) wnl (within normal limits), resident would raise head, open and close eyes, lower head, no response to questions, after the third time, I s/w (spoke with) his wife who agreed that we should send him to the hospital, about an hour later (at which point we were waiting for transport,), resident awoke and claimed to feel fine. (Of note: No bowel assessment documented prior to transport) On 1/2/25 at 15:43 (3:43 PM), a Progress Note is written by RN AA (Registered Nurse), that states, in part: Resident left facility at this time via [EMS Agency Name] EMS . On 1/2/25 at 23:15 (11:15 PM), R6 is documented to have a large bowel movement. On 1/2/25 at 23:23 (11:23 PM), a Progress Note is written by RN Z, that states, in part: Resident returned from ER (emergency room) visit at PM/NOC (Evening/Night) cross shift. Resident recorded not to have had a bowel movement since 1/1/25. Resident given a prn warm water soap suds enema of 750 ml which produced an x (extra) large liquid and soft formed stool bowel movement. After getting cleaned up, resident was given his scheduled PM shift bisacodyl suppository. On 1/4/25, R6 consumed 240 mL of fluid, according to the fluid intake record. The resident did not have a bowel movement. On 1/5/25, R6 consumed 480 mL of fluid, according to the fluid intake record. The resident is documented to have a large bowel movement at 14:00 (2:00 PM). On 1/6/25, no fluid intake is documented for R6. The resident is documented to have a small bowel movement at 20:56 (8:56 PM) and a large bowel movement at 23:03 (11:03 PM). On 1/6/25 at 23:08 (11:08 PM), a Progress Note is written by RN Z, that states, in part: Called to resident's room by CNA (Certified Nursing Assistant) stating that resident had a large emesis. Resident observed to have a large projectile emesis that was liquid brown in color with some small amounts of brown colored sediment that was highly suspicious of stool. Staff had been in resident's room to clean him up after him having a large liquid brown stool from his late PM shift scheduled bisacodyl suppository . Resident was alert and able to answer simple questions, but appeared worn out and very tired . Resident stated he drank very little for fluids . Phone call to [Physician Name] who was on call for [Physician Name] and permission to send resident to [Hospital Name] ER for evaluation . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	(Of note: No lung or bowel assessment documented prior to transport). On 1/7/25 at 03:46 AM, a Progress Note is written by RN Z, that states, in part: Phone call from [Hospital Name] ER and spoke with nurse caring for resident. Resident is being admitted for some more labs and possible ABX (antibiotic) TX (treatment) On 1/9/25 at 14:18, a Progress Note is written by RN BB that states, in part: Resident returned via stretcher from hospitalization [Hospital Name] discharge dx (diagnosis): Pneumonia . On 1/19/25 at 15:33 (3:33 PM), a Progress Note is written by RN BB that states, in part: 600 ml warm water/[NAME] soap enema given at 1530 (3:30 PM) producing large bowel movement-soft, formed . Resident's fluid intake has been only fluids at meals and with meds (medications) . On 1/20/25, R6's fluid intake was not recorded. Total urine output was 950 mL. The resident is not documented to have a bowel movement on this day. On 1/20/25 at 13:04 AM (1:04 PM), a Progress Note is written by LPN R that states, in part: Small emesis of yellow bile after enema this am . Denies pain. Drank 240 this am and 720 this afternoon. Working on water bottle in room at this time. On 1/21/25, R6's fluid intake was not recorded. Total urine output was 1,600 mL. The resident is not documented to have a bowel movement on this day. On 1/21/25 at 10:35 AM, a Progress Note is written by LPN R that states, in part: Resident lethargic this am (morning). Responds appropriately to verbal stimuli. Opens eyes to commands but falls back to sleep. Decline breakfast stating he is sick to stomach at this time. PRN (as needed) Zofran (anti-nausea medication) administered. Up in recliner at this time . On 1/21/25 at 13:56 (1:56 PM), a Progress Note is written that states, in part: Called [Physician Name]'s office regarding resident vomiting for 2-3 days, has not held anything down today, including morning meds and has been unable to stay awake. Writer concerned about dehydration . (of note, there is no indication if this author was an LPN or an RN) (Of note: There is only one prior note in the past 2-3 days referencing vomiting. No abdominal assessments were conducted during the past 2-3 days. R6 did not have a bowel movement on 1/20 or 1/21 per charting above.) On 1/22/25 at 10:04 AM, an After Visit Summary was printed that lists the diagnosis as: Nausea and Vomiting, unspecified vomiting type. On 1/21/25 at 23:13 (11:13 PM), a Progress Note is written that states, in part: Res returned from the hospital around 1900 (7:00 PM) via EMS on a stretcher. EMS reported that res had emesis coming up the elevator . BP (Blood Pressure) 98/46 . p (pulse): 56 . RR (Respiratory Rate) 22 . Res BP was rechecked later in the shift, with a BP reading of 100/57. Res was encouraged to increased fluid intake . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	(Of note: No abdominal assessment or bowel sounds recorded.) On 1/22/25, R6's fluid intake was documented as 30 mL. Total urine output was 900 mL, indicating a fluid loss of 870 mL. The resident is not documented to have a bowel movement on this day. (Of note: R6 did not have a BM on 1/20, 1/21 or 1/22 per charting) On 1/22/25 at 06:31 AM, a Progress Note is written by RN Z that states, in part: Resident lethargic this morning and minimally responsive to verbal commands to where it was unsafe for him to take his early morning meds. Resident[sic] has not had any results from his bisacodyl suppository administered at 0400am (4:00 AM) or on the PM shift. Resident vitals all within normal limits with exception of a pulse that seems slower than his usual . Order given to send to resident in to [Hospital Name] ER for evaluation again. Note resident has not had a reported or recorded BM since 1/19/25. When paramedics arrived to transport, resident responded enough to try and drink a small amount of water which almost immediately came [sic] back up. Resident had 200 ml emesis . On 1/22/25 at 10:04 AM, an After Visit Summary was printed from R6's ER visit that lists the diagnosis as nausea and vomiting, unspecified vomiting type. On 1/22/25 at 15:09 (3:09 PM), a Progress Note is written by LPN S that states, in part: Writer learned of resident's return to facility via [EMS Agency Name] service as he arrived to unit . He opened his eyes here and there but did not keep them open for any length of time . He opened his eyes to verbal stimuli but did not keep them open for too long. He did take noon med crushed in pudding but needed verbal cues to swallow the pudding once it was in his mouth. His mouth was so dry upon return that he was unable to suck on a straw so writer used the straw to put water in the side of his cheek which he was able to swallow w/o difficulty. Resident declined lunch . Just before the end of shift he drank 180 ml water that writer offered. He has had no emesis since . (Of note: No abdominal assessment was recorded over this time period. Additionally, the LPN notes signs of dehydration at this time, however Surveyor was unable to locate an RN assessment in reference to these concerns.) On 1/22/25 a Physician's Order is placed that states, in part: Send to [Hospital Name] ER for IV placement so resident can have his ordered IV fluids x 24 hrs. STAT - Immediately. STAT. Start Date: 1/22/25. End Date: 1/22/25. (Of note: an RN is licensed and trained to place IV's as part of the licensure process.) On 1/23/25 at 00:29 (12:29 AM), a Progress Note is written by RN Z that states, in part: [EMS Agency Name] arrived to transport resident to [Hospital Name] ER[sic] for IV placement. Resident had a medium emesis of yellow thin fluid . On 1/23/25 at 02:30 (2:30 PM), a Progress Note is written by RN Z that states, in part: . Resident had IV (intravenous) placed and they gave him a liter of fluid in the hospital. Will continue to administer the remainder of the fluids (2 liters) upon resident's return. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 1/23/25 at 04:16 (4:16 AM), a Progress Note is written by RN Z that states, in part: Resident has not had a recorded bowel movement since 1/19/25. PRN 750 ml warm soap suds enema was given in lieu[sic] of scheduled bisacodyl suppository. Resident did not appear to have any results immediately from the enema only expelling stool colored water. (Of note: Facility continues to acknowledge resident has not had a bowel movement, and it has now been 4 days since R6's previous bowel movement. Additionally, no bowel assessment has been conducted.) On 1/23/25 at 04:49 (4:49 AM), a Progress Note is written by RN Z that states, in part: Resident returned from [Hospital Name] ER . Resident has IV placed in left hand and reported to have received a liter[sic] of fluids while in the ER . had IV fluid order updated to infuse at 125ml/hr (milliters/hour) for sixteen hours. On 1/23/25 a Physician Order is placed that states, in part: Frequent oral cares d/t emesis and dehydration. Every shift. day, pm, noc. Start Date: 1/23/25. End Date: 1/25/25. On 1/23/25 at 12:20 PM, a Progress Note is written by LPN R that states, in part: Called to resident room at 1130 (11:30 AM). Resident with moderate amount of[sic] bile emesis present . [EMS Agency Name] picked resident up at 1200 (12:00 PM) for transport to [Hospital Name] . (of note: no evidence of an RN assessment being completed) On 1/23/25 at 16:38 (4:38 PM), a Progress Note is written that states, in part: [Hospital Name] RN called to request the medication record to be faxed to [phone number] . RN stated patient is admitted as admitting diagnosis was Altered Mental Status with S&S (Signs and Symptoms) of Confusion, Cough, and Nausea . On 1/27/25 at 11:50 AM, a Progress Note is written by RN BB that states, in part: Discharge diagnosis listed emesis and constipation . (no evidence of continued monitoring or assessments being completed on R6 after returning from the hospital other than documenting if R6 had N/V or not.) On 1/29/25 at 14:01 (2:01 PM), a Progress Note is written by LPN S that states, in part: . He received prn Soap Suds Enema from [LP[TRUNCATED]

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	525241	A. Building B. Wing	03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgerton Care Center, Inc	313 Stoughton Rd Edgerton, WI 53534

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39849 Based on observation, interview, and record review, the facility did not ensure each resident received adequate supervision to prevent accidents for 2 of 5 resident (R24 and R2) reviewed. R24 was observed not disposing of cigarette materials properly and not returning materials to staff after returning from smoking. R2 has had eight falls from 1/6/25 - 3/13/25 and has several care planned interventions including Dycem (a non-slip product that grips on both sides placed in a resident's wheelchair to prevent sliding out), gripper socks to be on resident's feet when out of bed, gripper strips on the floor, a mat on the floor by the bed, and shoes to be kept in the wheelchair at bedside when resident was in bed. The facility did not ensure these interventions were in place to prevent R2 from having further falls. Example 1: The undated facility policy, Smoking Policy and Procedure, indicates, in part: Policy: It is the policy of [NAME] Care Center to provide for the safety and welfare of all residents who wish to smoke while residing at the facility. Procedure: .2. Residents shall be permitted to smoke outside, in the designated area, only under the direct supervision of facility employee, approved volunteer, or with a family member, unless they are assessed to be safe to smoke independently by the Interdisciplinary Team .4. Smoking articles, such as cigarettes, e-cigarettes, cigars, pipes, tobacco, and lighters shall be kept at the Nurses Station. 5. Smoking articles may be checked out when leaving the facility and checked back in upon return to the facility. 6. These regulations shall be followed by the resident at all times . R24 was admitted to the facility on [DATE] with diagnoses that include, in part: Unspecified intestinal obstruction; Acquired absence of other specified parts of digestive tract; Colostomy (a surgical procedure that creates an opening (stoma) in the abdominal wall to divert stool from the colon (large intestine) to an external bag); Schizoaffective disorder (a mental health condition that combines symptoms of schizophrenia and mood disorders (depression or bipolar disorder); and Nicotine dependence . R24's most recent Minimum Data Set (MDS), target date 2/19/25, indicates a Brief Interview of Mental Status (BIMS) of 11. Indicating that R24's cognition is moderately impaired. On 3/24/25 at 11:48 AM, during the initial screening process, Surveyors observed a partial cigarette on R24's bedside table. R24 indicated he is currently independent with smoking and that someone came out with him when he first came and watched him and told him he didn't need anyone with him when he went out to smoke. R24 indicated he gets his cigarette and lighter from the nurse and gives the lighter back when he comes back in. R24 indicated he does not smoke a whole cigarette at a time. Surveyors reviewed R24's smoking assessments in the EHR (Electronic Health Record). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/28/25 - Smoking assessment -- Score = 0 2/24/25 - Smoking assessment -- Score = 1 3/12/25 - Smoking assessment -- Score = 6 Of note, the smoking score scale indicates a score of 0-9 is a safe smoker. Surveyors reviewed R24's progress notes, which include, in part: On 2/4/2025 at 8:44 AM: Writer met with resident in lounge to discuss getting lighter to lock up in med cart. Resident .was calm during discussion and gave writer the lighter to lock up. Writer gave resident lighter to med tech to lock up . On 2/4/2025 at 10:18 AM: Noted that lighter is not in med cart this morning, updated SW D/T (due to) behaviors R/T (related to) lighter and smoking yesterday. Resident gave SW lighter, and it is back in med cart . On 2/5/2025 at 9:27AM: Resident up and outside this morning before breakfast. Resident returned to his room after breakfast. Writer found resident laying in bed and asked about his lighter. Resident rolled his eyes at writer. Writer reminded resident of policy and the need for compliance D/T fire safety. Resident responded, I came back, didn't I? Re-iterated policy, resident verbalizes understanding . On 2/7/25 at 9:20 AM: .Resident provided one cigarette and his lighter to go outside, did not return lighter upon return to unit and writer had to track him down to lock it back up . On 3/21/25 at 6:15 PM: Resident sitting near nurses station .Distinct odor of partial cigarettes. Writer inquired if he had a partial cigarette. Resident laughed and stated, you got a keen sense of smell. Writer asked that he turn in his partial cigarette and lighter or go back outside to smoke it. Resident turned in lighter and 3 partial cigarettes. On 3/26/25 at 4:04 PM Surveyors interviewed RN T (Registered Nurse) who indicated when she is working she will give R24 his cigarette and lighter and he brings the lighter back after he is done smoking. Surveyors asked RN T if she has ever asked R24 if he finished his full cigarette. RN T indicated, no. Surveyors asked RN T if she has ever seen a partially smoked cigarette sitting in his room. RN T indicated, no. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/26/25 at 4:16 PM Surveyors observed R24 when he went outside to smoke. Surveyors interviewed R24 during the observation. R24 indicated he tosses his cigarette butts in the driveway of the facility and sometimes he puts them in the ashtray. There are multiple cigarette butts noted in the facility driveway. (Of note, there is an ashtray on one of the patio tables without any ash or cigarette butts in it.) Surveyors asked R24 if he was told how to dispose of his cigarette and R24 initially stated he was supposed to use the ashtray, then stated they told him to put it out, and then stated, [NAME], I don't remember. Surveyor asked R24 if he goes to talk to the nurse when he is done smoking. R24 indicated, he gives her his lighter and that sometimes before he goes back up he sits in the lobby because he likes to listen to the music. Surveyor asked R24 if he always gives his lighter to the nurse when he is done and R24 indicated sometimes he forgets. Surveyor asked R24 if staff then comes and asks him for the lighter and R24 indicated, yeah, it's a long story. During the observation R24 was noted to be flicking his cigarette ashes onto the cement where he sits and stated this is common for him to do. R24 put his cigarette out on the metal chair he was sitting in and threw the butt into the facility driveway. (Of note, R24 did complete the full cigarette) R24 then walked back into the facility and sat in a chair in the lobby without going upstairs to return his lighter. Surveyors continued to observe R24. On 3/26/25 at 4:40 PM Surveyors observed R24 leave the lobby and return to the 2nd floor. R24 went to the nurses station, looked into nurses station and proceeded to go to his room. Surveyors continued to observe R24. On 3/26/25 at 5:05 PM R24 was still in his room and surveyors then interviewed RN T. Surveyors asked RN T how long she waits after providing smoking materials before she checks to see if R24 has returned from smoking? RN T indicated that R24 sits downstairs for a while and she would probably wait 30 minutes. Surveyors asked RN T if she had his lighter and she indicated she did not. Surveyors reviewed the smoking observations made with RN T. RN T went to R24's room and she indicated he gave the lighter to her and showed it to surveyor. On 3/27/25 at 8:47 AM Surveyors interviewed NHA A (Nursing Home Administrator) who showed surveyors where the designated smoking area is outside and indicated residents should be disposing of cigarettes in the ashtray. Surveyors reviewed information from R24's smoking observation with NHA A. Surveyors asked NHA A if R24 should be flicking ashes onto the ground, putting his cigarette out on the chair, and throwing the butt into the facility driveway. NHA A indicated, no. Surveyors asked NHA A if it is the expectation that R24 give his lighter back to the nurse right away. NHA A indicated, it is, but that he does go in and sit in the lobby before he takes it up to the nurse. Surveyors asked NHA A how long she would expect staff to wait before checking with R24 if they he hasn't returned the lighter. NHA A indicated 30-45 minutes. Surveyors asked NHA A if she feels it is safe for R24 to be independent given the way he is disposing of ashes, his cigarette, and not returning the lighter right away. NHA A indicated, no. Surveyor asked NHA A if she was aware the progress notes in R24's chart indicating staff having to go get the lighter from R24. NHA A indicated, I'm sure they do have to do that. On 3/27/25 at 12:45 PM Surveyors interviewed NHA A and reviewed observation of partial cigarette on over the bed table and then reviewed 3/21 note where it indicates staff knew he was keeping partial cigarettes. NHA A indicated with that knowledge staff should be asking R24, when he returns, if he has a partial cigarette to turn in. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/31/25 at 8:48 AM Surveyors interviewed DON B (Director of Nursing) and asked what the process is for determining if someone is safe to smoke independently. DON B indicated, we have a nurse do an assessment and they are done quarterly. Surveyors asked if the assessment is the only thing they use to determine if the resident is safe to smoke independently. DON B indicated, when the assessment is done, they look at the BIMS (Brief Interview of Mental Status), because they can be ok today and not ok tomorrow, and they go outside with the resident and make sure they can smoke safely. Surveyors asked DON B where residents should put ashes and the cigarette after smoking. DON B indicated there is an ashtray out there and that is part of the assessment, they have to be able to put it in the ashtray. Surveyors asked DON B if someone is safe to smoke independently if they don't return their smoking materials after, are disposing of ashes on the ground and disposing of the cigarette butt on the ground. DON B indicated, no. Surveyors asked DON B if staff are noting that a resident is not returning smoking materials and are keeping partially smoked cigarettes, what would you expect staff to do. DON B indicated, they should notify LPN V (Licensed Practical Nurse) so she can repeat the assessment and provide education. Surveyors reviewed, with DON B, information from the chart that indicated staff were having to ask R24 to return his lighter. Surveyors read the note from 3/21 regarding the partial cigarettes and lighter in R24's possession. Surveyors asked DON B if R24 should be independent with smoking knowing he is doing these things. DON B indicated, probably not. 50285 Example 2: The facility's policy entitled, Falls - Clinical Protocol, dated 2001, indicates, in part: . Cause Identification: 1. For an individual who has fallen, the staff and practitioner will begin to try to identify possible causes within 24 hours of the fall . 2. If the cause of a fall is unclear, . or if the individual continues to fall despite attempted interventions, a physician will review the situation and help further identify causes and contributing factors . 3. The staff and physician will continue to collect and evaluation information until either the cause of the falling is identified . Treatment/Management: 1. Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences to falling . 2. If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation . Monitoring and Follow-up: . 2. The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling . 4. If he individual continues to fall, the staff and physician will reevaluate the situation and reconsider possible reasons for the resident's falling (instead of, or in addition to, those that have already been identified) and also reconsider the current interventions . R2 admitted to the facility on [DATE] with diagnoses that include, in part: Unspecified dementia, severe, with mood disturbance,, Acute kidney failure, unspecified, Altered mental status, Unsteadiness on feet, Muscle wasting and atrophy, Low back pain, and Epilepsy unspecified. R2's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/7/25 indicates BIMS (Brief Interview of Mental Status) score of 00 out of 15, indicating R2 has severe cognitive impairment. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's fall care plan, includes, in part: -Problem: HX (history) of multiple falls. At risk for further falls r/t (related to) impaired balance, decreased strength and activity tolerance, decreased functional mobility skills, decreased safety awareness. Start Date: 12/20/2017. Revision Date: 3/24/2025 -Approach: 2 assist, gait belt for squat pivot transfers. staff to assist with WC (wheelchair) mobility. Start Date: 3/10/25. Revision Date: 3/22/25. -Approach: WC delivered from (company name). Start Date: 3/10/25. Revision Date: 3/22/2025 -Approach: Trial pool noodle on outer side of bed to remind resident where edge of bed is to prevent rolling out of bed. Start Date: 3/14/2025 -Approach: Keep WC close to bed. 3/12/2025 -Approach: Air flow cushion to WC and/or recliner with Dycem to be placed under cushion. Start Date: 3/10/25. Revision Date: 3/11/25 -Approach: Scheduled toileting every 2-3 hours with 2 assist, gait belt. Resident to be checked every 1-2 hours at noc (nighttime) and if awake assist with toileting. Resident should be toileted with HS (bedtime) blood sugar check when awakened or check blood sugar prior to going to sleep and HS cares. Start Date: 3/10/2025 -Approach: Resident has roommate and is more receptive to attend meals and have cares done -Approach: When assisting roommate check to ensure that [Resident Name] has basic needs met i.e., toileting, room safety, H20 (water), hygiene needs, etc. Provide increased supervision during times in room whether caring for [Resident Name] or roommate. Start Date: 11/12/2024 -Approach: Will move [Resident Name's] bed to opposite side of room for better viewing from staff in trial to decrease fall risk with increased observation of movement. Start Date: 9/16/2024 - Approach: Frequent rounds with change of shift, am/pm cares, meals, scheduled activities, routine toileting and NOC rounds. Ensure that feet have grippy socks in place. Start Date: 7/03/2024 -Approach: Resident is to wear gripper socks at all times. Will frequently remove. Staff to monitor and assist with replacement. Explain to [Resident Name] that foot coverings should be worn for safety and to prevent falls. Start Date: 7/03/2024 -Approach: Regular mattress as resident has had difficulty rising from bariatric scoop mattress. Start Date: 4/19/2024 -Approach: Gripper strips on floor in BRM (bedroom). Gripper strips next to bed on floor. Start Date: -12/01/2023 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Approach: Activities to offer 1:1 visits for 30-60 minutes daily and PRN (as needed) to decrease restlessness and provide increased comfort. Activities will engage resident at change of day/pm shift report times for increased supervision while staff is performing report and walking rounds. Start Date: 8/30/2023 -Approach: Nursing staff to offer assistance with making bed Qshift (every shift). Start Date: 7/05/2023 -Approach: Lamp at bedside to be turned on when in bed in the evening and night hours. Start Date: 4/28/2023 -Approach: WC brakes checked by maintenance. Remind [Resident Name] to lock brakes prior to transfers/standing. Start Date: 2/24/2023 -Approach: Keep shoes in w/c at bedside to promote wearing when she gets up. Start Date: 7/25/2021 -Approach: New personal phone placed in resident room. Start Date: 2/15/2021 -Approach: Educate and encourage use of proper footwear for all transfers/ambulation. Start Date: 11/13/2019 -Approach: Keep call light and frequently used items in reach. Keep walker within reach. Start Date: 12/20/2017 R2's CNA (Certified Nursing Assistant) Basic Care Plan indicates in part: . Grip socks on at all times. (Does remove herself and needs monitoring to ensure placement) . Prompted toileting every 2-3 hours during day . Offer toileting every 1-2 hours at NOC . Lamp at bedside to be turned on when in bed in the evening and night hours . On 3/27/25 at 8:39 AM, Surveyor observed R2 at the table in the dining room eating breakfast. R2 was wearing regular socks, not gripper socks, and no shoes. On 3/27/25 at 10:02 AM, Surveyor observed R2 resting in bed with her wheelchair next to the bed. The wheelchair did not have Dycem in place, there were no gripper strips on the floor by the bed, there were no shoes in the wheelchair at bedside, and there was no mat on the floor. On 3/27/25 at 10:24 AM, Surveyor interviewed CNA U (Certified Nursing Assistant) and asked her what fall interventions were in place for R2. CNA U indicated a lower bed, if she's up they try to have her at the nurse's station to keep an eye on her because she likes to self-transfer, and they offer her activities, snacks, and drinks. On 3/27/25 at 10:31 AM, Surveyor interviewed LPN R (Licensed Practical Nurse) and asked her what fall interventions were in place for R2. LPN R indicated a low bed, a lamp that gets turned on the bedside table, anti-lock roll back brakes on her wheelchair, pool noodles on her mattress, gripper socks on all the time and when she is up she often sits at the nurse's station with her so that she can monitor her better. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/27/25 at 10:46, Surveyor interviewed CNA N and asked her what fall interventions were in place for R2. CNA N indicated a special wheelchair that won't roll back or tip back, she has a bed all the way to the floor with a floor mat, she's always to have gripper socks on, and rubber sticky stuff in her wheelchair. On 3/31/25 at 11:17 AM, Surveyor interviewed DON B (Director of Nursing) about R2's multiple falls and fall interventions. DON B stated that R2 is in her own world and thinks she is capable of moving independently. DON B indicated that the IDT (Interdisciplinary Team) evaluates the root cause of each fall by investigating the 5 whys of the fall, and that the physician and family are notified of each fall. DON B indicated that a new intervention is implemented after each fall, and that they have tried different wheelchairs, a Broda chair, and are currently on a waiting list for a different wheelchair for R2. DON B stated that PT (physical therapy) was currently working with R2 to increase her core muscles as one of the problems is that R2 slides out of her wheelchair. DON B stated that they have Dycem in her wheelchair to prevent sliding and have also tried a waffle cushion. DON B stated that R2 attempts to stand up independently and does not have good safety awareness. DON B stated they have increased toileting and rounding with R2 and try to keep eyes on her. Surveyor asked DON B if she expected the care planned interventions for falls to be in place. DON B stated yes, she expected the care planned interventions to be followed. Surveyor shared with DON B her observations and that a number of the care planned interventions were not being followed. Surveyor asked DON B how she monitors staff to ensure they are following care planned interventions. DON B indicated that she does rounds every day in the morning and afternoon, but last week she was off on vacation so the ADON (Assistant Director of Nursing) should have been checking. DON B stated the ADON was new in her role, however, and probably was not aware that she should be monitoring this. On 3/31/25 4:47 PM, Surveyor interviewed NHA A (Nursing Home Administrator) if she would expect the care planned interventions for falls for R2 to be followed. NHA A stated that yes, she would expect care planned interventions to be followed, but that with R2 it is sometimes difficult, because she will remove the Dycem from her wheelchair and hide it in the drawer, and that she is constantly taking off her gripper socks. NHA A stated that they have tried lots if interventions with her and that the are trying to keep her safe. The facility failed to ensure that fall interventions were being followed for R2, thereby failing to keep R2 safe from repeated falls.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49434 Based on interview and record review the facility did not ensure that a resident who enters the facility with an indwelling catheter receives appropriate treatment and services 1 of 1 residents (R28) reviewed for indwelling catheters. R28 has an indwelling catheter, and has no physician order for the catheter, including its size and replacement schedule. This is evidenced by: The facility policy, entitled: Catheter Care, Urinary, dated 10/2022, states, in part: .Catheter Evaluation 1. Review and document the clinical indications for catheter use prior to inserting. 2. Nursing and the interdisciplinary team should assess and document the ongoing need for a catheter that is in place . The facility policy, entitled: Medication Orders, dated 11/2014, states, in part: . Supervision by a Physician . 2. A current list of orders must be maintained in the clinical record for each resident . R28 was admitted to the facility on [DATE] with diagnosis that include, in part: heart failure, epilepsy (seizure disorder), history of cardiac arrest (heart stops beating), urinary incontinence, and obstructive and reflux uropathy (urinary tract becomes obstructed causing urine to flow backward into the kidneys). R28's Quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 2/27/25, indicates that R28 has a Brief Interview for Mental Status (BIMS) of 15 out of 15 indicating that she is cognitively intact. Section H indicates that R28 is currently utilizing an indwelling catheter. R28's Comprehensive Care Plan states, in part: Problem: Resident requires an indwelling urinary catheter R/T (related to) obstructive uropathy. Problem Start Date: 9/10/24. Approach: Assess the drainage every shift and PRN (as needed). Record the amount. Observe for leakage. Start Date: 9/10/24. Approach: Catheter, per MD order. Start Date: 9/10/24. Approach: Change catheter per MD order. Start Date: 9/10/24. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Approach: Follow Enhanced[sic] Barrier Precautions (EBP) r/t (related to) catheter use: 1) clean hands before entering and when leaving room. 2) Wear gloves and a gown for high contact resident care activities. (Dressing, bathing, transfers, linen, changes, hygiene cares, changing briefs of toileting, catheter care) 3) change gown and gloves for the care of more than one person. Start date: 9/10/24. Approach: Irrigate catheter only if an obstruction is suspected. Start Date: 9/10/24. Approach: Provide catheter care BID (twice a day) and as needed. Start Date: 9/11/24. Approach: Report signs of UTI (urinary tract infection) (acute confusion, urgency, frequency, bladder spasms, nocturia, burning, pain/difficulty urinating, nausea, emesis, chills, fever, low back/flank pain, malaise, foul odor, concentrated urine, blood in urine). Start Date: 9/10/24. R28's Physician Orders state, in part: Catheter care twice daily. Special Instructions: catheter care twice daily. Twice A Day. 06:30 - 14:30 (6:30 AM - 2:30 PM), 14:30 - 22:30 (2:30 PM - 10:30 PM). Start Date: 9/3/24. End Date: Open Ended. Change drainage foley bag every 30 days. Special Instructions: Change drainage foley bag every 30 days. Once between the 3rd - 7th of the Month. Start Date: 9/3/24. End Date: Open Ended Check catheter securement device three times a day and change every Monday. Special Instructions: Check catheter securement device three times a day and change every Monday. Once a Day on Mon (Monday). 14:30 - 22:30. Start Date: 9/3/24. End Date: Open Ended. Flush Foley catheter with 60ml (milliters) of sterile normal saline. Special Instructions: to maintain patency. As Needed. PRN (As Needed) 1, PRN 2, PRN 3. (Indicates this can be done as needed up to 3 times a day). Start Date: 10/3/24. End Date: Open Ended. Foley output Q (every) shift. Every Shift. day (day shift), pm (evening shift), noc (night shift). Start Date: 12/14/24. End Date: Open Ended. Historical orders: Change foley catheter 16 fr (French-indicates catheter size), 10 mL (milliters). Once - One Time. 22:00 (10:00 PM). Start Date: 3/11/25. End Date: 3/11/25. Change foley catheter as it is occluded. Once - One Time. 17:30 (5:30 PM). Start Date: 3/23/25. End Date: 3/23/25. (Of note, this order specifically does not give a previous foley size or the size of the new foley to be place in the resident). Of note: R28 has no active foley catheter order indicating the size of the catheter or how much to put into the catheter balloon. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/31/24 at 11:41 AM, Surveyor interviewed DON (Director of Nursing) B. Surveyor asked DON B what size foley catheter R28 is supposed to have. DON B reviewed R28's electronic medical record and indicated that she does not see the size in her care plan or in her physician orders. Surveyor asked DON B if there should be an order for R28's foley catheter and it's size. DON B states, yes.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49434 Based on observation, interview and record review, facility staff did not adequately assess and treat pain and provide necessary care and services to attain or maintain the highest practicable physical well-being for 1 (R10) of 2 residents reviewed for pain management. The facility failed to adequately assess and treat R10's pain while providing wound care, causing R10 to feel pain throughout the dressing change. This is evidenced by: The facility policy entitled, Pain Assessment and Management, dated 10/2022, states, in part: . 2. Pain Management is defined as the process of alleviating the resident's pain based on his or her clinical condition and established treatment goals. 3. Pain management is a multidisciplinary care process that includes the following: . b. Recognizing the presence of pain; . f. Identifying and using specific strategies for different levels and sources of pain; g. Monitoring for the effectiveness of interventions; and h. Modifying approaches as necessary . Recognizing Pain . 2. Possible Behavioral Signs of Pain, including: a. negative verbalizations and vocalizations such as groaning, crying, screaming; b. facial expression such as grimacing, frowning, clenching of the jaw, etc.; . d. behavior such as resisting care . irritability . R10 was admitted to the facility on [DATE], with diagnoses that include, in part: local infection of the subcutaneous tissue, cellulitis (infection of tissue beneath skin) of right lower limb, cellulitis of left lower limb, panic disorder, peripheral vascular disease, and systemic lupus erythematosus (immune system attacks healthy body tissues). R10's Quarterly Minimum Data Set (MDS), with a target date of 3/6/25, indicates R10 has a BIMS score of 9 out of 15, indicating R10 has moderate cognitive impairment. Section M indicates R10 has 3 venous or arterial ulcers present along with moisture associated skin damage. Section J indicates R10 occasionally has pain and her pain is rated 5 out of 10. R10's Comprehensive Care Plan states, in part: Problem: Resident has open lower extremity venous ulcers R/T (related to) Peripheral vascular disease. RLE (Right Lower Extremity)- 12.5cm (centimeters) x 17 cm, L shin- 2.7 cm x 2.5 cm, L medial leg 1.2 cm x 2.0 cm, L posterior calf- 10.5 cm x 9.5 cm. Problem Start Date: 2/26/25. Problem: Resident has a BLE (Bilateral Lower Extremity) venous ulcer. DX (Diagnosis): PVD (Peripheral Venous Disease). Problem Start Date: 12/9/24. Approach: Give prn (as needed) morphine (opioid pain medication) one hour prior to BID (twice a day) lower leg dressing change. Approach Start Date: 3/11/25. Approach: Prevent or treat pain during dressing changes and debridement by premedication as ordered. Approach Start Date: 12/9/24. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Approach: Treatments as ordered. Approach Start Date: 12/9/24. Problem: Resident has complaints of chronic pain R/T venous stasis ulcer to BLE, dx (diagnosis): arthritis. Problem Start Date: 12/9/24. Approach: Administer medications as ordered and prn. Monitor and record effectiveness. Report adverse side effects. Alert MD (Medical Doctor) if meds (medications) are not effective. Approach Start Date: 12/9/24. Approach: Evaluate effectiveness of pain management interventions. Adjust if ineffective or adverse side effects emerge. Approach Start Date: 12/9/24. Approach: Monitor and record any complaints of pain: location, duration, quantity, quality, alleviating factors, aggravating factors. Approach Start Date: 12/9/24. Approach: Monitor and record any non-verbal signs of pain: (e.g., guarding, moaning, restlessness, grimacing, diaphoresis, withdrawal, etc.). Approach Start Date: 12/9/24. Approach: Use pain relief measure to promote relaxation and comfort. (repositioning, back rub, family visits, etc.) Monitor effectiveness. Utilize activities and conversation to help the resident focus on something other than pain or discomfort. Approach Start Date: 12/9/24. R10's Physician Orders state, in part: Morphine (opioid pain medication) - Schedule II (Federal Controlled Substance Level) tablet immediate release; 15 mg; amt: 0.5 tab; oral. Special Instructions: give 1 hour prior to wound care BID prn. As Needed. PRN 1, PRN 2. Start Date: 12/31/24. End Date: Open Ended. Cleanse LLE (Left Lower Extremity) with NS (Normal Saline), apply Santyl (removes dead tissue from wounds) to wound beds, add Calcium Alginate (absorbs drainage from wound) to wound beds, cover with Optilock (non-adherent, absorbent dressing) f/b (followed by) ABD (abdominal) pads (large, thick gauze dressing) and secure with Kerlix (gauze wrap). Special Instructions: Premedicate resident with prn Morphine 30-60 minutes prior to wound care. Twice A Day. 06:30 - 14:00 (6:30 AM - 2:00 PM), 14:30 - 22:30 (2:30 PM - 10:30). Start Date: 3/4/25. End Date: Open Ended. Complete treatment to RLE (Right Lower Extremity): apply Optilock to ankle and cover with ABD (Abdominal Pad) and wrap with Kerlix. Change twice a day[sic] and prn. Twice A Day. 08:00 - 15:00 (8:00 AM - 3:00 PM), 15:00 - 22:30 (3:00 PM - 10:30 PM). Start Date: 3/25/25. End Date: Open Ended. Give prn morphine one hour prior to BID (twice a day) lower leg dressing change. Special Instructions: sign out med in the prn list. Twice A Day. 06:30 - 14:00. 14:30 - 21:00 (9:00 PM). Start Date: 12/24/24. End Date: Open Ended. Of note: R10 had other medications available as needed which were tylenol, cyclobenzaprine, lidocaine and tramadol. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/26/25 at 10:46 AM, Surveyors observed LPN S (Licensed Practical Nurse) complete wound treatment for R10. During the wound treatment, after the old bandages were removed, Surveyor observed macerated (occurs when skin is in contact with moisture for too long and is often a sign of improper wound care) skin on the right leg from below R10's knee to her ankle, around the entire circumference of her lower leg. LPN S proceeded to wet gauze with normal saline (water and 0.9% salt mixture) then dab and wipe R10's leg. As this occurred, R10 started crying and saying, That's enough! repeatedly. LPN S replied, I know I just want to get it all. Surveyor asked LPN S about the leg wound. LPN S indicated R10's right lower leg wound started as a fluid-filled blister below her knee than became more and more macerated from the fluid-soaked dressings. Surveyor observed purulent (pus-like fluid) drainage and macerated skin on the left lower extremity. Surveyor also noted a large wound on the posterior (back of) left lower extremity. Slough (necrotic tissue that accumulates on the surface of the wound) present in this wound. LPN S began the wound treatment on this leg by appearing to peel off skin. Resident began yelling Ow! Ow! and wincing. LPN S replied I'm sorry, we got to get all the bad stuff off. R10 clenching teeth throughout process. LPN S instructed R10 to take a deep breath. Resident continued to cry out and her breathing was shallow. LPN S continued the wound treatment as ordered. R10 continued to cry out please!. LPN S replied, I just need to clean it. LPN S continued the wound treatment by applying the Santyl directly to the wound as ordered. R10 continued wincing and crying. On 3/26/25 at 11:46 AM, Surveyor interviewed LPN S. Surveyor asked LPN S when she premedicated R10. LPN S indicate she gave R10 morphine at about 9:57 AM. Surveyor asked LPN S about LPN S mentioning R10 was more uncomfortable today. LPN S indicated she believed R10 had anxiety related to her phone call with her family prior to her wound care treatment. Surveyor asked LPN S if she has ever stopped a wound treatment due to a resident being in pain or uncomfortable. LPN S indicates she has not, but slow, deep breaths usually work for R10. Surveyor asked LPN S if she should have stopped R10's treatment due to her crying out in pain. LPN S indicates, yeah, maybe I should have stopped. Surveyor asked LPN S if she has ever refused treatment due to pain. LPN S indicates R10 used to refuse due to pain but not so much anymore. On 3/31/25 at 2:56 PM, Surveyor stopped by R10's room to interview her about her pain with wound treatments. At this time, R28, R10's roommate stopped Surveyor to let her know that R10 screams in pain during her dressing changes. On 3/31/25 at 3:23 PM, Surveyor interviewed DON B and ADON HH. Surveyor asked DON B if it is ordered, should staff premedicate residents prior to wound care. DON B indicates yes, unless the resident refuses. Surveyor asked DON B if a resident is yelling out in pain and displaying visible signs of discomfort, what should the nurse do. DON B indicates the nurse should stop and reassess the pain. Surveyor asked ADON HH if she usually participates in R10's wound care. ADON HH indicates she completes wound treatments with the wound Advanced Practice Nurse Prescriber. Surveyor asked ADON HH what R10's usual demeanor is with wound treatments. ADON HH indicates R10 has good and bad days and that it usually depends on what is going on in her life, specifically family dynamics. ADON HH also indicates R10 has high anxiety days where very few interventions will be effective. Surveyor asked ADON HH what interventions are effective on the high anxiety days. ADON HH indicates lorazepam generally works best on those days. Surveyor advised ADON HH of the observations of pain made during wound treatment and asked what ADON HH would have done had she been completing the wound treatment. ADON HH indicated she would have stopped the treatment and evaluated R10's pain.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 39849 Based on observation, interview, and record review, the facility did not ensure that each resident receives food and drink that is palatable and at a safe and appetizing temperature for 1 of 17 sampled Residents (R15) and 1 of 1 test trays. R15 voiced a concern about hot foods being served cold. Surveyor received a breakfast test tray and the food temperatures were not palatable. Evidenced by: The undated facility policy, Food Temperatures, indicates, in part: Policy: Food temperatures shall be tested & recorded prior to meal service by food service employee. Purpose: To ensure that food is held at safe temperatures to prevent food borne illness and to ensure palatable food temperatures . On 3/25/25 at 2:00 PM, Surveyors interviewed R15 as part of the initial screening process. R15 indicated that the scrambled eggs and vegetables are sometimes cold. R15 indicated the food is cold around 3 times a week and that she stopped eating scrambled eggs because of it. On 3/26/25 at 3:50 PM Surveyors interviewed CNA M (Certified Nursing Assistant) and asked if residents have brought up concerns regarding cold food. CNA M indicated staff will be passing out trays and the kitchen will want to be quick and they will prep the last few trays and leave them for us to get. CNA M indicated that she may be running a tray to a room and by the time she gets back the trays are sitting there and then it can be cold. CNA M provided the following example: If she drops off a tray and then that resident wants mayo and then I have to go get the mayo and go back, then the tray the kitchen has scooped up is sitting there getting cold. Surveyors asked CNA if she felt this was something she should have reported. CNA M indicated, probably, now that I'm saying it out loud. 50285 Example 2: On 3/26/25 at 8:32 AM, Surveyor received a test tray after both dining rooms and all hall trays had been served on the 3rd floor. (Of note, the plates for the room trays are set directly onto the tray and are covered by a plastic cover). Surveyor took the temperatures of the food that was served, including scrambled eggs, sausage links, oatmeal, milk and coffee. Surveyor noted that several of the items were in the temperature danger zone, including the scrambled eggs (temperature of 115.3 degrees F (Fahrenheit), which also tasted cold), sausage links (temperature of 91.6 degrees F), and milk (temperature of 45.4 degrees F). (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/26/25 at 8:54 AM, Surveyor interviewed DM E (Dietary Manager). Surveyor asked DM E if she would expect the food that is served to be at the desired temperatures. DM E stated that the hot foods are expected to be 165 degrees F when they are brought up from the kitchen and placed in the steam table. Surveyor asked DM E if the eggs were served at a safe temperature at 115 degrees F. DM E replied she would have to look at the palatability of the eggs. Surveyor asked DM E about the safety of milk served at 45 degrees F. DM E stated that milk should be 41 degrees F or lower and that they had it in a tray of ice to keep it cold. The facility failed to ensure that each resident received food and drink that is palatable and at a safe and appetizing temperature.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50285 Based on observation, interview and record review, the facility did not distribute and serve food in accordance with professional standards for food service safety. This has the potential to affect all 45 residents. Facility staff were observed touching multiple items in the kitchenette while serving and handling food without changing gloves or performing proper hand hygiene. Cook D was observed dishing up lunch from the steam table with gloves on, stepping away from the steam table, touching other surfaces in the kitchenette, returning to the steam table for meal plating and touching ready to eat foods while wearing the same pair of gloves. Surveyor observed visible build on and debris in two ovens. Surveyor observed a visible white substance on inside and outside of a steam kettle. Surveyor observed a visible white substance on the outside of an ice machine. Surveyors observed a refrigerator containing resident food and drink in a kitchenette on 2nd floor without daily temperature monitoring being completed. Evidenced by: Facility policy, entitled Handwashing/Hand Hygiene, dated 2021 with Revision Date of October 2023, includes in part, Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. Administrative Practices to Promote Hand Hygiene: 1. All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors . Indications for Hand Hygiene: 1. Hand hygiene is indicated . g. immediately after glove removal .5. The use of gloves does not replace hand washing/hand hygiene . Example 1: On 3/26/25 at 7:44 AM, Surveyor observed [NAME] D wearing disposable gloves during meal service. Surveyor observed [NAME] D dishing up food at the steam table, stepping away from the steam table, opening the refrigerator door to remove a can of Sun Drop for a resident, then touching bread to make toast for the breakfast service. [NAME] D touched the bread, the toast lever, and the toast coming out of the toaster without changing gloves or performing hand hygiene. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/26/25 at 8:36 AM, Surveyor interviewed [NAME] D who indicated they had received annual education about hand hygiene and food safety, as well as periodic refresher training's throughout the year. Surveyor asked [NAME] D when hand hygiene should be performed. [NAME] D stated before entering the kitchenette to start meal service. Surveyor asked [NAME] D if gloves should be changed, and hand hygiene performed before touching ready to eat foods. [NAME] D replied yes, you should wash hands or change gloves before touching ready to eat foods. Surveyor asked [NAME] D if she had missed an opportunity for hand hygiene during meal service. [NAME] D replied no, that she had not left the kitchenette at all during meal service. Surveyor asked how often the common surfaces in the kitchenette were sanitized such as door handles. [NAME] D stated they are cleaned daily. Surveyor asked [NAME] D if cross contamination could occur if the kitchen staff were touching common surfaces and then touching food such as bread to make toast without changing gloves or performing hand hygiene. [NAME] D replied yes. On 3/26/25 at 8:44 AM, Surveyor interviewed DM E (Dietary Manager). Surveyor asked DM E when she would expect staff to perform hand hygiene or change gloves. DM E indicated that she would expect staff to perform hand hygiene before they start to dish up food, anytime they leave the kitchenette, or if they are touching food in between. Surveyor asked DM E if staff should change gloves or perform hand hygiene before touching ready to eat items such as bread. DM E stated that if they were wearing gloves no because there was no bare hand contact. Surveyor asked DM E should the staff change gloves or perform hand hygiene if they had touched surfaces such as door handles and before touching bread. DM E stated yes, if they had touched any door handles or surfaces then staff need to change gloves before they touch food again. Facility staff failed to perform proper hand hygiene, causing a risk for cross contamination by touching multiple surface areas in the kitchen then touching ready to eat foods. 49434 Example 2: On 3/24/25 at 12:15, Surveyor was observing dining on the 3rd floor. Surveyor observed a gallon of milk placed on a cart, not on ice or device to keep the milk at a safe temperature. On 3/24/25 at 12:42, Surveyor observed staff start to return the milk to a refrigerator. Surveyor asked DM E to take the temperature of the milk at that point. DM E showed Surveyor the thermometer, which showed 44F (Fahrenheit). Surveyor asked DM E what temperature the milk should be at. DM E indicates milk should be at 40F or below. DM E then indicated she would be disposing of the milk as it had reached an unsafe temperature. The facility did not distribute and serve food in accordance with professional standards for food service safety. 39849 Example 3 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The undated facility policy, Department of Dietary Infection Control: Steam Kettle, indicates, in part: Policy: The steam kettle shall be cleaned after each period of use by designated Dietary personnel . The facility policy, Department of Dietary Infection Control: Convection Oven, without an implementation or revision date, indicates, in part: Policy: The convection oven shall be cleaned monthly or if a spill by the cook . On 3/24/25 at 8:49 AM, Surveyor completed the initial kitchen tour with DM E (Dietary Manager). Surveyor observed debris on the inside of the baking convection oven and the cooks convection oven. Both ovens were observed to have dried matter on the front portion of the ovens under where the doors close. DM E indicated that she felt these ovens needed to be cleaned and that they are supposed to be cleaned monthly. Surveyor observed a white substance on the inside and outside of the steam kettle and on the floor by the steam kettle. DM E Indicated the steam kettle should be cleaned daily when they use it. DM E indicated she felt if it was being cleaned at that frequency it would not have this much build up and needed to be cleaned. Surveyor observed the ice machine (located by the clean dish area) to have a white substance build up on the right outer side of the machine. DM E indicated that any build up should be cleaned by staff between maintenance cleanings and that this needed to be cleaned. DM E indicated there is not a log for when the ice machine should be cleaned. On 3/27/25 at 2:22 PM Surveyors interviewed DM E and requested cleaning policies for the ovens and steam kettle. DM E indicated she had a cleaning schedule that indicates which person should be doing which cleaning. Of note, cleaning logs that were provided did not list ovens or the steam kettle. Example 4 On 3/24/25 at 12:20 PM, Surveyors observed clip boards on the 2nd floor refrigerator in the kitchenette nearest the elevators. A sign observed on the refrigerator indicates it is for resident items. The March 2025 Fridge/Freezer temperature log has temperatures documented on March 1st and on March 18th - 23rd. The February 2025 Fridge/Freezer log has temperatures documented for February 5th, 6th, and 10th. On 3/24/25 at 1:51 PM, Surveyors interviewed CNA N who indicated she thought the refrigerator was only being used for things residents bring in, like soda. Surveyors observed the inside of the refrigerator/freezer with CNA N. CNA N confirmed the fast food bag and an unopened bottle of soda noted in the refrigerator belong to residents. CNA N indicated the kitchen staff is responsible for monitoring and documenting temperatures of the fridge and freezer. On 3/26/25 at 4:38 PM, Surveyors interviewed NHA A (Nursing Home Administrator) and reviewed the temperature logs referenced above. NHA A indicated she would expect the temperature log to be filled out completely for all dates. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/27/25 at 2:22 PM Surveyor reviewed the temperature logs with DM E who indicated the temperatures should have been monitored by the kitchen staff and recorded.