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	06/18/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** Based on interview and record review the facility did not ensure that residents received treatment and care in accordance with professional standards of practice (Wisconsin Nurse Practice Act N6) for 1 of 6 sampled residents (R9) out of a total sample of 16 Residents.R9 had a change of condition that was not assessed properly, communicated to on-coming shifts, nor reported to the resident's medical provider. R9 was sent to the hospital where they remained for 3 days, receiving IV antibiotics.Evidenced by:The Wisconsin Nurse Practice Act states in part .N 6.04ˆStandards of practice for licensed practical nurses. (1)ˆPerformance of acts in basic patient situations. 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: (a) Accept only patient care delegated acts which the L.P.N. is competent to perform. (b) Provide basic nursing care. (c) Record nursing care given and report to the appropriate person changes in the condition of a patient. (d) Consult with a provider in cases where an L.P.N. knows or should know a delegated act may harm 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. or other provider and provide basic health care instruction. 4. Participate with other health team members in meeting basic patient needs.The facility's policy titled Notification of Changes no date states in part .The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification.2. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include: a. Life-changing conditions, or b. Clinical complications.R9 admitted to the facility on [DATE] with diagnoses that include hypertensive heart disease with heart failure, type 2 diabetes mellitus, chronic respiratory failure with hypoxia, obstructive sleep apnea, and hydrocephalus.R9's most recent Minimum Data Set (MDS) dated [DATE] states that R9 has a Brief Interview of Mental Status (BIMS) of 15 out of 15, indicating that R9 is cognitively intact. R9's MDS also indicates that they are dependent on staff for most of their Activities of Daily Living (ADLs) including bed mobility, transfers, personal hygiene, toileting, and bathing.Nures note entered on 6/16/26 indicated: 5/24/26 at 5:30 PM: Writer was alerted to the hallway by CNA (Certified Nursing Assistant), CNA stated resident turned blue in DR (Dining Room), at that time resident was sitting in WC (wheelchair) being taken to room, resident alert, no coughing, no SOB (Shortness of Breath), no c/o (complaints), no Blue tinge noted. Writer made observation on resident, lungs diminished, no SOB, VSS (Vital Signs Stable), Afebrile, asked resident if she was ok, resident responded I'm fine, that's normal for me, that's my color, I have rocasea[sic] Resident assisted back to room, went to sleep with BIPAP (a noninvasive ventilatory device that helps patients breathe by delivering two levels of air pressure: higher during inhalation and lower during exhalation) on, no further c/o noted or reported.It is important to note that this note was entered on 6/16/26. Additionally, there were no vital signs documented on 5/24/26, no evidence an RN assessment was completed or that a provider was updated.On 6/17/26 at 10:28 AM, Surveyor interviewed DA V (Dietary Aide). Surveyor asked DA V to explain what they observed on 5/24/26 regarding R9, DA V stated that R9 had started coughing (continued on next page)

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	during dinner and got really blue in the face. DA V stated that the CNAs came over and looked at R9 but was unsure if they reported it to the nurse.On 6/17/26 at 11:13 AM, Surveyor interviewed CNA K (Certified Nursing Assistant). Surveyor asked CNA K to explain the aspiration event with R9 on 5/24/26, CNA K reported that last night (6/16/26), the nurse called them and asked if R9 was blue, CNA K stated that R9 reported that they were fine and that they passed it on to another CNA. CNA K stated that they had R9's group and reported to Surveyor that R9 didn't look right that night. CNA K stated that they think the other CNA reported the incident to the nurse but is not sure and that they just left it alone. Surveyor asked CNA K who typically applies R9's BiPAP, CNA K stated that the CNAs put it on. Surveyor asked CNA K what time R9 likes for the BiPAP to be applies, CNA K stated between 8:30 PM-9:00 PM. Surveyor asked CNA K on 5/24/26 was R9's BiPAP put on at 5:30, CNA K stated no, and that they don't think R9 was even in bed at that time, typically R9 goes to bed late.On 6/17/26 at 12:32 PM, Surveyor interviewed CNA P. Surveyor asked CNA P to explain the events on 5/24/26 regarding R9, CNA P stated that they were at the nurse's station and another CNA called and said that R9 was blue so they went to see R9. CNA P stated that when they got to R9, they were blue in the face. CNA P stated that they ran to get the nurse and by the time that the nurse got down there, R9 was not blue anymore. CNA P stated that the nurse asked R9 if they were ok and R9 stated yes. Surveyor asked CNA P if the nurse did an assessment, CNA P stated that they said they were going to and then walked away.On 6/17/26 at 3:15 PM, Surveyor interviewed LPN U (Licensed Practical Nurse) Surveyor asked LPN U to explain the events of 5/24/26 regarding R9, LPN U stated that they were sitting at the nurse's station and the CNAs reported that R9 was turning blue. LPN U reported that they went to see R9 and they were sitting in front of their room, and they asked R9 what was going on. LPN U stated that R9's lungs were diminished, R9 had a cough, took vital signs and R9 was then put to bed. LPN U stated that R9 looked fine when they saw them. LPN U stated that R9 reported that they were that color because they had rosacea. Surveyor asked LPN U if rosacea turns skin blue, LPN U stated no, but R9 was not blue when they saw them. Surveyor asked LPN U if that means that the event did not occur, LPN U stated no. Surveyor asked LPN U if they notified the physician about the event, LPN U stated no because when they saw R9 they were fine and that did not need to be reported to the physician. Surveyor asked what R9's vital signs were at that time, LPN U stated that they did not know because they did not document them. Surveyor asked LPN U if R9's aspiration event was documented on the 24-hour board, LPN U stated no.Nurse note on 5/25/26 at 11:04 AM, indicated: Resident blue/grey to face this morning upon writer walking into room to assist with hoyer transfer. Resident started bobbing head slightly. Resident had no complaints of SOB. No loss of consciousness. Alert and oriented x 4 still. SPO2 (oxygen level) was at 48%. Put her on 4L (liters) via nasal cannula and SPO2 increased to 85%. Writer seen that oxygen was not connected to her bipap machine last night. Lungs diminished posterior and anterior in all lobes. She has developed a wet productive cough. Writer was notified by staff that resident had aspiration event last night during dinner and turned blue to the face. She was afebrile 98.4 and BP (Blood Pressure) 131/70. Pulse 111. RR (Respiratory Rate) 20. Oak medical was updated. Agreed with sending out via 911. 911 was called and EMS (Emergency Medical Service) arrived and resident was put on 8L via non re-breather mask. SPO2 increased to 96%. Resident requesting to be sent to [Hospital name]. Writer asked resident if she wanted writer to call her mother and she said only if she is admitted to the hospital. Resident was transferred to stretcher via hoyer and left via ambulance. Call placed to [Hospital] ER (Emergency Room) and resident will be admitted for aspiration pneumonia and placed on IV ABX (Intravenous Antibiotics). Residents mother arrived to facility just now and was updated on resident. DON notified of residents send out/being admitted .On 6/17/26 at 7:54 AM, Surveyor interviewed LPN G (Licensed Practical Nurse). Surveyor asked LPN G to explain the events that occurred with R6 on 5/25/26, LPN G stated that the CNA that was providing cares for R9 asked for assistance with a transfer and reported that R9 was blue/gray in color and didn't look right. R9 was bobbing their head, pulse ox was 48% and then it jumped to 55%. LPN G stated that R9 was able to answer questions and was talking to (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	them. LPN G stated that they noted that R9's oxygen concentrator was not on and was not connected to their BiPAP machine. LPN G stated they got R9 up into the wheelchair, R9 started coughing with a wet cough, oxygen was applied at 4 liters and they were unable to get R9's sats up higher. LPN G stated they called the physician and EMS for evaluation. LPN G reported that the kitchen staff reported that R9 had turned blue at dinner the night before, and it was reported to the nurse who stated that R9 was fine and walked away. Surveyor asked LPN G how a change of condition is communicated between shifts, LPN G stated that it is usually reported at change of shift, but no one had said anything about R9's aspiration event. Surveyor asked LPN G who is responsible for applying R9's BiPAP, LPN G stated that the CNAs and nurses work together and then the nurse has to check it. LPN G stated that R9 never puts their mask on early, it's usually around 10:00 PM before they are ready. LPN G reported that R9 has orders for the nurse to ensure that the O2 is bled into the BiPAP and that there is water in the reservoir.Hospital documentation states in part:5/25/26 at 11:20 AM: Hospitalist admission History and Physical.Chief Complaint: Hypoxia.History of present illness: Patient is a [R9 age and gender] with a history of Chronic hypercapnic respiratory failure, wears BiPAP at night.who is being admitted with pneumonia (new problem).The patient was recently admitted to [Hospital Name] between April 14 and 23 for hypercapnic respiratory failure requiring intubation.Most recently, the patient has had a cough for several days. Her mom says that yesterday it sounded wet. The patient also says that whenever she eats, she has coughing. This morning when staff at her facility checked her pulse ox it was in the low 80s.She was sent to the ER where she was found to be hypoxic and hypercapnic (excessive carbon dioxide in the blood) with multilobar pneumonia (a type of lung infection that affects more than one lobe of the lungs, often causing more severe illness than pneumonia confined to a single lobe). She was placed on BiPAP.Abnormal lab results dated 5/25/26 at 11:00 AM include:pH Arterial 7.27 (H(High)) (indicates a significant acid-base disturbance)pCO2 Arterial 79 (HH) (indicates hypercapnia - an excess of carbon dioxide in the arterial blood.)HCO3 Arterial 36.3 (H) (indicates a metabolic alkalosis or a condition where the body has retained bicarbonate).O2 Saturation Arterial 99.1 (H)BE (base excess) Arterial 6.5 (H) (the blood is more alkaline than normal).CT Angio Chest Pulm (Pulmonary) Embolism (the most common and effective imaging test for diagnosing pulmonary embolism) results dated 5/25/26 state in part: .2. As before, low lung volumes are noted along with elevated diaphragms, left more than right. 3. As before, significant atelectasis is seen of the both lower lobes, along with moderate size dense pneumonic appearing consolidations with some internal air bronchograms in the both lower lobes. However, there appears to be moderate worsening in the right lower lobe and mild worsening in the left lower lobe. 4. Note is made of low density mucoid contents in the lumen of the main bronchi of both lower lobes, suggestive of either mucus impaction or obstructing lesions causing combination of aspiration and/or postobstructive pneumonia with atelectasis.XR Chest 1Vw Portable (Chest x-ray 1 view) results dated 5/25/26: Personally reviewed and shows very diminished lung volume, suspect bilateral lower lobe pneumonia. Assessment and Plan: .I suspect she has aspiration due to the history and appearance on CT. Continue BiPAP. Recheck VBG (Venous Blood Gases). Continue cefepime and vanco (antibiotics). Follow up with blood and sputum cultures. Consider Pulmonary consult tomorrow if not improved, due to appearance of significant mucus plugging on CT. Speech evaluation for aspiration once stable.Hospitalist note dated 5/26/26 at 2:52 PM states in part Reason for visit: Hypoxic hypercarbic respiratory failure. [R9] was able to come off BiPAP this morning and maintain her sats on 4L to 6L of nasal cannula oxygen.Also of note she has extremely poor inspiratory effort and deep inspiration triggers causing coughing jags are problematic for her. At baseline, her mother reports that she does not have significant cough so this is all likely new related to a recent aspiration event.Assessment and Plan: .I suspect she has aspiration pneumonia nd [sic] bronchitis due to the history and appearance on CT, baseline restrictive ung [sic] disease duet o [sic] [NAME] (Obesity Hypoventilation Syndrome), kyphosis, and atelectasis requiring Bipap at night. Continue BiPAP at night, monitor on cannula vs open mask O2 (oxygen) today. Continue cefepime.follow up blood and (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	sputum cultures. Bronchial hygiene, incentive spirometry. Speech evaluation for silent aspiration with VSS. Dose Lasix 20 IV since held on admission.Hospitalist note dated 5/27/26 at 3:57 PM states in part Reason for visit: Hypoxic hypercarbic respiratory failure. [R9] did well on her video swallow evaluation today. She is not short of breath reportedly but is still requiring 4L of nasal cannula oxygen to maintain her sats over 89%. She is coughing intermittently but producing minimal sputum.It is important to note that R9 received IV antibiotics throughout their hospitalization.R9 returned to the facility on 5/28/26.On 6/17/26 at 9:24 AM, Surveyor interviewed R9. Surveyor asked R9 what time they like to have their BiPAP put on, R9 stated between 8:00 PM- 9:00 PM. Surveyor asked R9 if they have ever had it put on at 5:30 PM, R9 stated no.On 6/17/26 at 1:34 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B when they became aware of R9's aspiration event from 5/24/26, DON B stated that they were not aware of an aspiration event occurring on 5/24/26, because there was no documentation indicating an aspiration event and they were not contacted. DON B stated that they read the nurse's note on 5/25/26 and then became aware of an aspiration event. Surveyor asked DON B if they would expect a change of condition to be documented timely, DON B stated yes. Surveyor asked DON B if the provider was updated on 5/24/26, DON B stated not that they were aware of. Surveyor asked DON B if the provider should have been updated, DON B stated yes. Surveyor and DON B reviewed LPN U's late documentation from 5/24/26. Surveyor asked DON B what R9's vital signs were at that time, DON B stated that there was none documented. Surveyor asked DON B how changes of condition are reported shift-to-shift, DON B stated that they have a 24-hour board that changes are put on. Surveyor asked DON B if this event was put on the 24-hour board, DON B stated they would have to look. Surveyor asked DON B if R9's change of condition should have been passed on to the next shift and respiratory assessments should have been completed, DON B stated yes.It is important to note that DON B did not provide Surveyor with any documentation from the 24-hour board regarding this event.R9 had a change of condition and the facility failed to ensure that a complete assessment was performed, the physician was notified, and ongoing monitoring was facilitated, resulting in R9 having a 3 day hospital stay requiring IV antibiotics.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections. This has the potential to affect 36 of 36 residents. Infection control concerns:The facility's employee line list is not inclusive and does not document and track employee symptom onset, well date, last day worked, and date may return to work.Surveyor observed NS H (Nursing Scheduler) delivering linens to resident rooms with the cart uncovered.Surveyor also observed boxes of gloves on the same linen cart touching towels, washcloths, chux (washable bed pads), and gowns. As evidenced by:The facility policy, Handling Clean Line, undated, documents in part, as follows: It is the policy of this facility to handle, store, process, and transport clean linens in a safe and sanitary method to prevent contamination of the linen, which can lead to infection. Linen includes sheets, blankets, pillows, towels, washcloths, and similar items from departments such as nursing, dietary, rehabilitative services, beauty shops, and environmental services. 2. Linen can become contaminated with pathogens from contact with intact skin or body substances, or from environmental contaminants or contaminated hands.5. Guidelines for the storage of clean linen include, but are not limited to, the following.a. Clean linen shall be delivered to resident care units on covered linen carts with covers down. The facility policy, Employee Work Restrictions - Infectious Disease, undated, documents in part, as follows: It is our policy to take appropriate precautions to prevent transmission of infectious agents. Employees with a communicable disease or infected skin lesion will be prohibited from working if direct contact with residents or their food will likely transmit the disease. 3.it is the responsibility of the employee's supervisor, or the supervisor on duty, to make determinations regarding work-restrictions, depending on the circumstances. The designated Infection Preventionist may be consulted to provide guidance in decision-making. 4. In the absence of state and local regulations, CDC (Centers for Disease Control) guidelines will be utilized in determining work restrictions. 5. Employees who are restricted from work shall remain away from work until no longer contagious or cleared by a medical provider as needed. Example 1Surveyor reviewed infection control log from March 2026 to Present (June 2026) and noted the following: Dietary I - Date called off (3/2/26) Symptoms (Vomiting) Date of return: (3/5/26)Dietary J Date called off (3/5/26) Symptoms (Vomiting) Date called off (3/5/26) Date of return (3/10/26)CNA K (Certified Nursing Assistant) Date called off (3/13/26) Symptoms (Headache, scratchy throat) Date of return (3/16/26)Dietary I - Date called off (3/17/26) Symptoms (Diarrhea) Date of Return (3/21/26)NS H (Nursing Scheduler) Date called off (3/30/26) Symptoms (Headache, sneezing) Date of return (3/31/26)Med Tech L (Medication Technician) Date called off (4/6/26) Symptoms (Sore throat, fever) Date of return (4/8/26)Activities M Date called off (4/14/26) Symptoms (Congestion) Date of return (4/16/26) Med Tech N Date called off (5/8/26) Symptoms (Vomiting) Date of return (5/10/26)Front Desk O Date called off (6/2/26) Symptoms (Headache, ear ache, sore throat, sweats) Date of return (6/4/26)CNA P Date called off (6/5/26) Symptoms (Congestion, cough, headache) Date of return (6/8/26)CNA Q Date called off (6/15/26) Symptoms (Vomiting, nausea) Date of return: ----Of note: The facility's employee line list is not inclusive and does not document and track employee symptom onset, well date, last day worked, and date may return to work.On 6/17/25 at 1:40 PM and 2:15 PM, Surveyor spoke with ADON/IP C (Assistant Director of Nursing/Infection Preventionist). Surveyor asked ADON/IP C how long staff should be off work when ill (e.g. fever). ADON/IP C stated 24 hours without fever reducing medication and 48 hours for GI (vomiting, diarrhea). Surveyor asked ADON/IP C if she tracks employee symptom onset date. ADON/IP C stated, no. Surveyor asked ADON/IP C if she tracks employee well dates. ADON/IP C stated, no. Surveyor asked ADON/IP C if she tracks employee last day worked. ADON/IP C stated, no. Surveyor asked ADON/IP C if she tracks the date an employee may return to work. ADON/IP C stated, no. Surveyor asked ADON/IP C if she should be tracking (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	employee symptom onset, well date, last day worked and date may return to work. ADON/IP C stated, yes. ADON/IP C stated, she recently took over Infection Control and will track these moving forward. ADON/IP C stated she will also be tracking any ill employee physician visit notes and if there is any testing such as influenza or covid. Surveyor asked ADON/IP C, would any other staff member have this information such as HR (Human Resources). ADON/IP C stated, she would check and get back to Surveyor. ADON/IP C stated that HR does not have any additional detail to add to the Infection Control line list information.Example 2:On 6/15/26 at 2:33 PM, Surveyor observed NS H (Nursing Scheduler) delivering linens on 3rd floor with an uncovered two (2) tiered laundry cart. The top shelf contains towels, washcloths, chux pads, and gowns all touching boxes of gloves. The bottoms tier contains chux pads and gowns. Surveyor asked NS H, should the linen cart be covered while delivering linens on the unit. NS H stated, yes. Surveyor asked NS H, is it acceptable to have supplies on the clean linen cart touching the linens. NS H stated, she can find the answer however, this is usually the way it is done. Surveyor asked NS H, why is it important to have the linen cart covered and not having supplies in the clean linen cart touching the clean linen. NS H stated, Infection. On 6/17/25 at 1:40 PM and 2:15 PM, Surveyor spoke with ADON/IP C (Assistant Director of Nursing/Infection Preventionist). Surveyor asked ADON/IP C, should the linen cart be covered when delivering linens on the units. ADON/IP C stated, yes. Surveyor asked ADON/IP C, if it is acceptable to have supplies (e.g. boxes of gloves) on the linen cart in direct contact with clean linens. ADON/IP C stated, no, supplies should not be on the same shelf or touching clean linens.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure written bed holds were completed for 4 of 6 residents (R1, R2, R4 and R19) reviewed for bed holds out of a sample of 16. R1 was transferred to the hospital. The facility did not provide written bed hold notice to R1 and/or R1's resident representative. R2 was transferred to the hospital. The facility did not provide written bed hold notice to R2 and/or R2's resident representative. R4 did not receive a bed hold notice prior to going to the hospital. R19 was sent to the hospital for a change of condition and the facility failed to provide a bed hold. Findings include: The facility's Bed Hold Notice policy, dated 2025, includes, in part: Policy: It is the policy of this facility to provide written information to the resident and/or the resident representative regarding bed hold practices both well in advance, and at the time of, a transfer for hospitalization or therapeutic leave. Policy Explanation and Compliance Guidelines: 1. As part of the admission packet and at the time of a transfer to the hospital or therapeutic leave, the facility will provide the resident and/or the resident representative written information that specifies: a. The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;. c. The facility policies regarding bed-hold periods to include allowing a resident to return to the next available bed. 2. In the event of an emergency transfer of a resident, the facility will provide written notices of the facility's bed-hold polices to the resident and/or the resident representative within 24 hours. 3. The facility will keep a signed and dated copy of the bed-hold notice information given to the resident and/or resident representative in the resident's file and/or medical record. Example 1: R1's medical record indicated R1 was sent to the hospital on 5/10/26. R1's medical record did not contain written bed hold notice. On 6/17/26 at 1:29 PM, Surveyor interviewed CNO D (Chief Nursing Officer) who indicated that there were no bed holds for R1 for that date. Example 2: R2's medical record indicated R2 was transferred to the hospital on 2/27/26. R2's medical record did not contain a written bed hold notice. On 6/17/26 at 1:29 PM, Surveyor interviewed CNO D (Chief Nursing Officer) who indicated that there were no bed holds for R2 for that date. Example 3: (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R4 was hospitalized on [DATE]. A bed hold notification was not found in R4's medical record. On 6/17/2026 at 1:12 PM CNO D (Chief Nursing Officer) approached surveyors and indicated the facility did not have a bed hold for the 3/13/26 hospitalization. Example 4: R19 was hospitalized on [DATE]. A bed hold notification was not for in R19's medical record. On 6/17/26 at 8:18 AM, NHA A (Nursing Home Administrator) reported to Surveyor that R19 did not have a bed hold. On 6/18/26 at 8:45 AM, Surveyor interviewed SW E (Social Worker) about bed hold notices. SW E indicated that the admissions nurse gets the initial bed hold on admission, and that a copy of the bed hold notice should go with each resident when they go out to the hospital. SW E stated that the bed hold notice should be included with the other transfer paperwork and given to the resident in their transfer folder. SW E indicated that the facility should keep a copy of the bed hold notice for the resident's medical record.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, the facility did not ensure their abuse policy was implemented for 1 of 8 employees reviewed for background checks. The facility did not complete the Background Information Disclosure (BID) form, Integrated Background Information System (IBIS) and Department of Justice (DOJ) upon hire and every 4 years thereafter for LPN G (Licensed Practical Nurse). Findings include:The facility policy entitled Abuse, Neglect and Exploitation, with a review date of 4/1/26. Policy: It is the policy of this facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. A. Screening: Potential employees will be screened for history of abuse, neglect, exploitation, or misappropriation of resident property. 1. Background, reference, and credentials checks shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers, and consultants. 2. Screenings may be conducted by the facility itself, third-party agency or academic institution. 3. The facility will maintain documentation of proof that the screening occurred.During this recertification survey with an exit date of 6/18/26, Surveyor asked for background check information on LPN G. On 2/25/21, LPN G was hired by the facility. The facility did not have LPN G complete the BID (Background Information Disclosure), IBIS (Integrated Background Information System) and DOJ (Department of Justice) upon hire and 4 years thereafter. On 6/15/26 Surveyor spoke with NHA A (Nursing Home Administrator). Surveyor asked NHA A if the facility has a more recent BID, IBIS and DOJ for LPN G. NHA A stated, no, there is no documentation. NHA A stated she just ran LPN G's IBIS and DOJ for Surveyor. NHA A stated LPN G's BID, IBIS and DOJ should have been completed on 2/25/25. NHA A stated that a BID, IBIS and DOJ should be run upon hire and every 4 years thereafter.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not follow through with the appropriate steps of the PASARR (Preadmission Screening and Resident Review) process for 3 of 5 residents (R6, R7, and R27) reviewed for PASARR screening. R6 did not have a level II PASARR screening completed. R7 did not have a level II PASARR screening completed. R27 was admitted with diagnoses that include schizophrenia and anxiety disorder and was prescribed medications to treat the symptoms of schizophrenia and anxiety. No PASARR 1 or PASARR 2 was completed. Evidenced by: The facility policy, Resident Assessment – Coordination with PASARR Program, indicates, in part: Policy: This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. Policy Explanation and Compliance Guidelines: 1. All applicants to the facility will be screened for serious mental disorders (MD) or intellectual disabilities (ID) and related conditions in accordance with the State's Medicaid rules for screening. a. PASARR level I – initial prescreening that is completed prior to admission i. Negative Level I Screen – permits admission to proceed and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later. ii. Positive Level I Screen – necessitates a PASARR Level II evaluation prior to admission. b. PASARR Level II – a comprehensive evaluation by the appropriate state-designed authority (cannot be completed by the facility) that determines whether the individual has MD, ID, or related condition, determines the appropriate setting for the individual, and recommends any specialized services and/or rehabilitative services the individual needs.3. A record of the pre-screening shall be maintained in the resident's medical record.4. Exceptions to the preadmission screening program, dependent upon State requirements, include those individuals who: .b.has been certified by the attending physician before admission that the individual is likely to require less than 30 days of nursing facility services. 5. If a resident who was not screened due to an exception above and the resident remains in the facility longer than 30 days: a. The facility must screen the individual using the State's Level I screening process and refer any resident who has or may have had MD, ID, or a related condition to the appropriate state-designated authority for Level II PASARR evaluation and determination. b. The Level II resident review must be completed within 40 calendar days of admission. 6. The Social Services Director shall be responsible for keeping track of each resident's PASARR screening status, and referring to the appropriate authority. Example 1 R7 was admitted to the facility on [DATE] with diagnoses, that include, in part: Major Depressive Disorder; Anxiety Disorder; and Depression. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyors reviewed R7's Level I PASARR screening which indicated the facility answered Yes to Does the person have a major mental disorder. Surveyors requested documentation for a Level II PASARR. On 6/16/26 at 1:28PM NHA A (Nursing Home Administrator) informed surveyors that the previous social worker did not complete a Level II screening for R7 and they ran the Level II today. Example 2: R27 was admitted to the facility on [DATE] with diagnoses that include schizophrenia and anxiety disorder. PASARR Level 1 Screen was completed on 7/11/25 and was marked as .Hospital Discharge Exemption- 30 Day Maximum: YES. Surveyor requested documentation of PASARR completion for R27. On 6/17/26 at 4:49 PM, NHA A (Nursing Home Administrator) reported that R27 had a 30- day exemption filled out, so it did not trigger for them to complete another PASARR. Surveyor asked NHA A if R27 should have had a PASARR completed, NHA A stated yes. Example 3: R6 was admitted to the facility on [DATE] with diagnoses, that include, in part: Adjustment disorder with anxiety, and Generalized anxiety disorder. Surveyors reviewed R6's Level I PASARR screening which indicated the facility answered No to Does the person have a major mental disorder. On 6/18/26 at 9:51 AM, Surveyor interviewed NHA A (Nursing Home Administrator and requested documentation of a Level !! PASARR. NHA A stated that they didn't have one and should have done one. NHA A indicated that she would be re-doing it today.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that a resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility for 1 of 2 residents out of a sample of 16 Residents (R40). The facility was not walking R40 in accordance with her plan of care. This is evidenced by: Facility policy titled Restorative Nursing Programs, dated 2025 states, in part: Policy: It is the policy of this facility to provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practical level. Policy Explanation and Compliance Guidelines: . 3. Nursing personnel are trained on basic, or maintenance nursing care that does not require the use of qualified therapist or licensed nurse oversight. This training may include but is not limited to: . c. Encouraging residents to remain active and assisting with any exercises according to the plan of care. 7. Residents may receive restorative nursing services upon admission when not a candidate for specialized rehabilitation services, when restorative needs arise during the course of a longer-term stay, in conjunction with specialized rehabilitation therapy. 11. The discharging therapist. will communicate to the appropriate restorative aide, the provisions of the resident's restorative nursing plan. 12. Restorative aides will implement the plan. R40 was admitted to the facility on [DATE] with diagnoses that include, in part: Muscle wasting and atrophy, not elsewhere classified, multiple sites, Muscle weakness, generalized, Unsteadiness on feet, Repeated falls, Adult failure to thrive, and Pain disorder with related psychological factors. R40's most recent Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 4/30/26 documented that R40 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R40 is cognitively intact. R40's Care Plan, initiated on 5/7/24, with last edit date of 4/12/26, includes, in part: Problem: Transfers from another SNF for long term care placement. Assistance is needed with all ADL's (Activities of Daily Living) d/t (due to) increased weakness. Goal: Resident will ambulate to/from room to dining area with 1 assist and walker. Target Date: 7/9/26.Approach: Walking calendar on table in room for staff to sign after ambulating [Resident Name]. Start Date: 7/9/25. Transfers/ambulates with 4WW (wheeled walker) ad lib in room. 1 assist when walking outside of room. Cues for upright posture and slower gait speed for improved control. Start Date: 6/12/25. R40's Basic CNA Care Plan, dated 8/7/24, with last edit date of 4/12/26, includes, in part: .Mobility: Propels W/C (wheelchair) per self. Ambulate in hallways with staff assist and 4 wheeled walker. Cues for upright posture and slower gait speed for improved control. Walking calendar on table in room for staff to sign after ambulating [Resident Name]. R40's Physical Therapy Treatment Encounter Notes, dated 4/29/26, states, in part: . Writer will care plan walking program for pt (patient) to maintain strength and mobility. R40's Rehab Plan of Care Changes for Nursing, dated 4/29/26, states, in part: . to walk 2-3 times a day, distance as tolerated, assist needed: 1. R40's General Administration History indicates, in part: Document how far resident ambulates in halls with staff.-on June 2, 2026, a zero is documented for ambulation-on June 6, 2026, a zero is documented for ambulation-on June 8, 2026, a zero is documented for ambulation R40's Point of Care History indicates, in part: Walk 10 feet-36 shifts marked Not Applicable in May, 2026-18 shifts marked Not Applicable in June, 2026 R40's Walking Calendar, kept in the room, to be signed by the CNAs (Certified Nursing Assistants) after ambulating with R40, indicated:-15 blank days with no ambulation-3 days marked AM/day shift ambulation On 6/15/26 at 9:45 AM, Surveyor interviewed R40 who stated that she's supposed to be walking every day, but that staff don't always do it. R40 indicated that sometimes days go by, and no one walks with her. R40 stated that she has had a fall recently and that she feels better and gets stronger when staff walk with her according to her walking plan. On 6/16/26 at 10:18 AM, Surveyor interviewed CNA Q (Certified Nursing Assistant) about R40's walking program. CNA Q stated that R40 likes to walk daily and that staff sign the calendar in her room after (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they walk with her, as well as documenting it in the electronic health record. Surveyor asked CNA Q how often staff are to be walking with R40. CNA Q stated that she thought it was every shift. Surveyor asked CNA Q if R40 ever refused to walk with staff. CNA Q stated that R40 had a fall a few months ago and she might have refused a few times then, but now she is very eager to do therapy and get better with walking. CNA Q indicated that R40 is very motivated and is improving in her mobility with consistent walking with one assist of staff. Surveyor asked if there were times when there weren't enough staff scheduled to take R40 for her walks. CNA Q indicated that yes, sometimes staff is unable to get to taking R40 for her walks, especially on days when there is less staff. CNA Q stated that after R40's fall she had been depressed and refusing to get out of bed because of pain, but now she is really active, always on the go, out of her room and wanting to walk. CNA Q indicated that if staff don't go and ask R40 if she wants to walk, she will put on her call light and ask them if they have time to walk with her. On 6/16/26 at 10:25, Surveyor interviewed CNA R about R40's walking program. CNA R stated that R40 was being walked once a day, and it was documented on the room calendar and in the electronic health record. CNA R indicated that R40 never refuses to do her walks, and that she is eager to walk and always ready to go. CNA R stated that R40's mobility has gotten slightly better when staff are consistent with walking with her. On 6/17/26 at 3:07 PM, Surveyor interviewed CNA T about R40's walking program. CNA T indicated that R40 is to be walked with staff 15 minutes once a shift. CNA T indicated that R40 never refused to walk with staff, except when she had a fall and was in pain, but not recently. CNA T stated that R40's mobility has gotten better with her walking consistently. On 6/16/26 at 10:28 AM, Surveyor interviewed LPN S (Licensed Practical Nurse) about R40's walking program. LPN S stated that she thought R40 was to be walked twice a day, although in the computer it noted only once a day. LPN S stated that after R40 had a fall she had some pain and refused to walk a few times but since she has been going to therapy, she has been eager to walk daily. LPN S stated that R40 is now at least back to her baseline or maybe a little better since she has been walking daily. On 6/16/26 at 11:29 AM, Surveyor interviewed PT F (Physical Therapist Manager) about R40's walking program. PT F indicated that R40 was discharged from PT on 4/29/26. PT F stated that the facility does not have a restorative aide, so she wrote a care plan for R40 to walk with the CNAs as a maintenance type program to prevent a decline in mobility. PT F stated that right after R40 fell she was refusing to walk with staff, so they admitted her back into PT and now she is back to baseline from prior to the fall. PT F stated it was her expectation that R40 ambulate in the hallway with staff each day per her walking plan of care. PT F stated she was unsure why her electronic health record stated to walk only once daily, instead of 2-3 times a day as she had ordered. PT F indicated that she had staff using the calendar in R40's room to remind her of when she was walked last, so she wouldn't forget. On 6/17/26 at 2:16 PM, Surveyor interviewed DON B (Director of Nursing) about R40's walking program. DON B indicated that when PT writes a plan of care for a resident's walking, they give a copy to the floor nurse who is responsible for entering them into the electronic health record. DON B indicated that she would expect that R40's electronic health record would have been updated with her current treatment plan, and she would expect the therapy plan of care to be followed.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility did not ensure each resident received the necessary respiratory care and services that are in accordance with professional standards of practice for 1 of 1 resident reviewed (R9) out of a total sample of 16.R9 has orders for a BiPAP (a noninvasive ventilatory device that helps patients breathe by delivering two levels of air pressure: higher during inhalation and lower during exhalation) that has not been applied properly and that CNA (Certified Nursing Assistant) staff were not trained to apply, Evidenced by:The facility's policy titled Noninvasive Ventilation (CPAP, BiPAP, AVAPS, Trilogy) no date, states in part .2. The facility will obtain an order for the use of CPAP, BiPAP, AVAPS, or Trilogy device and settings from the practitioner.5. The facility will follow manufacturer's instruction for use of the machine.The manufacturer's manual for R9's BiPAP machine ([NAME] DreamStation) states in part .Personnel qualifications: .The operator should read and understand this entire manual before using the device.Oxygen: When administering fixed-flow supplemental oxygen, the oxygen concentration may not be constant. The inspired oxygen will vary, depending on the pressures, patient flows, and circuit leak. Substantial leaks may reduce the inspired oxygen concentration to less than the expected value. Appropriate patient monitoring should be used. Supplemental oxygen: Oxygen (up to 15 LPM (Liters Per Minute) maybe entrained into the patient circuit provided that a pressure valve us used.R9 admitted to the facility on [DATE] with diagnoses that include hypertensive heart disease with heart failure, type 2 diabetes mellitus, chronic respiratory failure with hypoxia, and obstructive sleep apnea.R9's most recent MDS (Minimum Data Set) dated 6/15/26 states that R9 has a BIMS (Brief Interview for Mental Status) of 15 out of 15, indicating that R9 is cognitively intact. R9's MDS also indicates that she is dependent on staff for most of her ADLs (Activities of Daily Living) including bed mobility, transfers, personal hygiene, toileting, and bathing.R9's physician orders state the following:3/31/23: Place BiPAP at settings of S mode 12/5 with 30% FIO2 (the proportion of oxygen in the gas mixture that a person breathes in) which is 3L nc (nasal cannula) connected into BiPAP machine. Verify Distilled water is in resivoir [sic].5/28/26: BIPAP: Apply Bipap per settings with 3L bleed in. Assist resident to apply mask at HS (bedtime). Ensure unit is in working order. At Bedtime. Bleed in 3L, connected to Bi-pap machine. VERIFY DISTILLED WATER IS IN RESIVIOR [sic].R9's April 2026 MAR/TAR (Medication Administration Record/Treatment Administration Record) states that R9's BiPAP was signed out by a Med Tech 5 out of 21 opportunities.R9's May 2026 MAR/TAR states that R9's BiPAP was signed out by a Med Tech 4 out of 28 opportunities.R9's care plan states in part .Problem: Problem Start Date:10/25/2021. Requires Bi-pap at noc (night) r/t (related to) dx (diagnosis): chronic/acute respiratory failure and sleep apnea.Approach: .Approach Start Date: 9/7/2022. Place Bi-pap at settings of S mode 12/5, with 30% FIO2 which is 3/liters nc connected to Bi-pap machine. Observe oxygen precautions.It is important to note that there have not been any updates to R9's BIPAP care plan after their hospitalizations.Surveyor reviewed the facility's competency checklist for RNs (Registered Nurses,) LPNs (Licensed Practical Nurses,) and CNAs (Certified Nursing Assistants) - the facility does not have competency/trainings for staff regarding BiPAP use.On 4/14/2026 at 8:59 AM Nurses note states in part: Resident sent to [Hospital Name] ED (Emergency Department). Reported around 0700 that resident was combative while getting up for breakfast which is abnormal for her. Resident did not eat or drink anything at the breakfast table which is also abnormal. Upon observation at dining table, resident confused, slurred speech and not making sense. Lethargic, arms and neck flaccid. BP (Blood Pressure) 148/108 RR (Respiratory Rate) 16 T (Temperature) 97.7 O2 (Oxygen) 92%ra (room air) P (Pulse) 74. [DON Name], DON (Director of Nursing) aware, [Nurse Practitioner Name], APNP (Nurse Practitioner) aware, awaiting response from [POA Name] POA (Power of Attorney) .On 6/17/26 at 7:54 AM, Surveyor interviewed LPN G (Licensed Practical Nurse.) Surveyor asked LPN G about R9 and what occurred on 4/13/26-4/14/26, (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN G reported that they worked until 6:00 PM on 4/13/26 and they were monitoring R9 for confusion. LPN G stated that R9 had not gone to bed before they left so they passed onto the next shift that R9 would need her BiPAP put on. LPN G stated that when they came in the next morning, R9 did not have her BiPAP on.R9s note on 4/15/26 at 8:25 AM states in part: SW spoke with resident's mother this am regarding hospitalization. [Mother's Name] stated that resident is intubated and in ICU.It is important to note that facility documentation states that the Med Tech signed out R9's BiPAP on the TAR on 4/13/26.Hospital documentation states in part, the following:R9's note on 4/14/26 at 2:58 PM, History and Physical: [R9's Name, age] developmentally disabled [R9's gender].[R9's gender] has a chronic hypercapnic respiratory failure and is on Bipap all noight [sic] but noi [sic] extra O2 and no O2 during the day .I am told that [R9's gender] did not wear her Bipap last night and when staff checked on [R9's gender] the AM (morning), [R9's gender] was not responsive. [R9's gender] was brought to the [Hospital Name] ED and placed on Bipap but had significantly respiratory acidosis but did not awaken. Eventually, after discussion with the family [R9's gender] was intubated with the guidance of Anesthesia.Hospital lab results dated 4/14/26 at 9:46 AM:pH Venous 7.31 (L(Low))- blood is more acidic than average.pCO2 Venous 72 (HH (High))- indicates hypercapnia - an abnormally high level of carbon dioxide in the blood.pO2 Venous 57 (H)Bicarbonate Venous 36 (H)- indicator of the metabolic component of acid-base balanceO2 Saturation Venous 86%BE (Base Excess) Venous 7.2 (H)- indicates a metabolic alkalosisCO2 Total Venous 39 (H)- blood has a higher-than-normal bicarbonate contentHospitalist Discharge summary dated [DATE] at 11:47 AM states in part .Discharge Diagnoses: Acute respiratory failure with hypoxia and hypercapnia, acute hypoxemic respiratory failure.Hospital Course: [R9 Name, Age, Gender] with a history of chronic hypercapnic respiratory failure (BiPAP dependent at night), morbid obesity, sleep apnea, congenital hydrocephalus with VP shunt, myelopathy, and prior neck and back surgeries, who was admitted for acute respiratory failure with hypoxia and hypercapnia after being found unresponsive at [R9's gender] care facility following a missed BiPAP session. On admission, she was noted to have significant respiratory acidosis and altered mental status, prompting initiation of BiPAP in ED, followed by intubation for persistent hypoventilation and lack of improvement.[R9's gender] was managed in the ICU (Intensive Care Unit) with mechanical ventilation, sedation, and empiric antibiotics (used when a patient shows signs of infection, but the specific bacterium, fungus, or other pathogen has not yet been confirmed through laboratory tests or cultures).During her ICU course, she developed acute kidney injury, which is improved with supportive care and diuresis.Ventilator weaning was attempted over several days, with extubation to nasal cannula on 4/18 after successful trials of pressure support and clinical improvement. Post- extubation, she required BiPAP at night and supplemental oxygen during the day.R9 returned to the facility on 4/23/26.It is important to note that there have not been any updates to R9's BIPAP care plan after their hospitalizations.On 5/24/26 at 5:30 PM, Nurses note states in part: Writer was alerted to the hallway by CNA (Certified Nursing Assistant), CNA stated resident turned blue in DR (Dining Room), at that time resident was sitting in WC (wheelchair) being taken to room, resident alert, no coughing, no SOB (Shortness of Breath), no c/o (complaints), no Blue tinge noted. Writer made observation on resident, lungs diminished, no SOB, VSS (Vital Signs Stable), Afebrile, asked resident if she was ok, resident responded I'm fine, that's normal for me, that's my color, I have rocasea [sic] Resident assisted back to room, went to sleep with BIPAP on, no further c/o noted or reported.It is important to note that this note was entered on 6/16/26. Additionally, there were no vital signs documented on 5/24/26.5/25/26 at 11:04 AM: Resident blue/grey to face this morning upon writer walking into room to assist with hoyer transfer. Resident started bobbing head slightly. Resident had no complaints of SOB. No loss of consciousness. Alert and oriented x 4 still. SPO2 (oxygen level) was at 48%. Put her on 4L (liters) via nasal cannula and SPO2 increased to 85%. Writer seen that oxygen was not connected to her bipap machine last night. Lungs diminished posterior and anterior in all lobes. She has developed a wet productive cough. Writer was notified by staff that resident had aspiration event last night during dinner and turned blue to the face. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She was afebrile 98.4 and BP (Blood Pressure) 131/70. Pulse 111. RR (Respiratory Rate) 20. Oak medical was updated. Agreed with sending out via 911. 911 was called and EMS (Emergency Medical Service) arrived and resident was put on 8L via non re-breather mask. SPO2 increased to 96%. Resident requesting to be sent to SSM Janesville. Writer asked resident if she wanted writer to call her mother and she said only if she is admitted to the hospital. Resident was transferred to stretcher via hoyer and left via ambulance. Call placed to SSM Janesville ER (Emergency Room) and resident will be admitted for aspiration pneumonia and placed on IV ABX (Intravenous Antibiotics). Residents mother arrived to facility just now and was updated on resident. DON notified of residents send out/being admitted .On 6/17/26 at 3:15 PM, Surveyor interviewed LPN U and asked LPN U to explain the events of 5/24/26 regarding R9. LPN U stated that they were sitting at the nurse's station and the CNAs reported that R9 was turning blue. LPN U reported that they went to see R9 and they were sitting in front of their room, and they asked R9 what was going on. LPN U stated that R9's lungs were diminished, R9 had a cough, took vital signs and R9 was then put to bed. LPN U stated that R9 looked fine when they saw them. LPN U stated that R9 reported that they were that color because they had rosacea. Surveyor asked LPN U if rosacea turns skin blue, LPN U stated no, but R9 was not blue when they saw them. Surveyor asked LPN U if that means that the event did not occur, LPN U stated no. Surveyor asked LPN U if they notified the physician about the event, LPN U stated no because when they saw R9 they were fine and that did not need to be reported to the physician. Surveyor asked what R9's vital signs were at that time, LPN U stated that they did not know because they did not document them. Surveyor asked LPN U if R9's aspiration event was documented on the 24-hour board, LPN U stated no. Surveyor asked LPN U who applies R9's BiPAP at night, LPN U stated that it was either themselves or the CNAs. Surveyor asked LPN U if they knew if the CNAs had been trained on BiPAP, LPN U stated that they did not know. Surveyor LPN U if when they checked on R9 that night, did they have the BiPAP on, LPN U reported that they put it in their note, but are not sure if it was on.Hospital documentation states in part:5/25/26 at 11:20 AM: Hospitalist admission History and Physical.Chief Complaint: Hypoxia.History of present illness: Patient is a [R9 age and gender] with a history of Chronic hypercapnic respiratory failure, wears BiPAP at night.who is being admitted with pneumonia (new problem).The patient was recently admitted to [Hospital Name] between April 14 and 23 for hypercapnic respiratory failure requiring intubation.Most recently, the patient has had a cough for several days. Her mom says that yesterday it sounded wet. The patient also says that whenever she eats, she has coughing. This morning when staff at her facility checked her pulse ox it was in the low 80s.She was sent to the ER where she was found to be hypoxic and hypercapnic (excessive carbon dioxide in the blood) with multilobar pneumonia (a type of lung infection that affects more than one lobe of the lungs, often causing more severe illness than pneumonia confined to a single lobe.) She was placed on BiPAP.Abnormal lab results dated 5/25/26 at 11:00 AM include:pH Arterial 7.27 (H(High)) (indicates a significant acid-base disturbance)pCO2 Arterial 79 (HH) (indicates hypercapnia - an excess of carbon dioxide in the arterial blood.)HCO3 Arterial 36.3 (H) (indicates a metabolic alkalosis or a condition where the body has retained bicarbonate).O2 Saturation Arterial 99.1 (H)BE Arterial 6.5 (H) (the blood is more alkaline than normal).CT Angio Chest Pulm (Pulmonary) Embolism (the most common and effective imaging test for diagnosing pulmonary embolism) results dated 5/25/26 state in part: .2. As before, low lung volumes are noted along with elevated diaphragms, left more than right. 3. As before, significant atelectasis is seen of the both lower lobes, along with moderate size dense pneumonic appearing consolidations with some internal air bronchograms in the both lower lobes. However, there appears to be moderate worsening in the right lower lobe and mild worsening in the left lower lobe. 4. Note is made of low density mucoid contents in the lumen of the main bronchi of both lower lobes, suggestive of either mucus impaction or obstructing lesions causing combination of aspiration and/or postobstructive pneumonia with atelectasis.XR Chest 1Vw Portable (Chest x-ray 1 view) results dated 5/25/26: Personally reviewed and shows very diminished lung volume, suspect bilateral lower lobe pneumonia. (continued on next page)

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	525241	A. Building B. Wing	06/18/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assessment and Plan: .I suspect she has aspiration due to the history and appearance on CT. Continue BiPAP. Recheck VBG (Venous Blood Gases). Continue cefepime and vanco (antibiotics). Follow up with blood and sputum cultures. Consider Pulmonary consult tomorrow if not improved, due to appearance of significant mucus plugging on CT. Speech evaluation for aspiration once stable.Hospitalist note dated 5/26/26 at 2:52 PM states in part Reason for visit: Hypoxic hypercarbic respiratory failure. [R9] was able to come off BiPAP this morning and maintain her sats on 4L to 6L of nasal cannula oxygen.Also of note she has extremely poor inspiratory effort and deep inspiration triggers causing coughing jags are problematic for her. At baseline, her mother reports that she does not have significant cough so this is all likely new related to a recent aspiration event.Assessment and Plan: .I suspect she has aspiration pneumonia nd [sic] bronchitis due to the history and appearance on CT, baseline restrictive ung [sic] disease duet o [sic] [NAME] (Obesity Hypoventilation Syndrome), kyphosis, and atelectasis requiring Bipap at night. Continue BiPAP at night, monitor on cannula vs open mask O2 (oxygen) today. Continue cefepime.follow up blood and sputum cultures. Bronchial hygiene, incentive spirometry. Speech evaluation for silent aspiration with VSS. Dose Lasix 20 IV since held on admission.Hospitalist note dated 5/27/26 at 3:57 PM states in part Reason for visit: Hypoxic hypercarbic respiratory failure. [R9] did well on her video swallow evaluation today. She is not short of breath reportedly but is still requiring 4L of nasal cannula oxygen to maintain her sats over 89%. She is coughing intermittently but producing minimal sputum.It is important to note that R9 received IV antibiotics throughout their hospitalization.R9 returned to the facility on 5/28/26.On 6/17/26 at 7:54 AM, Surveyor interviewed LPN G and asked LPN G to explain the events that occurred with R6 on 5/25/26, LPN G stated the CNA that was providing cares for R9 asked for assistance with a transfer and reported that R9 was blue/gray in color and didn't look right. R9 was bobbing her head, pulse ox was 48% and then it jumped to 55%. LPN G stated R9 was able to answer questions and was talking to them. LPN G stated they noted that R9's oxygen concentrator was not on and was not connected to her BiPAP machine. LPN G stated they got R9 up into the wheelchair, R9 started coughing with a wet cough, oxygen was applied at 4 liters and they were unable to get R9's sats up higher. LPN G stated they called the physician and EMS for evaluation. LPN G reported that the kitchen staff reported that R9 had turned blue at dinner the night before, and it was reported to the nurse who stated that R9 was fine and walked away. Surveyor asked LPN G how a change of condition is communicated between shifts, LPN G stated that it is usually reported at change of shift, but no one had said anything about R9's aspiration event. Surveyor asked LPN G who is responsible for applying R9's BiPAP, LPN G stated that the CNAs and nurses work together and then the nurse has to check it. LPN G stated that R9 never puts her mask on early, it's usually around 10:00 PM before she is ready. LPN G reported that R9 has orders for the nurse to ensure that the O2 is bled into the BiPAP and that there is water in the reservoir.On 6/17/26 at 9:24 AM, Surveyor interviewed R9. Surveyor asked R9 what time she likes to have her BiPAP put on, R9 stated between 8:00 PM- 9:00 PM. Surveyor asked R9 if she's ever had it put on at 5:30 PM, R9 stated no.On 6/17/26 at 11:13 AM, Surveyor interviewed CNA K. Surveyor asked CNA K to explain the aspiration event with R9 on 5/24/26, CNA K reported that last night (6/16/26), the nurse called them and asked if R9 was blue, CNA K stated that R9 reported that she was fine and that they passed it on to another CNA. CNA K stated they had R9's group and reported to Surveyor that R9 didn't look right that night. CNA K stated they think the other CNA reported the incident to the nurse but is not sure and that they just left it alone. Surveyor asked CNA K who typically applies R9's BiPAP, CNA K stated the CNAs put it on. Surveyor asked CNA K what time R9 likes for the BiPAP to be applies, CNA K stated between 8:30 PM-9:00 PM. Surveyor asked CNA K on 5/24/26 was R9's BiPAP put on at 5:30, CNA K stated no, and they don't think R9 was even at bed at that time, typically R9 goes to bed late. Surveyor asked CNA K who typically applies R9's BiPAP at night, CNA K stated the CNAs do. Surveyor asked CNA K if they had been trained on how to apply a BiPAP, CNA K stated no. Surveyor asked CNA K if they connect the oxygen to the BiPAP machine, CNA K stated they assume the machine is already set up and ready (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to go.On 6/17/26 at 12:32 PM, Surveyor interviewed CNA P and asked CNA P to explain the events on 5/24/26 regarding R9. CNA P stated they were at the nurse's station and another CNA called and said R9 was blue so they went to see R9. CNA P stated when they got to R9, she was blue in the face. CNA P stated they ran to get the nurse and by the time the nurse got down there, R9 was not blue anymore. CNA P stated the nurse asked R9 if she was ok and R9 stated yes. Surveyor asked CNA P if the nurse did an assessment, CNA P stated they said they were going to and then walked away. Surveyor asked CNA P if they have put R9's BiPAP on at night, CNA P stated yes and that they know how to put a C-PAP on. Surveyor asked CNA P if they had training on how to apply R9's BiPAP, CNA P stated they haven't been trained at this facility but have been trained at another and they know how to put a C-PAP on.It is important to note that R9 does not have a C-PAP machine.On 6/17/26 at 1:21 PM, Surveyor interviewed CNA T, who is also a Med Tech. Surveyor asked CNA T if they have been trained on how to apply R9's BiPAP, CNA T stated no. Surveyor asked CNA T if the CNAs and Med Techs typically apply R9's BiPAP at night, CNA T stated 100% of the time.On 6/17/26 at 1:34 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B when they became aware of R9's aspiration event from 5/24/26, DON B stated they were not aware of an aspiration event occurring on 5/24/26, because there was no documentation indicating an aspiration event and they were not contacted. DON B stated they read the nurse's note on 5/25/26 and then became aware of an aspiration event. Surveyor asked DON B if they would expect a change of condition to be documented timely, DON B stated yes. Surveyor asked DON B if the provider was updated on 5/24/26, DON B stated not that they were aware of. Surveyor asked DON B if the provider should have been updated, DON B stated yes. Surveyor and DON B reviewed LPN U's late documentation from 5/24/26. Surveyor asked DON B what R9's vital signs were at that time, DON B stated there were none documented. Surveyor asked DON B how changes of condition are reported shift-to-shift, DON B stated they have a 24-hour board that changes are put on. Surveyor asked DON B if this event was put on the 24-hour board, DON B stated they would have to look. Surveyor asked DON B if R9's change of condition should have been passed on to the next shift and respiratory assessments should have been completed, DON B stated yes. Surveyor asked DON B who is responsible for applying a BiPAP to a resident, DON B stated the nurses. Surveyor asked DON B if the CNAs/Med Techs have had training on how to apply a BiPAP, DON B stated not since they have been at the facility.On 6/18/26 at 8:18 AM, CNO D (Chief Nursing Officer) reported to Surveyor that there are no CNA competencies for BiPAP/C-PAP.On 6/16/26 at 8:25 AM, Surveyor interviewed CNA W and asked if they have ever applied R9's BiPAP, CNA W stated yes. Surveyor asked CNA W to explain the process, CNA W stated there are 3 parts - the mask set up, the CPAP, and the oxygen. CNA W stated they have to make sure that the oxygen is attached but believes that they are waiting for a part. Surveyor asked CNA W if they have received any training from the facility about BiPAPs, CNA W stated no.On 6/18/26 at 8:32 AM, Surveyor interviewed CNA Q and asked if they got R9 up for the day, CNA Q stated yes. Surveyor asked V to explain what R9's BiPAP set up looked like this morning, CNA Q stated it was strapped on her face, and she had the oxygen on underneath it. Surveyor asked CNA Q if the oxygen tube was connected to the BiPAP, CNA Q stated no and that R9 had the nasal cannula on under the mask. Surveyor asked CNA Q if they have received any training on BiPAP machines, CNA Q stated no.On 6/18/26 at 8:43 AM, Surveyor interviewed DON B. Surveyor asked DON B if a resident on BiPAP should have a nasal cannula attached to the oxygen concentrator underneath the BiPAP mask, DON B stated no because there would not be a good seal. Surveyor asked DON B if having the nasal cannula attached to the oxygen concentrator be considered and oxygen bleed to the BiPAP machine, DON B stated no.On 6/18/26 at 9:59 AM, Surveyor interviewed RT X (Respiratory Therapist-from DME (Durable Medical Equipment) provider). Surveyor asked RT X what a BiPAP set up should look like, RT X stated that there should be oxygen to the machine, then a corrugated line with oxygen adapter, then the mask is placed on the resident. RT X stated that there should be an adapter for oxygen, and the oxygen tubing connects the BiPAP to the oxygen concentrator. Surveyor asked RT X if there would (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ever be a time to use a nasal cannula under the BiPAP mask, RT X stated no because you wouldn't get a good seal.The facility did not ensure that nursing staff had proper training to apply a BiPAP to R9. cross reference F684.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not ensure laboratory services were obtained as ordered by the physician for 1 of 3 residents (R19) reviewed for laboratory services out of 16 sampled Residents. R19's laboratory orders were not carried out as ordered. Evidenced by: R19 was admitted to the facility on [DATE] with diagnoses that include alcohol dependence, history of a stroke, toxic encephalopathy, vascular dementia, and adjustment disorder with anxiety. R19 is being seen by a behavioral health Nurse Practitioner (NP). On 6/9/26, the facility had a Quarterly Psychotropic Review. Documentation states in part: Medication.depakote, olanzapine. Target Behavior: 1. Paranoid Behaviors. 2. Agg-Abuse behave (behavior). Paranoia beh- accusatory of theft etc. at home in past. Depakote lab ordered for levels. Surveyor reviewed R19's electronic health record and did not find documentation of the behavior meeting or orders for labs to be drawn. On 6/16/26 at 2:55 PM, Surveyor interviewed Behavioral Health NP Y (Nurse Practitioner). NP Y reported that they had a behavior meeting with the facility on 6/9/26 and had ordered labs to be drawn prior to increasing R19's medications. Surveyor asked NP Y when the labs were to be drawn, NP Y stated on the facility's next lab day.On 6/16/26 at 3:19 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B when R19's labs that were ordered on 6/9/26 were drawn, DON B stated that they would call the lab. DON B reported that the facility's lab draws are done on Mondays and Thursdays. DON B called the lab with Surveyor present and found that R19 has not had any labs drawn since the behavior meeting on 6/9/26.DON B provided Surveyor with written communication from the facility/ provider Huku app stating in part . 6/9/26 at 1:00 PM We need Depakote, CMP (Complete Metabolic Panel) & CBC (Complete Blood Count) level on resident. [Behavioral Health NP Name] wants to increase resident's Depakote. 6/9/26 at 2:23 PM [Primary NP Name] Noted, please add to 6/11 lab day.On 6/16/26 at 5:45 PM, R19's Nurses note states in part: Labs drawn to left hand x1 stick. CBC, CMP and Depakote level. Resident tolerated fair. No bruising or active bleeding noted.On 6/17/26 at 10:59 AM, Surveyor interviewed DON B. Surveyor asked DON B who participated in R19's behavior meeting on 6/9/26, DON B stated NP Y, the pharmacist, the Social Worker, and that they couldn't remember if they were there or not. Surveyor asked DON B who is responsible for entering the orders that were given during the meeting, DON B stated that NP Y sends the recommendations, the Social Worker gets them and is supposed to pass them to myself. Surveyor asked DON B what happened with R19's labs, DON B reported that they didn't get done but were obtained yesterday (6/16/26). Surveyor asked DON B if the orders were put in prior to yesterday, DON B stated no. Surveyor asked DON B if the provider was made aware that the labs were not obtained as ordered, DON B stated no.