STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525242	A. Building B. Wing	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Kensington	1810 Kensington Dr Waukesha, WI 53188

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility did not ensure 1 (R50) of 1 injury of unknown origin that was reviewed was submitted to the State survey agency. On 4/22/25, R50's daughter informed the facility of a bruise on R50's left eyelid of R50's left eye. The facility did not report this injury of unknown source to the State survey agency. Findings include: The facility's policy dated November 2024 and titled, Abuse, Neglect and Exploitation documents under the policy section: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Under section IV Identification of Abuse, Neglect and Exploitation includes documentation of B. Possible indicators of abuse include, but are not limited to: 3. Physical injury of a resident, of unknown source. Under section VII. Reporting/Response documents A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g. law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. 1.) R50's diagnosis includes diabetes mellitus (high blood sugar), urinary retention, metabolic encephalopathy (metabolic disturbances affecting how the brain functions), malignant neoplasm (cancer) of lateral wall of bladder, hypertension (high blood pressure) and depression. R50's significant change MDS (minimum data set) with an assessment reference date of 4/10/25 documents a BIMS (brief interview mental status) score of 15 which indicates that R50 is cognitively intact. Surveyor reviewed R50's nurses notes from 4/12/25 to 4/21/25 and did not note any documentation of R50 having trouble putting his glasses on and/or hitting his face with his glasses. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R50's nurses note dated 4/22/25 at 18:21 (6:21 p.m.) written by Licensed Practical Nurse/Unit Manager (LPN/UM)-E documents: Daughter brought to staff's attention a bruise to resident's left eye lid that she noticed on Sunday. Bruise was not reported to staff, and staff just noticed it today. Writer assessed resident, bruise is covering almost the entire eyelid, resident reports no pain. Resident is a hoyer. Daughter shared she noticed that resident rests the left side of his face against the hoyer sling during transfers, and she had to apply a towel to secure resident's head straight. Hoyer education will be provided for staff. CNAs (Certified Nursing Assistant) reported to writer that resident has a hard time trying to put on his glasses and keeps on hitting different spots on his face before getting behind his ears. Resident wants to be independent but refuses assistance. Writer spoke with resident and asked him to allow staff to assist to avoid injuries. R50's head to toe skin check dated 4/22/25 under the skin integrity section is checked for new bruises. Under the describe new or existing other issues it states: Bruise to left eyelid. Under the site section it documents: 4) Face, type is Bruising, length in centimeters is 4 and width in centimeters is 2.5. Under the further description of skin issues section it documents: Bruise covering left eyelid. R50's nurses note dated 4/23/25 at 06:42 (6:42 a.m.) and written by Registered Nurse (RN)-S documents: Res. (Resident) has flat bruise to lateral left upper lid and to skin lateral of eye. Bruise is purple. Res. states he was not injured in any way that he is aware of. Slept well in intervals with no c/o's (complaint of) pain. R50's nurses note dated 4/23/25 at 10:46 a.m. and written by Director of Nursing (DON)-B documents: IDT (interdisciplinary team) met and discussed: 4-22-25 1450 (2:50 p.m.) Daughter brought to staff (unit manager) attention a bruise to resident's left eyelid, that she shared she noticed it on Sunday but did not say anything then. Very tiny on Sunday she thought maybe because he was resting his face on sling in hoyer. I have no idea how it happened. I did not hit or bump my eye I do not think. Nobody hurt me. Nurse assessed resident, bruise is covering almost the entire eyelid, resident reports no pain. Resident is a hoyer. Daughter shared she noticed that resident rests the left side of his face against the hoyer sling during transfers, and she had to apply a towel to secure resident's head straight. Hoyer education will be provided for staff. CNAs reported to writer that resident has a hard time trying to put on his glasses and keeps on hitting different spots on his face before getting behind his ears. Resident wants to be independent but refuses assistance. Nurse spoke with resident and asked him to allow staff to assist to avoid injuries with glasses and/or other tasks. Denies any pain. NP (Nurse Practitioner) updated. New interventions: offer wash cloth against cheek to keep head straight in hoyer sling, hoyer education with staff, offer A1 (assist one) with glasses. R50's nurses note dated 4/23/25 at 21:51 (9:51 p.m.) and written by Licensed Practical Nurse (LPN)-U documents: Resident has ecchymosed sic (ecchymosis) area to left eye. Skin remains intact, no c/o pain or discomfort. Resident denied any trauma and was unable to recall incident. Denied double or blurred vision, no s/sx (signs/symptoms) of trauma to sclera. R50's nurses note dated 4/24/25 at 14:51 (3:51 p.m.) and written by Infection Control (IC)/RN-T documents: Resident continues to be monitored for 2000FR (fluid restriction). FR maintained this shift. Resident continues with bruise to L (left) eye remains dark Burgundy in color, no c/o (complaint of) pain or discomfort noted. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/19/25, at 11:10 a.m., Surveyor informed R50 last month he had a bruise on his left eye and asked R50 if he remembers what caused the bruise. R50 replied no. R50's representative, who was also in the room, informed Surveyor she saw the bruise on Sunday and was bigger on Monday & Tuesday. R50's representative thought it was from the hoyer lift and after the bruise occurred, staff started to put a towel on the hoyer. On 5/20/25, at 12:02 p.m., Surveyor asked Licensed Practical Nurse/Unit Manager (LPN/UM)-E if R50's injury of unknown source to R50's left eye lid was reported to the State Agency. LPN/UM-E replied that's a question for [first name of Nursing Home Administrator (NHA)-A]. On 5/20/25, at 12:39 p.m., Surveyor asked NHA-A if R50's bruise on left eye identified on 4/22/25 was reported to the State agency. NHA-A replied no. Surveyor asked NHA-A why this wasn't reported. NHA-A replied we didn't feel it was of unknown origin. Surveyor asked NHA-A how this was determined. NHA-A informed Surveyor R50 hits himself with his glasses. Surveyor asked NHA-A if there was any concerns with the hoyer lift. NHA-A replied I don't recall I'll have to look back. Surveyor informed NHA-A R50's bruise to the left eye lid should have been reported as the eye isn't an area which generally bruises. NHA-A informed Surveyor the eye is an area does get bruised often. On 5/20/25, at 1:59 p.m., NHA-A informed Surveyor the eye is not an area that is suspicious if you wear glasses and informed Surveyor she gathered information regarding R50's bruise. Surveyor asked NHA-A for any information regarding R50's injury of unknown source. On 5/20/25, at approximately 3:45 p.m., Surveyor reviewed information provided by NHA-A during regarding R50's injury of unknown source. Surveyor noted included in this information is Division of Quality Assurance's Injury of Unknown Source Flowchart. Surveyor noted this flowchart was not completed to show on the Facility determined this injury of unknown source did not need to be reported to the State agency. A statement from Med Tech-V that wad not dated indicated R50 had difficulty putting on glasses & often jabbed the nose piece or the arms of the glasses into his face and education to staff regarding hoyer education as R50's representative thought the hoyer lift could have caused the injury. On 5/21/25, at 10:20 a.m., Surveyor informed NHA-A that Surveyor had reviewed the facility's Abuse, Neglect and Exploitation policy and asked if there is any other policy that address injury of unknown source. NHA-A informed Surveyor she will have to look. Surveyor informed NHA-A R50's bruise to the left eye should have been reported as the injury was not observed by anyone, a CNA thought it was due to his glasses but R50's representative thought the hoyer lift, R50 did not know how he sustained the bruise, and the bruise is in a location not generally vulnerable to trauma, R50's left eye with measurements of 4 by 2.5 cm (centimeters). NHA-A stated it was little, referring to the size of R50's bruise. NHA-A informed Surveyor she read the regulations and did not consider the eye suspicious because R50 wears glasses and stated to Surveyor we have a difference of opinion. No additional information was provided as to why the facility did not report R50's injury of unknown source to the State Agency.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, the facility did not have evidence that an injury of unknown source was thoroughly investigated for 1 (R50) of 1 residents. On 4/22/25, R50 was observed to have a bruise to the left eye. This injury of unknown source was not thoroughly investigated. Findings include: The facility's policy titled, Abuse, Neglect and Exploitation and reviewed/revised 11/24 under Policy documents It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Under section V. Investigation of Alleged Abuse, Neglect and Exploitation documents A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigation include: 1. Identifying staff responsible for the investigation; 2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence); 3. Investigating different types of alleged violations; 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and other who might have knowledge of all the allegations; 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation. 1.) R50's diagnosis includes diabetes mellitus (high blood sugar), urinary retention, metabolic encephalopathy (metabolic disturbances affecting how the brain functions), malignant neoplasm (cancer) of lateral wall of bladder, hypertension (high blood pressure) and depression. R50's significant change MDS (minimum data set) with an assessment reference date of 4/10/25 documents a BIMS (brief interview mental status) score of 15, which indicates R50 is cognitively intact. Surveyor reviewed R50's nurses notes from 4/12/25 to 4/21/25 and did not note any documentation of R50 having trouble putting his glasses on and/or hitting his face with his glasses. R50's nurses note dated 4/22/25 at 18:21 (6:21 p.m.) written by Licensed Practical Nurse/Unit Manager (LPN/UM)-E documents Daughter brought to staff's attention a bruise to resident's left eye lid that she noticed on Sunday. Bruise was not reported to staff, and staff just noticed it today. Writer assessed resident, bruise is covering almost the entire eyelid, resident reports no pain. Resident is a hoyer. Daughter shared she noticed that resident rests the left side of his face against the hoyer sling during transfers, and she had to apply a towel to secure resident's head straight. Hoyer education will be provided for staff. CNAs (Certified Nursing Assistant) reported to writer that resident has a hard time trying to put on his glasses and keeps on hitting different spots on his face before getting behind his ears. Resident wants to be independent but refuses assistance. Writer spoke with resident and asked him to allow staff to assist to avoid injuries. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R50's head to toe skin check dated 4/22/25 documents under the skin integrity section: new bruises. Under the describe new or existing other issues section it documents Bruise to left eyelid. Under the site section it documents 4) Face, type is Bruising, length in centimeters is 4 and width in centimeters is 2.5. Under the further description of skin issues section it documents: Bruise covering left eyelid. R50's nurses note dated 4/23/25 at 06:42 (6:42 a.m.) and written by Registered Nurse (RN)-S documents Res. (Resident) has flat bruise to lateral left upper lid and to skin lateral of eye. Bruise is purple. Res. states he was not injured in any way that he is aware of. Slept well in intervals with no c/o's (complaint of) pain. R50's nurses note dated 4/23/25 at 10:46 a.m. and written by Director of Nursing (DON)-B documents IDT (interdisciplinary team) met and discussed: 4-22-25 1450 (2:50 p.m.) Daughter brought to staff (unit manager) attention a bruise to resident's left eyelid, that she shared she noticed it on Sunday but did not say anything then. Very tiny on Sunday she thought maybe because he was resting his face on sling in hoyer. I have no idea how it happened. I did not hit or bump my eye I do not think. Nobody hurt me. Nurse assessed resident, bruise is covering almost the entire eyelid, resident reports no pain. Resident is a hoyer. Daughter shared she noticed that resident rests the left side of his face against the hoyer sling during transfers, and she had to apply a towel to secure resident's head straight. Hoyer education will be provided for staff. CNAs reported to writer that resident has a hard time trying to put on his glasses and keeps on hitting different spots on his face before getting behind his ears. Resident wants to be independent but refuses assistance. Nurse spoke with resident and asked him to allow staff to assist to avoid injuries with glasses and/or other tasks. Denies any pain. NP (Nurse Practitioner) updated. New interventions: offer wash cloth against cheek to keep head straight in hoyer sling, hoyer education with staff, offer A1 (assist one) with glasses. R50's nurses note dated 4/23/25 at 21:51 (9:51 p.m.) and written by Licensed Practical Nurse (LPN)-U documents Resident has ecchymosed sic (ecchymosis) area to left eye. Skin remains intact, no c/o pain or discomfort. Resident denied any trauma and was unable to recall incident. Denied double or blurred vision, no s/sx (signs/symptoms) of trauma to sclera. R50's nurses note dated 4/24/25 at 14:51 (3:51 p.m.) and written by Infection Control (IC)/RN-T documents Resident continues to be monitored for 2000FR (fluid restriction). FR maintained this shift. Resident continues with bruise to L (left) eye remains dark Burgundy in color, no c/o (complaint of) pain or discomfort noted. On 5/19/25, at 11:10 a.m., Surveyor informed R50 last month he had a bruise on his left eye and asked R50 if he remembers what caused the bruise. R50 replied no. R50's representative who was also in the room informed Surveyor she saw it on Sunday and was bigger on Monday & Tuesday. R50's representative thought it was from the hoyer lift and after the bruise staff started to put a towel on the hoyer. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/20/25, at 12:02 p.m., Surveyor asked Licensed Practical Nurse/Unit Manager (LPN/UM)-E if there was an investigation for R50's left eye bruise identified on 4/22/25. LPN/UM-E replied yes we investigated and explained R50's representative kind of assisted them. LPN/UM-E explained R50 was a hoyer lift at that time, every time R50 was brought up R50 would turn his face so a towel was folded on the side. LPN/UM-E informed Surveyor she asked the CNA right after. LPN/UM-E informed Surveyor after R50 came back from the hospital R50 really declined, R50 used to be a stand pivot and after hospitalization R50 was a hoyer. LPN/UM-E informed Surveyor R50 was hallucinating, changed the Gabapentin and the way R50 was trying to put on his glasses was going everywhere on R50's face. LPN/UM-E informed Surveyor R50 tries to be independent and wasn't realizing he needed help. Surveyor asked LPN/UM-E the CNA who she spoke with did she write down what the CNA said or did the CNA write down a statement. LPN/UM-E replied no he did not. Surveyor asked LPN/UM-E who she spoke with during the investigation. LPN/UM-E replied the daughter, first name of Med Tech-V, obviously first name of DON-B and first name of NHA-A because they didn't know how the bruise happened so they had to figure it out. Surveyor asked LPN/UM-E if any other staff were interviewed. LPN/UM-E replied I can't remember, know we were having a conversation with first name of Med Tech-V. LPN/UM-E informed Surveyor R50 was confused, he had declined and R50 said he had no idea how it happened. LPN/UM-E informed Surveyor she implemented an intervention of putting a towel so R50 wasn't against the sling. On 5/20/25, at 1:59 p.m., NHA-A informed Surveyor she gathered information regarding R50's bruise. Surveyor asked NHA-A for any information regarding R50's left eye bruise. On 5/20/25, at approximately 3:45 p.m., Surveyor reviewed information provided by NHA-A during the end of the day meeting regarding R50's injury of unknown source. Surveyor noted included in this information is Division of Quality Assurance's Injury of Unknown Source Flowchart. A statement from Med Tech-V not dated which documents [R50's name] had difficulty putting on glasses, often jabbed the nose pieces or the arms of the glasses into his face. Most likely cause of the bruising documented 4/22/25. A statement from LPN/UM-E dated 5/20/25 which documents On 4/22/25, I [LPN/UM-E's name] received a verbal statement from CNA (Certified Nursing Assistant)[Med Tech-V's name] that he observed resident hitting his eye several times with his glasses while attempting to put them on. A note NP (Nurse Practitioner) 4/23, 4/25, & 4/30 had no concerns. R50's head to toe skin check dated 4/22/25 under the skin integrity section is checked for new bruises. Under the describe new or existing other issues section it documents Bruise to left eyelid. Under the site section it documents 4) Face, type is Bruising, length in centimeters is 4 and width in centimeters is 2.5. Under the further description of skin issues section it documents Bruise covering left eyelid. A handwritten note which documents completed hoyer education as a precautionary, since the R50's family member felt it may have come from leaning on the hoyer with education material & in-service sign in sheets. Surveyor noted there is was no evidence other staff who provided cares to R50 on 4/20/25, the day R50's representative stated she first observed the bruise, 4/21/25, or 4/22/25 other than Med Tech-V were interviewed regarding R50's left eye bruise. On 5/21/25, at 10:20 a.m., Surveyor informed NHA-A R50's there is not evidence R50's left eye bruise was thoroughly investigated. No additional information was provided.

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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** 3.) R62 was transferred to the hospital on 2/7/25 after experiencing a change of condition. R62 was discharged from the hospital and returned to the facility on 2/18/25. Surveyor conducted a review of R62's medical record and could not locate any evidence that R62 or their representative were given the required bed hold notice information in writing to identify the reserve bed payment rate for all payer sources for R62's bed hold after 15 days. The Ombudsmen was not notified of 62's transfer and discharge on [DATE]. No additional information was provided. Based on interview and record review, the facility did not ensure 10 (R16, R50, R62, R23, R33, R9, R12, R40, R58, & R72) of 10 residents reviewed were notified of the reason for transfer/discharge in writing to the resident & their representative. Residents were not notified of the rate to reserve the residents bed because it was not documented in the transfer & discharge notice and the ombudsman was not notified of the transfer/discharge. Findings include: The facility's policy titled, Bed Hold Notice and date reviewed/revised 2/2025 under Policy documents It is the policy of this facility to provide written information to the resident and/or the residents representative regarding bed hold practices both well in advance, and at the time of, a transfer for hospitalization or therapeutic leave. The facility's policy titled, Transfer and Discharge (including AMA (against medical advice)) and date reviewed/revised 2/2025 under Policy Explanation and Compliance Guidelines documents 5. The facility will maintain evidence that the notice was sent to the Ombudsman. Under section 10 Emergency Transfers to Acute Care g. documents Provide a notice of transfer and the facility's bed hold notice policy to the resident and representative as indicated. h.The Social Services Director, or designee, will provide copies of notices for emergency transfers to the Ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis, as long as the list meets all requirements for content of such notices. On 5/19/25, at 1:24 p.m., Surveyor asked Social Service Director (SSD)-P who notifies the Ombudsman of residents who have been transferred or discharged . SSD-P informed Surveyor Medical Records Director (MRD)-Q. Surveyor asked SSD-P if she is involved when a resident is transferred or discharged to the hospital. SSD-P informed Surveyor she might assist with printing paperwork or opening the door for the ambulance. Surveyor asked SSD-P if she has any involvement with transfer/discharge notices or bed hold forms. SSD-P replied no. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/19/25, at 1:30 p.m., Surveyor asked MRD-Q if she is responsible for notifying the Ombudsman of resident transfers/discharges. MRD-Q replied not any more. MRD-Q explained it was changed to the MDS (minimum data set) nurse but she doesn't think they taught the MDS nurse to do it. Surveyor asked when the notification was changed to the MDS nurse. MRD-Q informed Surveyor three years ago. MRD-Q informed Surveyor she used to send it once a month. MRD-Q explained PCC (pointclickcare) came up with a report, MDS would print and send the report. MRD-Q informed Surveyor when the MDS nurse left she asked her when she sent the reports and she told her she wasn't doing it. Surveyor asked MRD-Q who is the MDS nurse now.MRD-Q replied there isn't one, she just moved on, she's been gone for two weeks. Surveyor asked MRD-Q if she is involved with transfer/discharge notices or bed hold when a resident goes to the hospital. MRD-Q replied no. MRD-Q informed Surveyor there is a transfer notice. Surveyor then accompanied MRD-Q to the one central nurses station. MRD-Q looked for the transfer/discharge notice form but wasn't able to find one and asked Licensed Practical Nurse (LPN)-R where they keep the transfer/discharge notice form. LPN-R informed MRD-Q she thought it was in the computer. MRD-Q then called Unit Secretary (US)-N asking where the new transfer/discharge notice forms are. US-N indicated they were in her office. On 5/19/25, at 1:45 p.m., Surveyor asked US-N who completes the transfer/discharge notice form. US-N informed Surveyor she does and if she's not here then the nurse will do it. Surveyor asked where these forms are kept. US-N informed Surveyor in the business office. US-N explained if the resident has a POA (power of attorney) she will get a verbal consent. If the resident is their own person and is able to sign she will have them sign. If the resident can't sign then she will get a verbal consent. On 5/20/25, at 8:45 a.m., Nursing Home Administrator (NHA)-A informed Surveyor the MDS (minimum data set) nurse was the one who sent the transfer/discharge list to the ombudsman. NHA-A stated that when the MDS nurse left and they hired a new MDS person but that the transfer/discharge duties were not transferred to the new MDS nurse. Surveyor asked when the MDS nurse left. NHA-A replied about a year ago. NHA-A stated to Surveyor we did a PIP (performance improvement plan), transferred the responsibility to medical records and sent a list to [name of] Ombudsman for residents who have been discharged during the last three months. Surveyor informed NHA-H since the MDS nurse left a year ago until yesterday there has been no notification to the Ombudsman for transfers/discharges. NHA-A replied correct, we've talked to her about other things. Surveyor was provided with the PIP not dated and an email to the ombudsman dated 5/19/25. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/20/25, at 9:40 a.m., Surveyor showed US-N the transfer/discharge notice. US-N informed Surveyor she does these forms if she is here but she's not here on the weekends. US-N informed Surveyor she will get a verbal consent and will send the form if the POA requests it. US-N explained some of the POA's live out of state. Surveyor asked US-N if she is the one who sends the form if requested. US-N replied no me personally I would have the receptionist type the envelope. Surveyor asked US-N if Surveyor was a POA for a resident how would Surveyor know what the cost of the room is to hold the bed. US-N informed Surveyor the business office helps out with all that. If the resident is title 19 the room is automatically saved, if they are private pay that's when we have to tell them the rate. Surveyor asked US-N if she tells the POA what the room rate is or does the business office. US-N informed Surveyor she doesn't have the rates for that. US-N informed Surveyor the nurses will call the POA and let them know why they are sending the resident out. US-N informed Surveyor the white copy of the transfer/discharge notice goes to the hospital and they keep the yellow copy. US-N informed Surveyor sometimes if the nurses are doing the transfer/discharge notice they send the yellow to the hospital and keep the white copy. Surveyor stated to US-N the white copy goes to the hospital, facility keeps the yellow copy, and a copy is sent to the POA if they request it. US-N replied correct. On 5/20/25, at 10:12 a.m. Surveyor asked Business Office Manager (BOM)-O if she is involved with residents being transferred/discharged to the hospital. BOM-O informed Surveyor the only time she gets involved is when she gets the transfer/discharge notices, other than that no. Surveyor asked what she does with these transfer/discharge notices. BOM-O explained the first thing she does is check to see if the nurse or unit secretary has filled them out correctly & if they marked bed hold or no bed hold. BOM-O explained if they are private pay in their computer and don't have a secondary insurance she always calls the POA to see if they want to pay for the bed hold. Surveyor asked if this is documented anywhere. BOM-O replied just on the bed hold sheets. Surveyor asked if a resident is medicaid would she contact the resident representative. BOM-O replied no. Surveyor asked if the transfer/discharge notice are mailed out. BOM-O informed Surveyor the white one goes to the hospital and the yellow one gets mailed to the family. Surveyor asked BOM-O if she documents the bed hold rates and reason for transfer are documented anywhere. BOM-O replied no. 1.) R16's diagnoses includes seizures (sudden burst of electrical activity in brain which can cause changes in behavior, movement, & level of consciousness), neurogenic bowel (loss of normal bowel function caused by a nerve problem), and hemiplegia (paralysis on one side of the body) & hemiparesis (weakness on one side of the body) following cerebral infarction (type of stroke) affecting right dominate side. R16's power of attorney for healthcare was activated on 12/8/21. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Kensington	1810 Kensington Dr Waukesha, WI 53188

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R16's nurses note dated 2/21/25, at 04:01 (4:01 a.m.) written by Licensed Practical Nurse (LPN)-K documents Resident was sent out via 911 ambulance at 0300 (3:00 a.m.). Writer was notified by floor CNA (Certified Nursing Assistant) that Res (Resident) was not doing well when she went in to do his cares. Writer immediately went to residents room and he was sitting up in bed visibly working hard to breath and writer could hear crackles in his chest standing at bedside. Writer listened to residents chest with stethoscope and heard loud lung crackles. Resident was diaphoretic, jaundice in his face/eyes, his whole right arm was purple, his torso and lower extremities were gray, his feet and ankles were more swollen than normal. BP (blood pressure): 79/56, HR (heart rate): 95, T (temperature):97.3, O2 (oxygen): 70% and dropping. A second and third attempt at a BP was unsuccessful. Writer immediately called 911(0255) (2:55 a.m.), ambulance arrived at 0300 (3:00 a.m.) and departed at 0303 (3:03 a.m.). Writer called [hospital initials] ER (emergency room) [Name] to give report; On call nurse notified at 0300; Residents POA (power of attorney) notified at 0318 (3:18 a.m.). Writer sent a notification in HUCU (healthcare communication platform) to providers to update them on the situation at 0346 (3:46 p.m.). R16 was readmitted to the facility on [DATE]. R16's nurses note dated 3/4/25 at 21:48 (9:48 p.m.) documents Writer noticed pt (patient) having a hard time breathing, respirations were increasing, O2 71% on room air. Messaged HUCU with no response. Placed resident on 2L (liter), resident stating at 81%. Placed pt on 3L, pt stating at 85%. Pt is now diaphoretic and only responding to person. Writer called [Name] Medical and left a message with receptionist who was unable to get a hold of provider, have not received call back at this time. Sent pt to ER (emergency room) Called in report to [Name] Memorial Hospital. Called POA (power of attorney) sister and left voicemail to contact facility for update. Called Case worker and left voicemail to contact facility for update. R16 was readmitted to the facility on [DATE]. Surveyor reviewed R16's medical record and was unable to locate a bed hold policy and reason for transfer was provided to R16 and R16's representative in writing for R16' discharge on [DATE] & 3/4/25. On 5/19/25, at 3:09 p.m., during the end of the day meeting with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, and Consultant-I Surveyor informed staff Surveyor was unable to locate the bed hold policy and reason for transfer was provided to R16 & R16's representative when R16 was discharged to the hospital on 2/24/25 & 3/4/25. On 5/20/25 Surveyor was provided with the white & yellow copy of the transfer and discharge notice for R16's discharge on [DATE]. Surveyor noted Title 19 Bedhold Policy is circled. The Title 19 Bedhold policy documents Medical Assistance (T19) will pay to hold the bed while you are in a general hospital for up to 15 days per hospital stay. If the hospital stay is longer than 15 days, you may choose to continue the bedhold by paying privately for duration of hospital stay. If the leave extends beyond the paid bedhold, the bed will not be held. However, if you wish to be readmitted to the facility following hospital stay, readmission could occur upon the first availability of an appropriate semi-private room. Surveyor noted there is not a bed hold rate documented on this form. Surveyor also noted there was verbal consent but there is no evidence written notification was provide to R16's representative. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/20/25 Surveyor was provided with a yellow copy of the transfer and discharge notice for R16's discharge on [DATE]. Surveyor noted there is not a bed hold rate documented on this form. Surveyor also noted there was verbal consent from R16's POA but there is no evidence written notification was provided to R16's representative. 2.) R50's diagnosis includes diabetes mellitus (high blood sugar), urinary retention, metabolic encephalopathy (metabolic disturbances affecting how the brain functions), malignant neoplasm (cancer) of lateral wall of bladder, hypertension (high blood pressure) and depression. R50's nurses note dated 12/30/24 at 14:37 (2:37 p.m.) documents Writer reassessed pt (patient) after previous shift replaced Foley for hematuria. Writer pulled 800 cc (cubic centimeters) of dark, blood urine out of Foley. APNP (Advanced Practice Nurse Prescriber) was contacted and patient is being sent out to ER (Emergency Room) for further evaluation. Writer contacted [Name] ambulance for a ride to [Name] Memorial Hospital. [Hospital's initials] was called with report. Vitals are within normal limits at this time. R50 was readmitted to the facility on [DATE]. The nurses note dated 3/29/25 at 19:30 (7:30 p.m.) documents Called to residents room by CNA (Certified Nursing Assistant). Residents daughter was concerned about possible decline since surgery for super pubic placement on 3/26/2025. Daughter was stating that she noticed more weakness, confusion, and is hallucinating. Notified NP (Nurse Practitioner) via HUCU (healthcare communication platform) and was informed that resident was seen by a NP yesterday and there was not a indication to send to ER (emergency room) for eval. (evaluation). NP wanted to monitor resident here, push fluids and have resident rest. Daughter was not happy with this information and insisted that resident be sent anyway [hospital initials] for eval. Updated NP and DON (Director of Nursing). Order received to send resident to hospital for eval. Will continue to monitor. R50 was readmitted to the facility on [DATE]. Surveyor reviewed R50's medical record and was unable to locate a bed hold policy and reason for transfer was provided to R50 and R50's representative in writing for R50's discharge on [DATE] & 3/29/25. On 5/19/25, at 3:09 p.m., during the end of the day meeting with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, and Consultant-I Surveyor informed staff Surveyor was unable to locate the bed hold policy and reason for transfer was provided to R50 & R50's representative when R50 was discharged to the hospital on [DATE] & 3/29/25. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/20/25 Surveyor was provided with the yellow copy of the transfer and discharge notice for R16's discharge on [DATE]. Surveyor noted there is a star next to Title 19 Bedhold Policy. The Title 19 Bedhold policy documents Medical Assistance (T19) will pay to hold the bed while you are in a general hospital for up to 15 days per hospital stay. If the hospital stay is longer than 15 days, you may choose to continue the bedhold by paying privately for duration of hospital stay. If the leave extends beyond the paid bedhold, the bed will not be held. However, if you wish to be readmitted to the facility following hospital stay, readmission could occur upon the first availability of an appropriate semi-private room. Surveyor noted there is not a bed hold rate documented on this form. Surveyor also noted there was verbal consent but there is no evidence written notification was provide to R50's representative. On 5/20/25 Surveyor was provided with a yellow copy of the transfer and discharge notice for R50's discharge on [DATE]. Surveyor noted there is not a bed hold rate documented on this form. Surveyor also noted there was verbal consent from R50's representative but there is no evidence written notification was provided to R50's representative. 4.) R23 was admitted to the facility on [DATE] and has diagnoses that include chronic systolic and diastolic congestive heart failure, type 2 diabetes with circulatory complications, muscle wasting and atrophy, major depressive disorder, peripheral vascular disease, chronic kidney disease stage 3, and anxiety disorder. R23 power of attorney (POA) was activated. On 4/25/2025 R23 was admitted to the hospital for an upper respiratory infection/ Bronchitis and readmitted to the facility on [DATE]. Surveyor reviewed R23's medical and was unable to locate a bed hold or transfer notice that was provided to R23's and R23's POA in writing for R23's discharge on [DATE]. On 5/19/25, at 3:09 p.m., during the end of the day meeting with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, and Consultant-I Surveyor informed staff Surveyor was unable to locate the bed hold policy and reason for transfer was provided to R23 & R23's representative when R23 was discharged to the hospital on 4/25/2025. On 5/20/25 Surveyor was provided with the white & yellow copy of the transfer and discharge notice for R23's discharge on [DATE]. Surveyor noted Title 19 Bed hold Policy is circled. The Title 19 Bed hold policy documents Medical Assistance (T19) will pay to hold the bed while you are in a general hospital for up to 15 days per hospital stay. If the hospital stay is longer than 15 days, you may choose to continue the bed hold by paying privately for duration of hospital stay. If the leave extends beyond the paid bed hold, the bed will not be held. However, if you wish to be readmitted to the facility following hospital stay, readmission could occur upon the first availability of an appropriate semi-private room. Surveyor noted there is not a bed hold rate documented on this form. Surveyor also noted there was verbal consent but there is no evidence written notification was provide to R23's representative. On 5/20/25 Surveyor was provided with a yellow copy of the transfer and discharge notice for R23's discharge on [DATE]. Surveyor noted there is not a bed hold rate documented on this form. Surveyor also noted there was verbal consent from R23's POA but there is no evidence written notification was provided to R23's representative. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5.) R33 was admitted to the facility on [DATE] and has diagnoses that include metabolic encephalopathy, type 2 diabetes with neuropathy, schizoaffective disorder, pneumonia, cognitive communicative deficit, and history of cerebral infarction affecting the right dominant side. R33's power of attorney (POA) is activated. On 1/24/2025 R33 was admitted to the hospital with a diagnosis on Pneumonia and readmitted to the facility on [DATE]. On 3/12/2025 R33 was admitted to the hospital with a change of condition and readmitted to the facility on [DATE]. Surveyor reviewed R23's medical and was unable to locate a bed hold or transfer notice that was provided to R23's and R23's POA in writing for R23's discharge on [DATE]. On 5/19/25, at 3:09 p.m., during the end of the day meeting with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, and Consultant-I Surveyor informed staff Surveyor was unable to locate the bed hold policy and reason for transfer was provided to R33 & R33's representative when R33 was discharged to the hospital on 1/24/2025 and 3/12/2025. On 5/20/25 Surveyor was provided with the white & yellow copy of the transfer and discharge notice for R33's discharge on [DATE] and 3/12/2025. Surveyor noted Title 19 Bed hold Policy is circled. The Title 19 Bed hold policy documents Medical Assistance (T19) will pay to hold the bed while you are in a general hospital for up to 15 days per hospital stay. If the hospital stay is longer than 15 days, you may choose to continue the bed hold by paying privately for duration of hospital stay. If the leave extends beyond the paid bed hold, the bed will not be held. However, if you wish to be readmitted to the facility following hospital stay, readmission could occur upon the first availability of an appropriate semi-private room. Surveyor noted there is not a bed hold rate documented on this form. Surveyor also noted there was verbal consent but there is no evidence written notification was provide to R33's representative. On 5/20/25 Surveyor was provided with a yellow copy of the transfer and discharge notice for R33's discharge on [DATE] and 3/12/2025. Surveyor noted there is not a bed hold rate documented on this form. Surveyor also noted there was verbal consent from R33's POA but there is no evidence written notification was provided to R33's representative. No additional information was provided. 6.) R9 was admitted to the facility on [DATE] with pertinent diagnoses that include unstageable pressure ulcer of sacral region (a severe pressure sore that's difficult to stage because the base of the wound is obscured by slough or eschar, making it impossible to determine the true depth of tissue damage. The sacral region is located at the base of the spine), type 2 diabetes mellitus (happens when the body cannot use insulin correctly and sugar builds up in the blood), morbid obesity (body mass index (BMI) of 40 or higher), and chronic pain syndrome (a condition characterized by persistent pain that lasts for more than three months). R9's Quarterly Minimum Data Set (MDS) with an assessment reference date of 3/10/25, documents a Brief Interview for Mental Status (BIMS) score of 15, indicating that R9 is cognitively intact. R9's patient depression questionnaire (PHQ-9) score was 00 which means that R9 showed no depressive symptoms. R9 was coded to have adequate hearing, understands others and makes self understood. R9 is responsible for self. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor reviewed R9's electronic medical record which indicated R9 was transferred to Waukesha Memorial Hospital for a scheduled ostomy surgery on 1/7/2025, R9 returned to the facility on 1/10/25. R9 was transferred to Waukesha Memorial hospital on 1/15/25 for ostomy pain, R9 returned to the facility on 1/29/25. R9 was transferred to Waukesha Memorial hospital on 3/4/25 for bleeding under the colostomy bag due to cellulitis, R9 returned to the facility on 3/6/25. Surveyor requested evidence from the Facility that a bed hold notice information to identify the reserve bed payment rate for all payor sources for R9's bed hold after 15 days was provided to R9 or their representative. Surveyor was given a form Kensington Care and Rehabilitation Transfer and Discharge Notice that had verbal Consent written in each signature area on the form for each of the three transfers. Surveyor noted that the bed hold notice did not identify the rate for all payor sources for the bed hold after 15 days. Surveyor noted no evidence that the paperwork was provided in written form to R9 or R9's representative. On 5/20/25, at 03:19 PM, during the end of day meeting with Director of Nursing-B and Nursing Home Administrator-A Surveyor let know of concern that no payment information was included on the bed hold form and that it was not provided in a written form. No additional information was provided regarding bed hold payment information and forms being provided in writing. 7.) R12 was admitted to the facility on [DATE] with diagnoses that included Urinary Retention and Ileostomy. R12's Transfer and Discharge notice dated 12/03/24 documents that R12 was transferred and admitted to the hospital on [DATE]. R12's electronic medical record documents R12 was admitted for renal calculi (formation of mineral stones in the urinary tract). R12's Transfer and Discharge notice dated 04/19/25 documents R12 was transferred and admitted to the hospital on [DATE]. R12's electronic medical record documents R12 was admitted for small bowel obstruction (partial or complete blockage of the bowel). R12's Transfer and Discharge notice dated 04/24/25 documents R12 was transferred to the emergency room on [DATE]. R12's electronic medical record documents R12 was transferred for concerns with R12's Ileostomy (small abdominal opening to allow waste discharge from the small bowel). (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/20/25, at 03:18 PM, Surveyor informed Director of Nursing (DON)-B, Consultant-I, and Nursing Home Administrator (NHA)-A of Surveyor's concerns that the Ombudsman has not been notified at least monthly for the past year for any resident transfers or discharges and the bed hold notice provided for R12 did not identify the facilities reserve bed payment rate for all payor sources for bed hold after 15 days. NHA-A informed Surveyors the facility needs to update the form for the bed hold reserve bed payment rates and was unable to find Emails or documentation that the Ombudsman was notified of any resident transfers or discharges in the past year. 8.) R40 was admitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease and Emphysema. R40's Transfer and Discharge notice dated 03/17/25 documents that R40 was transferred and admitted to the hospital on [DATE]. R40's electronic medical record documents R40 was admitted for chest heaviness and shortness of breath. R40's Transfer and Discharge notice dated 05/19/25 documents R40 was transferred and admitted to the hospital on [DATE]. R40's electronic medical record documents R40 was admitted for exacerbation of Chronic Obstructive Pulmonary Disease On 05/20/25, at 03:18 PM, Surveyor informed Director of Nursing (DON)-B, Consultant-I, and Nursing Home Administrator (NHA)-A of Surveyor's concerns that the Ombudsman has not been notified at least monthly for the past year for any resident transfers or discharges and the bed hold notice provided for R40 did not identify the facilities reserve bed payment rate for all payor sources for bed hold after 15 days. NHA-A informed Surveyors the facility needs to update the form for the bed hold reserve bed payment rates and was unable to find Emails or documentation that the Ombudsman was notified of any resident transfers or discharges in the past year. 9.) R58 was admitted to the facility on [DATE] and 02/11/25 with diagnoses that included Unspecified Systolic (congestive) Heart Failure. R58's Transfer and Discharge notice dated 11/27/24 documents that R58 was transferred and admitted to the hospital on [DATE]. R58's electronic medical record documents R58 was admitted for chest pain. R58's Transfer and Discharge notice dated 01/2/25 documents R58 was transferred and admitted to the hospital on [DATE]. R58's electronic medical record documents R58 was admitted for Hypotension (low blood pressure). R58's Transfer and Discharge notice dated 04/7/25 documents R58 was transferred to the hospital on [DATE]. R58's electronic medical record documents R58 was treated for a nosebleed. On 05/20/25, at 03:18 PM, Surveyor informed Director of Nursing (DON)-B, Consultant-I, and Nursing Home Administrator (NHA)-A of Surveyor's concerns that the Ombudsman has not been notified at least monthly for the past year for any resident transfers or discharges and the bed hold notice provided for R58 did not identify the facilities reserve bed payment rate for all payor sources for bed hold after 15 days. NHA-A informed Surveyors the facility needs to update the form for the bed hold reserve bed payment rates and was unable to find emails or documentation that the ombudsman was notified of any resident transfers or discharges in the past year. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10.) R72 was admitted to the facility on [DATE] with diagnoses that included Contusion (bruising) of the left hip. R72's Transfer and Discharge notice dated 02/20/25 documents that R72 was discharged home because R72's health improved and no longer needed the facility's services. R72's Medical Doctor's Discharge summary dated [DATE], at 12:45 PM, documents that R72 was discharged home with home health services. On 05/21/25, at 12:50 PM, Surveyor informed Nursing Home Administrator (NHA)-A that the Surveyor found no documentation that R72's discharge was reported to the Ombudsmen and the bed hold notice provided for R72 did not identify the facilities reserve bed payment rate for all payor sources for bed hold after 15 days. No additional information was provided.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2.) R32 was admitted to the facility on [DATE] with diagnoses which includes fracture of T11-T12 vertebra, chronic kidney disease (characterized by progressive damage and loss of kidney function), congestive heart failure (heart doesn't pump enough blood to meet the body's needs), morbid obesity, anxiety disorder and depression. R32's hospital Discharge summary dated [DATE] includes under discharge diagnoses pressure injury. Under hospital course pressure injury wound care consulted. R32's nurses note dated 4/18/25 at 15:18 (3:18 p.m.) and written by Licensed Practical Nurse (LPN)-W documents New admit head to toe: Resident was brought into facility from [hospital's initials] for rehabilitation around 1230. Resident was in care of [Name] ambulance and transferred from cot to bed and positioned to comfort. Vitals were obtained BP (blood pressure) 129/62, HR (heart rate) 59, spo2 (peripheral oxygen saturation) 94, temp (temperature) 97.4, RR (respiratory rate) 18. Resident had complaints of pain in her upper and lower back from compressions and fractures, no other pain noted at this time. scalp was dry with no signs of bruises or abrasions, ears appeared clear and able to hear and understand directions. Eyes were tracking however, resident stated that she is legal blind which per her definition she cannot see straight ahead but that she can see outlines and fuzzy shapes. face is free from cuts or bruises, neck is able to freely move in all direction with no pain. Resident has bruise on left arm purple and yellow of color ROM (range of motion) present in both arms. chest raises and fall evenly with inhalation and exhalation, lungs sound are clear bilateral, no apparent bruises or abrasions noted. abdomen is soft, bowel sounds normoactive in all 4 quadrants. left left side has multiple bruise location, (1)left side of buttocks, (2) left lateral thigh (3) left side calf. all are a bluish/yellow color. ROM is present bilateral legs but stiff no pain. Back had a lidocaine patch on upper midline, no abrasions or bruising noted under or around the patch. back is clear of all bruising and abrasions. abrasion on left buttock roughly 10 cm long by 1cm wide with no active bleeding at this time. abrasion on right buttock roughly 5cm long by 1cm wide with no active bleeding at this time. resident remained in bed and left in a comfortable position with call light and bed controls within reach. R32's admission/readmission assessment dated [DATE] completed by LPN-W for the skin section under details/comments documents (1) left buttock abrasion 10cm (centimeter) by 1cm. (2) right buttock abrasion 5cm by 1cm. (3) left upper arm bruising. (4) left hip bruising. (5) left thigh bruising. (6) left lower calf bruising. Surveyor noted there is no Registered Nurse (RN) assessment of R32's buttocks until 4/23/25, 5 days after admission. R32's Braden assessment dated [DATE] has a score of 14 which indicates moderate risk. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R32's potential for impairment to skin integrity care plan initiated 4/18/25 & revised 5/15/25 documents the following interventions: Low air loss mattress to bed. Check function q (every) shift. Settings to resident weight or resident comfort. Initiated 4/24/25 & revised 5/15/25. Encourage good nutrition and hydration in order to promote healthier skin. Initiated 4/18/25. Encourage me to elevate my heels. Initiated 4/28/25. Encourage me to offload my heels. Initiated 4/28/25. Encourage/assist me with reposition as needed. Initiated 4/24/25. Keep my linen dry, clean, and free of wrinkles. Initiated 4/28/25. My skin will be assessed on a weekly basis on my scheduled bath day and document findings on a weekly skin assessment. Initiated 4/24/25. Report any skin redness/impaired integrity areas to my nurse. Initiated 4/24/25. Use draw sheet or lifting device to move resident. Initiated 4/28/25. Use barrier cream to prevent skin impairment issues, as needed. Initiated 4/28/25. Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. Initiated 4/28/25. R32's modification of admission MDS (minimum data set) with an assessment reference date of 4/20/25 has a BIMS (brief interview mental status) score of 6 which indicate severe impairment. R32 is assessed as not having any behavior including refusal of cares. R32 is assessed as requiring partial/moderate assistance for toileting hygiene, supervision/touching assistance for roll left & right, and dependent for chair/bed to chair transfer. R32 is assessed as always incontinent of urine and bowel. R32 is at risk for pressure injury development and has two unstageable slough and/or eschar pressure injuries which were present on admission. R32's pressure injury CAA (care area assessment) dated 4/28/25 under analysis of findings for nature of problem/condition documents Resident has 2 unstageable due to necrosis pressure injuries. Resident has a pressure relieving mattress and cushion to her manual wheelchair. Under care plan considerations documents Resident's pressure ulcers will improve with treatments. Advanced Practice Nurse Prescriber (APNP)-BB initial visit dated 4/22/25 does not address R32's pressure injuries. On 4/23/25 R32 was seen during wound rounds by Wound Nurse/Registered Nurse (WN/RN)-J and Wound Doctor (WD)-CC. This assessment is 5 days after R32 was admitted to the facility. WD-CC initial wound evaluation dated 4/23/25 documents for the left buttock etiology as pressure, Stage is Unstageable Necrosis, wound size for length is 8 cm (centimeters), width 9 cm, and depth is 0.1 cm. Thick adherent devitalized necrotic tissue is 40 % and intact normal color skin is 60%. The right buttock etiology is pressure and stage is unstageable necrosis. Wound size for length is 8 cm, width is 2 cm and depth is 0.1 cm. Thick adherent devitalized necrotic tissue is 30% and granulation tissue is 70%. Surveyor noted weekly assessments of R32's right and left buttock. R32's right buttock pressure injury resolved on 5/7/25 and the left buttock pressure injury resolved on 5/14/25. R32's weight on 5/18/25 was 220.5 pounds, on 5/19/25 221.5 pounds, and on 5/20/25 224.3 pounds. On 5/18/25, at 11:18 a.m., Surveyor observed R32's air mattress is set at 340 pounds. On 5/19/25, at 6:59 a.m., Surveyor observed R32 in bed on the right side. R32 has a comforter covering her head down to her feet. R32's air mattress is set at 340 pounds. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Kensington	1810 Kensington Dr Waukesha, WI 53188

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 5/19/25, 1:58 p.m., Surveyor observed Certified Nursing Assistant (CNA)-X provide incontinence cares to R32 who was incontinent of bowel. Surveyor observed the air mattress is set at 340 pounds. After CNA-X was finished with providing incontinence cares, a new incontinence product was placed on R32 and R32 was covered with bedding. The head of R32's bed was elevated, the call light was placed in reach and R32's bed was lowered. Surveyor observed R32's heels are resting directly on the mattress and are not being off loaded nor did CNA-X speak with R32 about offloading her heels. On 5/20/25, at 6:52 a.m., Surveyor observed R32 in bed on her back with the head of the bed elevated. R32 is wearing black gripper socks and R32's heels are resting directly on the mattress. R32's air mattress is set at 340 pounds. On 5/20/25, at 8:32 a.m., Surveyor observed R32 asleep in bed on the right side. R32 is now covered with an additional white blanket and R32's heels are not being offloaded. On 5/21/25, at 7:06 a.m., Surveyor observed R32 awake in bed on her back. Surveyor observed R32's heels are not being offloaded and the air mattress is set at 340 pounds. On 5/21/25 at 7:09 a.m. Surveyor asked R32 if staff has spoken to her about keeping her heels off the mattress. R32 replied no. On 5/21/25, at 12:29 p.m., Surveyor asked Wound Nurse/Registered Nurse (WN/RN)-J when a resident is admitted who assesses the residents skin. WN/RN-J informed Surveyor the admitting nurse. Surveyor asked WN/RN-J when would she or another RN assess the skin. WN/RN-J informed Surveyor she could be a second set of eyes if the nurse requests and then they do their weekly wound rounds with the doctor on Wednesday. Surveyor asked WN/RN-J if a resident comes in with a pressure injury on Saturday when would she assess the area. WN/RN-J informed Surveyor if the nurse wanted her to see it she would see it. Surveyor asked WN/RN-J when would she do an assessment. WN/RN-J replied Wednesday. Surveyor informed WN/RN-J of the concern that R32 pressure injuries were not assessed until 5 days later. WN/RN-J replied that's not how her role is. On 5/21/25, at 12:35 p.m., Surveyor asked Licensed Practical Nurse/Unit Manager (LPN/UM)-E how the air mattress should be set. LPN/UM-E informed Surveyor by the residents weight. Surveyor then asked LPN/UM-E to accompany Surveyor to R32's room where Surveyor showed LPN/UM-E R32's air mattress was set at 340 pounds and on May 20th R32 weight was 224.3 pounds. LPN/UM-E informed Surveyor it can be set for the resident's comfort. Surveyor informed LPN/UM-E of the observations of R32's heels not being offloaded or asking R32 to offload her heels. 3.) R64's diagnoses includes dementia, mild protein calorie malnutrition, spinal stenosis (space inside the bones of spine get too small putting pressure on the spinal cord), hypertension (high blood pressure) and anxiety disorder. R64 receives hospice services. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R64's alteration in skin integrity care plan initiated 11/28/24 & revised 5/15/25 documents the following interventions: 1/18/25 assessed brief size and tightness noted to be tight - sized up one size. Encourage resident to communicate any discomfort related to brief tightness & sizing. Initiated 1/30/25. Apply an alternating pressure mattress to the bed, check function every shift for proper inflation. Initiated & revised 12/26/24. Offered offloading boots, but declines. Initiated 12/26/24. Will continue to encourage all cares, treatments and interventions. Initiated 5/9/25. Administer treatments as ordered and monitor for effectiveness. Initiated 11/28/24. Apply barrier cream after incontinence. Initiated 11/28/24. Braden assessment on admission and per policy. Initiated 11/28/24. Encourage adequate hydration. Initiated 11/28/24. Encourage to float heels when in bed. Initiated 11/28/24. Monitor/document/report to MD (medical doctor) PRN (as needed) changes in skin status: appearance, color, wound healing, s/sx (signs/symptoms) of infection, wound size, stage initiated 11/28/24. Notify MD for new orders, administer treatments as ordered, inform family initiated 11/28/24. Skin inspection: requires a skin inspection weekly and with cares. Observe for redness, open areas, scratches, blisters, cuts, bruises. Report to nurse/MD initiated 11/28/24. Update MD s/sx of infection or deterioration of wound/skin initiated 11/28/24. R64's pressure injury CAA (care area assessment) dated 1/9/25 under analysis of findings for nature of problem documents Resident has skin prep applied to left ankle scab. The quarterly MDS (minimum data set) with an assessment reference date of 4/1/25 has BIMS (brief interview mental status) score of 5 which indicates severe cognitive impairment. R64 is dependent for toileting hygiene, roll left & right, and chair/chair to bed transfer. R64 is assessed as always incontinent of bowel and bladder. R64 is at risk for pressure injury development and does not have any pressure injuries. Hospice care is marked yes. R64's hospice aide visit note dated 4/30/25 documents There is an open area to her right buttocks. The only cream available was some anti fungal cream. Nurse [Name] was aware. She stated she will call the [hospice name] nurse. I informed her I will also send her a message. Surveyor noted there is no assessment of R64's right buttocks open area until 5/7/25. R64's weight on 5/2/25 was 93.7 pounds. R64's Braden assessment dated [DATE] has a score of 12 which indicates high risk. The physician orders dated 5/7/25 documents Wound Care: right buttocks - Cleanse with wound cleanser and pat dry. Apply xeroform f/b (followed by) bordered foam daily and as needed. In the evening for wound care and as needed for wound care. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The nurses note dated 5/9/25, at 10:44 a.m., documents IDT (interdisciplinary team) met and discussed: 5-7-25 1000 (10:00 a.m.). Resident was assessed on wound rounds by wound MD due to a report of an open area to resident's bottom. A 1cm (centimeter) x (times) 1 cm red and open area was noted to resident's right buttocks. The area is blanchable with light serious drainage. There is no pain at the site, but resident has generalized pain being controlled by comfort meds due to being on hospice. Wound MD gave treatment orders. Husband was in the room and updated on POC (plan of care). Hospice aware. NP (nurse practitioner) updated via Hucu (health communication platform) also. Daughter also aware. Resident has an air mattress. Intake is poor to fair and been generally declining (hospice). All prior interventions are in place. Encouraging intake and to turn and reposition, due to chronic pain and frail state resident is resistive and does not like to be bothered but with accept cares. She does cry out often, pain managed. MASD (moisture-associated skin damage) to buttock due incontinence, enc (encourage) to be check and changed as tolerated. Treatment as ordered to optimize wound healing but due to state of resident it maybe unavoidable as resident declines. Will continue to encourage all cares, treatments and interventions. All parties aware. On 5/18/25, at 1:09 p.m. Surveyor observed R64 in bed on her back with her eyes closed and the head of the bed elevated. There is a pillow under R64's right and left upper side and under R64's left arm. R64's heels are not being offloaded. The nurses note dated 5/19/25, at 21:26 (9:26 p.m.) and written by LPN-DD documents Resident area on right buttock is purple in color and skin intact. TX (treatment) was changed, no issues noted, continue monitoring. Surveyor did not note any change in treatment in R64's physician orders or on the May 2025 treatment administration record. There is no RN assessment of this area. The Braden assessment dated [DATE] has a score of 12 which indicates high risk. On 5/20/25, at 6:58 a.m., Surveyor observed R64 asleep in bed on her back. Surveyor observed R64's heels are not being offloaded. On 5/20/25, at 9:15 a.m., Surveyor observed Certified Nursing Assistant (CNA)-Z and CNA-AA in R64's room with gloves on. CNA-Z asked R64 if she could change her top. CNA-Z removed the pillow under R64's left upper arm. CNA-Z informed she would be gentle & removed R64's top, placed deodorant on and placed an undershirt and sweater on R64. CNA-AA informed R64 they were going to lay her head back and lowered the head of the bed. CNA-Z informed R64 they were going to check her brief and they would be fast. R64's incontinence product was unfastened. CNA-Z stated it's dry in the front and washed R64's frontal perineal area. CNA-Z then stated to R64 they were going to turn her towards CNA-AA and R64 was placed on her side. Surveyor observed there is a dressing on R64's sacrum dated 5/19/24 but there is no dressing on R64's right buttocks according to physician orders. CNA-Z washed R64's buttocks, placed an incontinence product under R64 & applied barrier cream on R64's buttocks. CNA-Z removed her gloves, washed her hand and left R64's room. CNA-Z returned with a draw sheet and R64 was positioned side to side to remove the incontinence product, straighten & fasten the new incontinence product and straighten the draw sheet. CNA-Z and CNA-AA positioned R64 up in bed and CNA-Z placed a pillow under R64's lower leg. Surveyor observed although CNA-Z placed a pillow under R64's lower legs, R64's heels were resting directly on the pillow and were not being offloaded. R64 was covered with bedding and CNA-Z & CNA-AA removed their gloves and washed their hands. On 5/20/25, at 10:26 a.m. Surveyor observed R64 continues to be in bed on her back with the head of the bed elevated. R64's heels are not being offloaded. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 5/20/25, at 12:55 p.m., Surveyor observed Licensed Practical Nurse (LPN)-W and CNA-Z enter R64's room. Surveyor observed R64 is in bed with the head of the bed elevated & a pillow under R64's left shoulder. LPN-W informed R64 they were going to roll her on the side, it's going to hurt a little bit but that's why they have her the medication. LPN-W washed his hands and placed gloves on. CNA-Z wearing gloves removed the bedding and the pillow under R64's lower legs. Surveyor observed R64's heels had been resting directly on the pillow. CNA-Z unfastened R64's incontinence product and washed R64's frontal perineal area. CNA-Z & LPN-W positioned R64 on the right side. LPN-W removed the incontinence product and the dressing from R64's sacrum area. After removing the dressing, LPN-W removed his gloves, washed his hands, and placed gloves on. LPN-W cleaned the sacrum area with wound cleaner, removed his gloves, washed his hands and placed gloves on. Surveyor observed a deep tissue injury on R64's sacrum area the approximate size of a dime. At 1:06 p.m. Infection Control/Registered Nurse (IC/RN)-T entered R64's room, washed her hands, and placed gloves on. IC/RN-T stated she's looking to see if its chronic. IC/RN-T removed her gloves, washed her hands and left R64's room. At 1:09 p.m., Surveyor asked LPN-W if he had seen R64's open area prior. LPN-W replied it's been a minute since he was on the unit. At 1:10 p.m., LPN-W placed xeroform over the deep tissue injury and covered the deep tissue injury with a foam dressing. Surveyor noted there is no dressing on R64's right buttock. LPN-W washed R64's buttocks, LPN-W & CNA-Z positioned R64 on the left side and LPN-W stated he was going to get [first name of Wound Nurse/Registered Nurse (WN/RN)-J. LPN-W removed his gloves & cleansed his hands and CNA-Z removed her gloves & washed her hands. On 5/20/25, at 1:28 p.m., LPN-W informed Surveyor at the moment there are 2 wounds on R64's bottom. The coccyx one on the right buttocks and other on center coccyx. LPN-W informed Surveyor he can't explain the center one on coccyx. LPN-W informed Surveyor the only thing he can think of they saw that (referring to Deep Tissue Injury) and though that the was the area. LPN-W informed Surveyor he knows people mislabel right & left but that's speculation. Surveyor stated to LPN-W there are no order for the deep tissue injury. LPN-W replied correct for that one. On 5/20/25, at 1:32 p.m. LPN-W removed the dressing from his pocket, opened treatment supplies and then left R64's room for gauze. On 5/20/25, at 1:37 p.m. LPN-W returned to R64's room with gauze, opened the gauze, moved the garbage can closer, washed his hands & placed gloves on. At 1:38 p.m. CNA-Z entered R64's room placed gloves on and informed R64 they were going to turn her to change the bandage on her bottom. On 5/20/25, at 1:39 p.m. WN/RN-J entered R64's room stating she's here to do a televisit. Surveyor noted Wound Doctor-CC was on the televisit. R64 was positioned on the left side, LPN-W removed the dressing and Wound Doctor-CC indicating coccyx more sacrum 1.5 by 1 DTI (deep tissue injury) and right buttocks doesn't look open any more, continue with barrier cream. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 5/20/25, at 1:44 p.m., CNA-Z who was wearing gloves positioned R64 on the side. LPN-W wash his hands, placed gloves on and sprayed wound cleanser on gauze and cleansed the deep tissue injury. LPN-W removed his gloves, washed his hands, and placed gloves on. LPN-W applied zinc oxide on R64's deep tissue injury & buttocks and R64 was positioned on her back. LPN-W removed his gloves and washed his hands. CNA-Z fastened the incontinence product, covered R64 with a blanket, removed her gloves and placed a pillow under R64's left arm. CNA-Z washed her hands, placed the over bed table across R64 and offered R64 a sip of water then left R64's room. At 1:54 p.m. CNA-Z returned to R64's room with a pillow case, placed the pillow in the pillow case and informed R64 she was going to lift her legs a little bit. CNA-Z placed the pillow under R64's lower legs. Surveyor observed R64's right heel is resting directly on the mattress and the left heel is on the pillow. R64's heels are not being offloaded. R64's nurses note dated 5/20/25 at 13:58 (1:58 p.m.) and written by WN/RN-J documents Nurse, [Name], reported to Writer that resident had a new wound to her sacral area. Writer assisted with completing a telemedicine visit with wound MD and resident. Wound MD was able to assess a 1.5cm x 1cm DTI to the sacrum and gave orders for barrier cream q (every) shift and as needed. Writer explained to husband who was in the room at time of assessment. Resident will be seen in person by wound MD on wound rounds. Wound MD also noted during assessment that the area to resident's right buttock is resolved. On 5/20/25, at 2:01 p.m. Surveyor informed WN/RN-J Surveyor has a concern R64's had a dressing over the deep tissue injury dated 5/19/25 and there is no documentation in R64's medical record regarding this pressure injury on the sacrum. Surveyor informed WN/RN-J R64 was suppose to have a dressing on the right buttocks but there was none. Surveyor asked WN/RN-J if there is any information regarding this. WN/RN-J informed Surveyor LPN-W came and said hey she (referring to R64) has a new area that had a dressing. WN/RN-J informed Surveyor Wound Doctor-CC will be here tomorrow. Surveyor asked WN/RN-J how the deep tissue injury developed. WN/RN-J replied just her end of life not wanting to move as much. R64's nurses note dated 5/20/25, at 15:22 (3:22 p.m.) and written by LPN-W documents Entered residents room to perform wound care on residents right buttocks. resident was informed of what was happening, rolled to residents left side dressing removed, washed and dried per order and while performing wound cares writer noted a new wound located about the sacrum/coccyx area. Wound care nurse, [Name], was notified who messaged wound care provider. left voice mail for [hospice name] RN, contacted daughter who has no concerns. management inform and added to the 24 hour board new vitals: 102/78, 97.5, 74HR (heart rate), 18 RR (respiratory rate) , 94% RA (room air). Change of condition added and resident will continue to be monitored. R64's nurses note dated 5/20/25 at 17:45 (5:45 p.m.) and written by Director of Nursing (DON)-B documents Discussed risks vs benefits with resident and POA r/t (related to) to refusing to turn/reposition, refusing cares, refusing wound treatment, refusing showers, poor intake r/t skin prevention and wound healing. Surveyor did not note a refusal care plan. On 5/21/25, at 7:12 a.m. Surveyor observed R64 awake in bed on her back with the head of the bed elevated. There is a pillow under R64's left shoulder and Surveyor observed R64's heels are not being offloaded. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 5/21/24, at 9:40 a.m., Surveyor observed R64 in bed awake on her back with the head of the bed elevated. Surveyor observed there are two pillows under R64's knees but R64's heels are resting directly on the mattress and are not being offloaded. R50 informed Surveyor hospice just left R64. On 5/21/25, at 9:46 a.m., Surveyor informed CNA-Z Surveyor noted R64 refused to wear pressure relieving boots but wondered if R64 allows her heels to be offloaded. CNA-Z replied yes, like yesterday I put a pillow. On 5/21/25, at 10:15 a.m. Surveyor informed WN/RN-J Surveyor had noted a hospice aide note dated 4/30/25 which documented an open area on the right buttocks and the nurse was aware. WN/RN-J informed Surveyor she was not aware of the right buttocks until 5/7/25. Surveyor asked what should have happened. WN/RN-J informed Surveyor our nurse should of done a skin check list on it. Surveyor informed WN/RN-J Surveyor was not able to locate this on 4/30/25. Surveyor also informed WN/RN-J of R64's heels not being offloaded. 4.) R49 was admitted to the facility on [DATE] and has diagnoses that include type 2 diabetes mellitus with diabetic chronic kidney disease and polyneuropathy, chronic diastolic heart failure, end stage renal disease, pressure ulcer of the sacral region, and dependence on renal dialyses. R49's admission minimum data set (MDS) dated [DATE] indicated R49 had intact cognition with a Brief Interview of Mental Status (BIMS) score of 13 and the facility assessed R49 needing minimal assistance with hygiene and repositioning. R49 did not have upper or lower extremity impairment and was occasionally incontinent of bowel and bladder. R49 was admitted to the facility with a stage 4 sacral wound, in the admission MDS the facility documented 1 unstageable pressure injury on the sacrum due to presence of slough or eschar. The facility assessed R49 on 1/10/2025 to be a low risk for pressure injury development with a Braden score of 18. On 1/10/2025, at 14:43 (2:43 PM) in the progress notes nursing documented (R49) admitted to the facility Admitting diagnoses of sacral wound and treatment in place. Surveyor reviewed R49's admission skin assessment documented on 1/10/2025 with the following: -Sacral wound is 4.5cm X 2.0cm X 1.0cm (length X width X depth) 1.0cm tunneling at 6 o'clock. Surveyor noted that there was not a comprehensive assessment completed to describe what R49's sacral wound looked like if there was drainage, or description of the wound bed or surrounding tissue. On 1/15/2025 the wound doctor completed an initial visit with R49 and documented the following: - Unstageable (due to necrosis) coccyx, full thickness . - 2.5cm X 2.5cm X 1cm, moderate serous (clear, thin, watery fluid) drainage, 30% slough, 70% granulation tissue. - debridement procedure to remove necrotic tissue and establish margins and viable tissue performed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R49's continues to get weekly wound assessments with the wound doctor with the most recent assessement documents: - Stage 4 pressure injury coccyx, full thickness . - 2.5cm X 2.5cm X 0.8cm, moderate serous drainage, 10% slough, 90% granulation tissue . On 5/20/2025, at 1:50 PM, Surveyor interviewed wound nurse (WN)-J who stated a head to toe assessment is required within at least 24 hours of admission. WN-J stated that nursing staff should do a full comprehensive assessment of any areas of concern which includes, wound measurements, staging, description of the wound bed and surrounding skin. Surveyor shared concern that a comprehensive assessment for R49's sacral pressure injury could not be located. WN-J looked through R49's medical record and agreed that a comprehensive assessment could not be located when R49 admitted into the facility on 1/10/2025. WN-J stated that nursing documented R49's sacral wound measurements but did not include a comprehensive assessment that detailed R49's sacral wound to include wound staging, or description of the wound bed/ surrounding skin. WN-J agreed that a comprehensive assessment for R49's sacral wound was not documented until R49 saw the wound doctor on 1/15/2025. On 5/20/2025, at 2:23 PM, Surveyor interviewed licensed practical nurse unit manager (LPNUM)-F who stated if an area of concern for a resident was noted on admission nursing would do a comprehensive assessment that included measurements, describe what the area looked like, surrounding area, describe the length, width, depth, stage if applicable, etc. Surveyor shared concern that 49 did not have a comprehensive assessment for R49's sacral pressure injury when admitted to the facility on [DATE] until the wound doctor's initial visit on 1/15/2025. LPNUM-F stated there should have been more description of what R49's sacral wound looked like on 1/10/2025 when R49 was admitted to the facility. On 5/20/2025, at 3:19 PM, Surveyor interviewed nursing home administrator (NHA)-A, director of nursing (DON)-B, and regional consultant (RC)- I. Surveyor asked what the expectations of staff are when a resident is admitted to the facility with an area of concerns such as a pressure injury. DON-B stated that nursing staff are expected to document a skin and body assessment that includes a head to toe assessment, if an area of concern is identified nursing staff is to measure and describe the area. Surveyor shared concern that R49 did not have a comprehensive assessment documented for R49's sacral pressure injury. Surveyor shared that staff did not describe what the pressure injury looked like, surrounding tissue, or if drainage was present until R49's initial visit with the wound doctor on 1/15/2025. DON-B stated a description should have been completed on admission. No additional information was provided. Based on observation, interview, and record review, the facility did not ensure that residents with pressure injuries received necessary treatment and services consistent with professional standards of practice to promote healing and prevent new pressure injuries from developing for 4 (R9, R32, R64, R49) of 8 residents reviewed for pressure injuries. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	* R9's unstageable pressure injury to the left posterior thigh reopened on 2/24/25. The facility states it is due to noncompliance with repositioning and offloading. Four Minimum Data Set (MDS) assessments were completed in 2025 and none document rejection of care or refusals by R9. R9 has an air mattress and no documentation for inflation setting guidance was found. The day after the pressure injury was discovered an intervention was added to the care plan related to refusals. The cushion in R9's wheelchair is not on the care plan or correct for R9's weight and type of pressure injury. 5/8/25 is the first documentation of a discussion with R9 regarding the risk and benefits of R9's noncompliance with wound care and interventions. After the weekly wound assessment on 2/26/25 was completed, two weeks are missed before the next comprehensive wound assessment. On all facility assessments the wound bed tissue type is selected but not the percentage of coverage over the wound. The wound has continued to increase to almost double the size from the time of discovery with no pertinent, new interventions attempted. * R32's hospital records state R32 admitted back to facility with 2 (unstageable) pressure ulcers. A Licensed Practical Nurse did the readmission assessment and noted abrasions with treatment of barrier cream. The wound was not comprehensively assessed until 5 days later. Surveyor made observations of R32's heels not being offloaded and the mattress setting was incorrect. * R64 has orders for a dressing to right buttocks due to MASD (Moisture Associated Skin Damage). Surveyor observed R64 had a dressing to sacrum area. Surveyor observed a nurse put dressing on a different area. When the dressing was removed, Surveyor observed a Deep Tissue Injury. Surveyor made observations of R64's heels not being offloaded. * R49 did not have a comprehensive assessment upon admission on [DATE] for a sacral wound until 1/15/25. Findings include: The facility's policy titled Pressure Injury Prevention and Management revised 2/2025, documents (in part): Policy: This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries . Policy Explanation and Compliance Guidelines .: 2. The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate. 3. Assessment of Pressure Injury Risk a. Licensed nurses will conduct a pressure injury risk assessment on all residents upon admission/readmission, weekly x (times) four weeks, then quarterly or whenever the condition changes significantly . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	c. Licensed nurses will conduct a full body skin

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility did not ensure residents received proper treatment and care to maintain mobility and good foot health for 2 (R50 & R64) of 2 residents. * R50 & R64's toenails were very long and in need of trimming. Findings include: The facility's policy titled, Podiatry Services with date reviewed/revised 5/2025 under Policy documents It is the policy of this facility to ensure residents receive proper treatment and care within professional standards of practice and state scope of practice, as applicable, to maintain mobility and good foot health. Under Policy Explanation and Compliance Guidelines documents 1. Foot care that is provided in the facility, such as toe nail clipping for resident without complicating disease processes, should be provided by staff who have received education and training to provide this service. 2. Residents requiring foot care who have complicating disease processes will be referred to qualified professionals such as Podiatrist, Doctor of Medicine, and/or Doctor of Osteopathy. 3. Foot disorders which require treatment include, but are not limited to: corns, neuromas (noncancerous growth of nerve tissue), calluses, hallux valgus (bunions), ,digiti flexus (hammertoe), heel spurs, and nail disorders. 4. Employees should refer any identified need for foot care to the social worker or designee. 5. The social worker or designee will assist residents in making appointments and arranging transportation to obtain needed services. 1.) R50 was admitted to the facility on [DATE] with diagnosis which includes diabetes mellitus (high blood sugar). On 5/18/25, at 3:33 p.m., Surveyor observed R50 in bed on his back with bare feet. Surveyor observed R50's toe nails on both feet are observed the toenails to be long and in need of trimming. On 5/19/25, at 11:19 a.m., R50's representative stated to Surveyor they, referring to R50 & R64, need to have their toe nails cut and trimmed and stated that the residents (R50 & R64) had not been seen by a podiatrist since they've been at the facility. Surveyor reviewed R50's medical record and was able to locate a podiatry consent form dated 11/24, but was unable to locate any documentation that R50 received podiatry services. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/19/25, at 1:11 p.m., Surveyor asked Unit Secretary (US)-N if the facility has a podiatrist who comes into the facility to provide foot care. US-N informed Surveyor that the facility has a podiatrist, eye, & dentist that comes in the building. Surveyor asked US-N how a resident gets on the list to be seen by the podiatrist. US-N explained she has consent forms from the company. After the resident or POA (power of attorney) signs the consent, US-N will send the consent along with their face sheet and then they are on their list. Surveyor asked US-N when the podiatrist saw R50. US-N informed Surveyor R50 was skipped over on April 8th when the podiatrist came. Surveyor asked US-N what she meant by R50 being skipped over. US-N explained R50 wasn't on the list and she didn't realize R50 wasn't on the list. US-N informed Surveyor R50's representative said something to her about the podiatrist and asked her to make sure R50 was on the list when the podiatrist comes in. Surveyor asked US-N since R50 was admitted in November 2024 has R50 been seen by the podiatrist. US-N stated to Surveyor let me take a peek when they signed because they don't always sign the consent right away. US-N checked R50's consent form and informed Surveyor the consent was signed on 11/29/24. Surveyor asked if the podiatry group make up the list of residents to be seen. US-N replied yes and explained she gets a list of who is to be seen. Surveyor asked US-N if she knows why the podiatrist didn't see R50. US-N informed Surveyor she has said something to them and they said he will be on the list. US-N informed Surveyor she has changed when the podiatrist comes in explaining they can't come in early as there was a problem with the podiatrist skipping people. US-N informed Surveyor the podiatrist can't come in until she gets here which is about 7:00 a.m. Surveyor asked US-N what time was the podiatrist coming in. US-N informed Surveyor he was coming in sometime on 3rd shift around 5:00 a.m. or 6:00 a.m. US-N informed Surveyor the podiatrist would say he saw residents and the residents would tell her they weren't seen. US-N stated she was in a pickle as she wasn't there and didn't know. On 5/20/25, at 12:07 p.m., Surveyor informed Licensed Practical Nurse/Unit Manager (LPN/UM)-E of the observation of R50's toe nails being very long and in need of trimming and that R50 hasn't been seen by the podiatrist since R50 was admitted in November 2024. No additional information was provided. 2.) R64 was admitted to the facility on [DATE] and has diagnosis which includes dementia. On 5/19/25, at 11:19 a.m., R64's representative stated to Surveyor that R50 & R64 need to have their toe nails trimmed and that R50 & R64 have not been seen by a podiatrist since they've been here. Surveyor reviewed R64's medical record and was able to locate a podiatry consent form dated 11/24 but was unable to locate when R50 was provided with podiatry services. On 5/20/25 from 9:15 a.m. to 9:31 a.m. Surveyor observed morning cares for R64 with CNA-AA & CNA-Z. During this observation, Surveyor observed that R64's toe nails are very long on both feet and in need of trimming. On 5/20/25, at 9:37 a.m. Surveyor asked Unit Secretary (US)-N if there is a signed podiatry consent for R64. US-N replied yes. Surveyor asked US-N if R64 has been seen by the podiatrist as Surveyor observed R64's feet today & R64's toe nails are very long. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	US-N stated to Surveyor that after Surveyor left yesterday, US-N realized that R64 wasn't not seen by the podiatrist. US-N informed Surveyor she has sent several emails to the podiatry group. US-N stated that yesterday they answered her telling her the person she sent the emails is gone and that the podiatrist did not receive her emails. US-N informed Surveyor she went back to her email dated 11/29/24 and forwarded the email informing them it was sent on 11/29/24 at 11:43 a.m. for both R50 & R64. The nurses note dated 5/20/24 at 17:02 (5:02 p.m.) and written by Infection Control/Registered Nurse (IC/RN)-T documents: This nurse assessed resident toenails, it was noted that the resident's toenails are excessively thick and difficult to trim safely. Due to the risk of injury, toenails trimming was not performed. A podiatry appointment has been scheduled to address this issue appropriately. The resident and POA (power of attorney) have been informed and is agreeable to the plan. No additional information was provided.

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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** Based on observation, record review and staff interviews, the facility did not ensure that 2 (R16 & R6) out of 3 residents reviewed for bowel and bladder incontinence received the appropriate treatment and services to restore continence to the extent possible. * R16 did not have a documented bowel movement for 6 days in February, 2025. The facility did not provide interventions to assist with proper bowel function nor did they notify R16's physician of R16's constipation. R16 was sent out to the hospital for an unrelated change of condition and was found to have a small bowel obstruction. * R6 had a decline in incontinence status without a comprehensive assessment completed to help maintain or restore bladder / bowel functioning. Findings include: The facility's policy dated as revised 2/2025 and titled, Incontince documents: Based on resident's comprehensive assessment, all residents that are incontinent will receive appropriate treatment and services. Policy Explanation and Compliance Guidelines: (includes) 1. The facility must ensure that residents who are continent of bladder and bowel upon admission receive appropriate treatment, services, and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. 2. Residents that are incontinent of bladder or bowel will receive appropriate treatment to prevent infections and to restore continence to the extent possible. 1.) R6 was admitted to the facility on [DATE] with diagnosis that included dementia, bilateral hearing loss, urge incontinence, anxiety disorder, insomnia, hypertension and type 2 diabetes. R6's annual MDS (Minimum Data Set) dated 1/20/25 documents a BIMS (brief interview for mental status) score of 7, indicating that R6 is severely cognitively imparied. The MDS documents that R6 is occasionally incontinent of bowel and bladder. The MDS asked if a trial of a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) has been attempted on admission/ entry or reentry or since urinary incontinence was noted in this facility. The facility answered No. The MDS also asked is a toileting program currently used to manage the resident's bowel continence. The facility answered No. R6's CAA (care area assessment) for Urinary Incontinence and Indwelling Catheter documents that R6 is occasionally incontinent of bladder and requires partial assistance for toileting. Under the care plan considerations sectionit documents that staff are to offer toileting assistance and assist resident with his toileting hygiene and transfers as indicated on the care card. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R6's individual plan of care documents that R6 has bladder incontinence/potential for incontinence r/t (related to)cognitive impairment dated as initiated on 08/23/2022 documents: Interventions include: o Check and change upon rising, before and after meals, HS (evening) and PRN (as needed). Date Initiated: 01/09/2024. o three-day bladder diary and assessment to be completed on admission, quarterly, annually, with significant change and as needed. Date Initiated: 08/23/2022. o Utilizes a bedpan, urinal, commode to void. Date Initiated: 08/23/2022. o wears a brief. Date Initiated: 08/23/2022. R6's alteration in the gastrointestinal tract care plan related to bowel incontinence and is at risk for constipation due to pain, meds, decrease in mobilit dated as revised on 12/27/2024 documents: Interventions include: *Check and change upon rising, before and after meals, HS and PRN. Date Initiated: 09/25/2023. * Describe and document any loose stools. Date Initiated: 08/23/2022. o monitor and document BM every shift. Date Initiated: 08/23/2022. o peri cares to be provided after any incontinence .Date Initiated: 08/23/2022 *Three-day bowel and bladder assessment on admission and per policy .Date Initiated: 08/23/2022 On 4/11/25, the facility conducted the quarterly MDS for R6. The assessment documented that R6 has a BIMS (brief interview for mental status) score of 7 - severe cognitive impairment. The MDS also documents that R6 is frequently incontinent of bowel and bladder. This would be a decline in both bowel and bladder incontinence since 1/10/25 when R6 was assessed to be only occasionally incontinent of bowel and bladder. Surveyor requested to review the most current bladder and bowel assessment. The facility provided a quarterly/annual/significant change assessment dated 4/11/25 that documents: Section J: Bladder/ Bowel How long has the resident been incontinent or has a catheter? A: incontinent longer than 1 year. How often is the resident wet? A: once or more per shift. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident is wet during: A: Day and nighttime Amount of urine? A: Small Medications affecting continence: A: Antipsychotics Bowels: continent of stool? A: yes Bowel pattern: normal formed stool, rarely/never depends on a laxative. This assessment was completed by Director of Nursing -B. Surveyor conducted a review of the CNA care card and noted that R6 is to be checked and changed upon rising, before bed and after meals, HS and PRN. R6 is incontinent of bowel and bladder at times. R6 is to wear pull ups- size large. On 05/20/25 at 1:42 PM, Surveyor observed R6 seated in his wheelchair in room. R6 was observed from the hallway, to have taken off his jeans and then removed the brief. The brief appeared soiled and R6 placed it in the waste basket. R6 was then observed attempting to put pants back on. Surveyor noted that R6 had not activated the call light for staff assistance. R6 stands up from wheelchair, without locking the breaks, pulls on pants and connects belt. R6 sits back into wheelchair and then wheels over to closet. R6 then removes the jeans he had just put on, throws then on the floor and takes out another pair of jeans from his closet. R6 is able to put the new pair of jeans on, stands again without locking the brakes on the wheelchair and connects belt. On 05/21/25 at 11:06 AM , Surveyor interviewed LPN Unit Manager- E regarding R6's decline in incontinence. LPN Unit Manager- E stated that R6 is for sure incontinent of urine. R6 will decline cares at times, he likes his independence. R6 can stand and pivot to toilet , so he likes to use the toilet for his bowels. R6 is stubborn and will take himself to the bathroom LPN Unit Manager-E confirmed that R6 is at high risk for falls and will often not lock his wheelchair brakes when standing. LPN Unit Manager- E also stated that R6 is not good at alerting staff his needs, staff must anticipate them. Surveyor asked if the staff follow a toileting schedule for R6 to help anticipate his toileting needs. LPN Unit Manager- E stated that there is not a set schedule other than asking/ checking when R6 gets up in the morning, before meals, before bedtime and as needed. Surveyor asked LPN Unit Manager- E if she was aware the MDS has identified R6 as having a decline in his incontinence from 1/10/25 to 4/11/25. LPN Unit Manager - E stated that she does not have access to the MDS. LPN Unit Manager- E stated that she is not sure how accurate the assessment might be because R6 might or might not always tell staff when he needs to be changed or toileted and he will sometimes do it himself. He might tell or might not. LPN Unit Manager- E stated that education to R6 won't work, he is confused and often will not remember. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	As of the time of exit, the facility was not able to provide evidence that they had comprehensively assessed R6's decline in bowel and bladder continence. The facility did not conduct any type of voiding pattern to develop an individualized toileting plan for R6 to help restore or maintain his bowel and bladder continence. 2.) R16's diagnoses includes seizures (sudden burst of electrical activity in brain which can cause changes in behavior, movement, & level of consciousness), neurogenic bowel (loss of normal bowel function caused by a nerve problem), and hemiplegia (paralysis on one side of the body) & hemiparesis (weakness on one side of the body) following cerebral infarction (type of stroke) affecting right dominate side. R16 incontinent of bowel at times and is at risk for constipation care plan initiated 1/28/23 & revised 3/10/25 documents the following interventions: Administer medications as ordered, initiated 1/18/23. Assess and document bowel sounds, pain, abdominal distention, appetite, initiated 1/18/23. Assist with toileting, initiated 1/18/23. Complete hydration assessment, if at risk notify dietician, initiated 1/18/23. Describe and document any loose stools, initiated 1/18/23. Follow facility protocol for no BM (bowel movement) for three days, initiated 1/18/23. Incont (incontinent) of bowel/bladder at check/change upon rising, before/after meals and HS (hour sleep) and PRN (as needed), initiated 1/9/24. Monitor and document BM every shift, initiated 1/18/23. Offer additional fluids, initiated 1/18/23. Peri cares to be provided after incontinence, initiated 1/18/23, and three day bowel & bladder assessment on admission and per policy, initiated 1/18/23. R16's quarterly MDS (minimum data set) with an assessment reference date of 1/26/25 has a BIMS (brief interview mental status) score of 7 which indicates severe impairment. R16 is assessed as being dependent for toileting hygiene and is always incontinent of urine & bowel. Surveyor reviewed R16's bowel documentation located under the task tab and noted the following: On 2/11/25 during the day shift (6:30 a.m. to 1430 (2:30 p.m.)) R16 was incontinent, BM (bowel movement) size is medium and consistency of BM is loose/diarrhea. The PM (1430 (2:30)-2230 (10:30)) shift and night shift (2230 (10:30 p.m.)-630 (6:30 a.m.)) are blank. On 2/12/25 day shift is blank, PM shift documents 2 no bowel movement, and night shift is blank. On 2/13/25 day shift documents 2 no bowel movement, PM shift documents 2 no bowel movement and night shift is blank. On 2/14/25 day shift, PM shift, and night shift are all blank. On 2/15/25 day shift is blank, PM shift documents 2 no bowel movement, and night shift is blank. On 2/16/25 day shift documents 2 no bowel movement, PM shift and night shift are blank. On 2/17/25 day shift is blank, PM shift documents 2 no bowel movement, and night shift is blank. On 2/18/25 day shift documents incontinent, BM size is large and consistency of BM is putty like, PM shift documents 2 no bowel movement and night shift documents 97 not applicable. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/19/25 day shift is incontinent, BM size is small, consistency of BM is formed/normal, PM shift & night shift document 2 no bowel movement. On 2/20/25 day, PM and night shift are blank. On 2/21/25 day shift document 2 no bowel movement and PM shift & night shift are blank. On 2/22/25 day shift, PM shift, and night shift are blank. On 2/23/25 day shift, PM shift, and night shift are blank. On 2/24/25 day shift & PM shift are blank and night shift documents 99 resident not available. R16's February 2025 MAR (medication administration record) reveals there are no scheduled bowel medications and the following PRN (as needed) bowel medications: order date 1/16/23 Bisacodyl Rectal Suppository 10 mg (milligrams) with directions to insert 1 suppository rectally as needed for PRN QD (as needed every day) for constipation. Order date of 1/16/23 Magnesium Hydroxide Oral Suspension 400 mg (milligrams)/5 ml (milliliter) with directions to give 30 ml by mouth as needed PRN QD for constipation. Surveyor noted during February 2025 R16 did not receive any PRN (as needed) bowel medications. R16's nurses note dated 2/24/25, at 04:01 (4:01 a.m.) written by Licensed Practical Nurse (LPN)-K documents Resident was sent out via 911 ambulance at 0300 (3:00 a.m.). Writer was notified by floor CNA (Certified Nursing Assistant) that Res (Resident) was not doing well when she went in to do his cares. Writer immediately went to residents room and he was sitting up in bed visibly working hard to breath and writer could hear crackles in his chest standing at bedside. Writer listened to residents chest with stethoscope and heard loud lung crackles. Resident was diaphoretic, jaundice in his face/eyes, his whole right arm was purple, his torso and lower extremities were gray, his feet and ankles were more swollen than normal. BP (blood pressure): 79/56, HR (heart rate): 95, T (temperature):97.3, O2 (oxygen): 70% and dropping. A second and third attempt at a BP was unsuccessful. Writer immediately called 911(0255) (2:55 a.m.), ambulance arrived at 0300 (3:00 a.m.) and departed at 0303 (3:03 a.m.). Writer called [hospital initials] ER (emergency room) [Name] to give report; On call nurse notified at 0300; Residents POA (power of attorney) notified at 0318 (3:18 a.m.). Writer sent a notification in HUCU (healthcare communication platform) to providers to update them on the situation at 0346 (3:46 p.m.). R16's hospital Discharge summary dated [DATE] under discharge diagnoses includes Small bowel obstruction. Under hospital course includes documentation of Small bowel obstruction: general surgery followed. Conservative mngmt (management) recommended at this time due to soft abdomen on exam. Concern for ischemic injury as a potential source of elevated lactate. Diet advanced and tolerating. R16's readmission note dated 3/3/25 at 2:00 p.m. and written by Licensed Practical Nurse/Unit Manager (LPN/UM)-F documents admitted from, transferred by, accompanied by: [Hospital's initials], Ambulance, no family present. admitted From: [Hospital's initials]. Admitting dx (diagnoses):: sepsis and small bowel obstruction. Transported by (family or ambulance company name): ambulance Assessment overview:: Resident was lethargic, was able to respond, and looked comfortable. Ambulatory/WC (wheelchair)/Gurney: gurney. Family Member(s) Present: General Mood/Affect Upon Arrival: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R16's nurses note dated 3/3/25 at 14:48 (2:48 p.m.) and written by LPN-L documents Pt (patient) arrived via stretcher. Pt seems lethargic, responds to name only, does not respond to other questions. readmitted post hospital stay for sepsis and a small bowel obstruction. Head to toe skin check revealed scabbing to left side of patient's neck. BUE (bilateral upper extremity) and BLE (bilateral lower extremity) +3 pitting edema. Tubi grips have been applied to BLE. Pt remains incontinent, dependent with all cares, hoyer for all transfers. Last BM (bowel movement) was 3/2/25. Pt has completed ABT (antibiotic) for sepsis. Bowel sounds present. New order for skin prep to scabs on neck daily. No other issues or concerns. R16's quarterly MDS with an assessment reference date of 4/28/25 documents a BIMS score of 7 which indicates severe impairment. R16 is assessed as dependent for toileting hygiene and is always incontinent of urine and bowel. On 5/20/25, at 10:02 a.m., Surveyor asked Licensed Practical Nurse/Unit Manager (LPN/UM)-F if there is a bowel protocol at the facility. LPN/UM-F replied yes we do and explained the CNA's chart bowel movements. LPN/UM-F explained if a Resident hasn't had a bowel movement in three days they will give MOM (milk of magnesia) unless it's contraindicated. If it's been four days then they give a Bisacodyl suppository and if the resident still does not have a bowel movement they contact the physician for further guidance. LPN/UM-F informed Surveyor when they give PRN MOM it will pop up to reassess and asks if the medication is effective or ineffective. On 5/20/25, at 11:54 a.m., Surveyor asked LPN/UM-E if there is a bowel protocol at the facility. LPN/UM-E explained if a resident is incontinent the CNA can tell how many times the resident has had a bowel movement and if the resident is independent they will ask the resident if they have had a bowel movement. LPN/UM-E informed Surveyor this is documented and when the nurses open PCC (pointclickcare) will show if a resident hasn't had a BM for 72 hours. Three days with no BM they will do an intervention. Surveyor asked what the intervention would be. LPN/UM-E informed Surveyor contact the NP (nurse practitioner) for increase in Senna or extra dose of Miralax or suppository depending on the situation. LPN/UM-E informed Surveyor the first thing she'll ask is if the resident is taking any stool softner. Surveyor asked if this would be documented in the residents medical record. LPN/UM-E replied yes and explained if there is a new order or anything happening with the resident should be documented. Surveyor informed LPN/UM-E Surveyor had reviewed R16's bowel documentation and noted R16 did not have a bowel movement from 2/12/25 until day shift on 2/18/25. Surveyor did not note any PRN bowel medication administered during this time. R16 was transferred to the hospital for change of condition on 2/21/25 and hospital discharge summary documents small bowel obstruction. Surveyor asked for any information regarding monitoring of R16's bowels. On 5/20/25 Surveyor was provided with a pink post it note which documented R16 had BM's on the dates that Surveyor provided. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/20/25, at 3:32 p.m., during the end of the day meeting with Nursing Home Administrator-A, Director of Nursing (DON)-B and Consultant-I Surveyor informed staff Surveyor had reviewed R16's bowel records which indicated R16 did not have a bowel movement from 2/12/25 until the day shift on 2/18/25, small bowel movement on the day shift on 2/19/25, no BM on 2/21/25, 2/22/25, &2/23/25, and discharged to the hospital on 2/24/25. R16 returned on 3/4/25 with a diagnosis of small bowel obstruction. Surveyor informed staff Surveyor was provided with a pink post it note from LPN/UM-E which indicated R16 had bowel movements during this time. Surveyor asked DON-B when staff document 2 with their initials and time what does 2 mean. On 5/21/25, at 6:57 a.m., DON-B provided Surveyor with a piece of paper which documented 2 could indicate small BM, incontinent, loose stool, etc .unable to determine which is which on this report. On 5/21/25, at 7:00 a.m., Surveyor asked Certified Nursing Assistant (CNA)-M if a resident doesn't have a bowel movement during his shift what does he document and could he show Surveyor how this is documented. CNA-M went over to the computer and showed Surveyor there is a tile which has no bowel movement. CNA-M showed Surveyor if no BM is clicked on the tiles for size of BM and consistency go away. Surveyor noted if the resident has a BM then these two options continue to be on the computer screen. On 5/21/25, at 9:48 a.m., Surveyor asked LPN/UM-E if she can go into the CNA charting. LPN/UM-E replied yes and stated she never has charted but can try. Surveyor explained to LPN/UM-E Surveyor would like to confirm on the CNA documentation for bowel movement when there is a 2 with initials & time the 2 means no bowel movement. LPN/UM-E was unable to chart in the bowel documentation. Surveyor then asked LPN/UM-E if Surveyor could ask one of the CNA's chart no bowel movement for today and then have the bowel documentation report printed out. On 5/21/25, at 9:58 a.m., Surveyor with LPN/UM-E spoke with CNA-M. Surveyor asked CNA-M to document in the CNA charting for R16 no bowel movement for today during the day shift. CNA-M then entered no bowel movement and saved this documentation. Surveyor showed LPN/UM-E the bowel movement report Surveyor had been provided and asked if she could print out this report for today. LPN/UM-E was unable to print this report and contacted DON-B to print this report. On 5/21/25, at 10:11 a.m., Surveyor accompanied LPN/UM-E to DON-B office. Surveyor showed DON-B the bowel documentation report Surveyor would like printed out as Surveyor had asked CNA-M to document R16 did not have a bowel movement on today's day shift. DON-B printed out this report which documented for 5/21/25 on the day shift 2 with CNA-M's initials and the time. Surveyor showed DON-B and Consultant-I this report for today (5/21/25) documents code 2 which means no bowel movement. Surveyor informed LPN/UM-E, DON-B & Consultant-I R16 went 6 days (2/12/25 to 2/17/25) and 5 days (2/20/25 to 2/24/25) without a bowel movement & without any interventions provided. No additional information was provided.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review the Facility did not ensure there was a medication error rate below 5 percent. There were 3 medication errors in 28 opportunities which resulted in a medication error rate of 10.71%. Medication errors were identified for R54 & R47. * R54 did not receive Glimepiride 4 mg before breakfast according to physician orders and received the incorrect eye drop medication. * R47 received the incorrect eye drop medication. Findings include: On 5/20/25, at 9:56 a.m., Surveyor asked Licensed Practical Nurse/Unit Manager (LPN/UM)-F if there are certain times when Resident's medication should be administered. LPN/UM-F explained they have scheduled times like 8:00 a.m. & 9:00 a.m., some are AM (morning) medications which are administered between 7:00 a.m. & 10:30 a.m., and noon medications which LPN/UM-F believes are between 12:00 p.m. to 2:30 p.m Surveyor asked LPN/UM-F if it's the expectation nurses follow physician orders. LPN/UM-F replied yes. Surveyor asked LPN/UM-F if a medication ordered by a physician to be given before a meal should the medication be given before the resident eats. LPN/UM-F replied yes. 1.) On 5/18/25, at 8:36 a.m. Surveyor observed Registered Nurse (RN)-C obtain R54's blood pressure of 117/83 and then wheel R54 into R54's room. Surveyor asked RN-C if R54 has eaten breakfast already. RN-C replied yup, R54 has eaten already. On 5/18/25, at 8:38 a.m., Surveyor observed RN-C cleanse her hands and then prepare R54's medication which consisted of Aspirin EC (enteric coated) 81 mg (milligrams) one tablet, Folic Acid 1 mg one tablet, Senna 8.6 mg one tablet, Glimepiride 4 mg one tablet, Losartan Potassium 50 mg one tablet and Miralax 17 grams. On 5/18/25 at 8:42 a.m., RN-C who was looking through the medication cart, informed Surveyor R54 gets eye drops and then stated RN-C will have to go downstairs to get them as RN-C doesn't see them in the cart. Surveyor then verified with RN-C there are 5 tablets in the medication cup. On 5/18/25, at 8:46 a.m., RN-C administered R54's medication whole with Miralax. On 5/18/25, at 8:53 a.m. RN-C dated artificial tears lubricant eye drops informing Surveyor R54 will be getting two drops in the right eye. On 5/18/25, at 8:55 a.m., RN-C placed gloves on, handed R54 a tissue, opened R54's right eye and administered two drops in R54's right eye. RN-C removed her gloves, wheeled R54 out of the room into the dining room and cleansed her hands. On 5/19/25, at 2:54 p.m., Surveyor reviewed R54's physician orders. Surveyor noted there is a physician orders dated 7/18/23 which documents Systane Ophthalmic Solution 0.4-0.3% (Polyethylene Glycol-Propylene Glycol (Opth) Instill 2 drops in right eye two times a day for eye redness. R54 received artificial tears lubricant eye drops and not Systane Ophthalmic Solution. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R54's physician orders dated 7/21/22 documents Glimepiride Tablet 4 mg. Give 1 tablet by mouth in the morning for DM (Diabetes Mellitus) (high blood sugar) before breakfast. R54 did not receive Glimepiride 4 mg before breakfast according to physician order. This observation resulted in two medication errors for R54. On 5/20/25, at 11:47 a.m., Surveyor asked LPN/UM-E if nurses should be following physician orders. LPN/UM-E replied absolutely. Surveyor informed LPN/UM-E of R54 not receiving Glimepiride 4 mg before breakfast and receiving the incorrect eye drop medication. 2.) On 5/18/25, at 9:07 a.m., Surveyor observed Med Tech-D prepare R47's medication which consisted of Acetaminophen 325 mg (milligrams) two tablets, Vitamin C 500 mg one tablet, Aspirin 81 mg one tablet, Multi Vitamin one tablet, Allopurinol 100 mg one tablet, Visine dry eye relief lubricant, Furosemide 20 mg one tablet, and Spironolactone 100 mg two tablets. On 5/18/25, at 9:14 a.m., Surveyor verified there are 9 tablets in the medication cup with Med Tech-D and Med Tech-D then placed gloves on. On 5/18/25, at 9:15 a.m., Med Tech-D administered one drop of Visine dry eye relief lubricant in R47's right & left eye and administered R47's medication whole with water. On 5/19/25, at 3:22 p.m., Surveyor reviewed R47's physician orders and noted a physician order dated 8/18/22 Artificial Tears Solution 1.4% (Polyvinyl Alcohol). Instill 1 drop in both eyes two times a day for eye redness. The active ingredients in Visine Dry Eye Relief Lubricant eye drops is polyethylene glycol 400 1%. This observation resulted in one medication error for R47. On 5/20/25, at 10:01 a.m., Surveyor informed LPN/UM-F of R47 receiving the incorrect eye drop on 5/18/25. No additional information was provided.

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and record review, the facility did not ensure it completed accurate mandatory submission of staffing information based on payroll data in a uniform electronic format to the Centers for Medicare & Medicaid Services (CMS). Staffing information for Quarter 1 (October 1 - December 31) of the Payroll Based Journal (PBJ) was not accurately submitted to CMS. This deficient practice has the potential to affect all 69 residents residing in the facility. Findings include: The CMS Electronic Staffing Data Submission Payroll-Based Journal, Long-term Care Facility Policy Manual, dated June 2022, documents: Chapter 1: Overview, 1.1 introduction .(U) mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS .1.2 Submission Timelines and Accuracy. Direct care staffing and census data will be collected quarterly and is required to be timely and accurate .Report Quarter: staffing and census data will be collected for each fiscal quarter. Staffing data includes the number of hours paid to work by each staff member each day within a quarter. Census data includes the facility's census on the last day of each of the three months in a quarter. The fiscal quarters are as follows: Fiscal Quarter, Date range: (quarter) 1 October 1-December 31, (quarter) 2 January 1-March 31, (quarter) 3 April 1-June 30, (quarter) 4 July 1-September 30. 1.) Surveyor reviewed the PBJ Staffing Data Report, CASPER Report 1705D, for Fiscal year 2025 (run on 5/12/25) documents that the Facility had excessively low weekend staffing and a one star staffing rating for the 1st Quarter (October 1-December 31). Surveyor reviewed the Facility's weekend schedules from October 2024 to December 2024. Surveyor noted licensed nurses and certified nursing assistants present on each shift and for each unit. Surveyor noted these schedules included call ins and showed that agency staff and staff who picked up the shifts. Surveyor noted there did not appear to be excessive call-ins. Surveyor reviewed the facility's assessment and noted staffing ratios and compared them to the provided schedules. No discrepancies were found. On 05/19/25, at 11:10 AM, Surveyor interviewed Scheduler-J who stated that minimum staffing levels of 4/4/2 is the set algorithm used but that more staff can be added. Scheduler-J stated that the facility will take census into account and resident acuity. Surveyor verified what the italicized names meant on the schedule and was told that person picked up the shift. If the name is handwritten it was a change after the schedule was printed. If there is a line through the name, it indicates the person was not there either due to call in or no show. (continued on next page)

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	On 05/19/25, at 12:10 PM, Surveyor interviewed Scheduler-J regarding who reports the scheduled working hours to CMS. Per Scheduler-J, the hours are pulled from the timekeeping system directly. Surveyor asked if Scheduler-J was aware that October through December was flagged for One Star Staffing and Excessively Low Weekend Staffing. Scheduler-J stated that corporate had talked to them and Nursing Home Administrator (NHA)-A had to give a report with a spreadsheet to them. On 05/19/25, at 12:11 PM, Surveyor interviewed NHA-A who stated corporate had flagged low and high days of staffing. NHA-A had to go through and see what was not being captured. NHA-A stated that when census is 75 or over the unit manager or Director of Nursing (DON)-B will help nursing staff. On 05/19/25, at 03:16 PM, Surveyor interviewed NHA-A and was told the staffing ratio on the Facility Assessment was wrong, NOC shift should actually be 1:20 (1 aide for 20 residents). NHA-A stated that corporate flagged nurses for low staffing, DON-B was a floating supervisor and the unit managers filled in. On 5/20/25, at 03:19 PM, during the end of day meeting with Director of Nursing-B and Nursing Home Administrator-A Surveyor stated need to figure out what was sent to CMS for data to determine why they triggered for low weekend staffing. On 05/21/25, at 09:47 AM, NHA-A followed up with Surveyor that they just got off phone with corporate was told that in the month of October no agency staff hours were transmitted, corporate fixed the error and has not triggered since. Surveyor informed NHA-A of concern related to improper reporting and NHA-A stated understanding.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility's policy titled, Enhanced Barrier Precautions date as reviewed/revised 2/2025 documents under the Policy section: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Under the Policy Explanation and Compliance Guidelines section it documents: 2. Initiation of Enhanced Barrier Precautions documents a. The facility will have the discretion in using EBP (enhanced barrier precautions) for residents who do not have a chronic wound or indwelling medical device and are infected or colonized with an MDRO (multidrug resistant organism) that is not currently targeted by CDC (Centers for Disease Control) but may be considered epidemiologically important. b. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC (peripherally inserted central catheter) lines, midline catheters) even if the resident is not known to be infected or colonized with a MDRO. (Peripheral IVs, continuous glucose monitors, insulin pumps, or ostomies without an associated indwelling medical device are not an indication for EBP.) ii. Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply. 4. High-contact resident care activities include: a. Dressing. b. Bathing. c. Transferring. d. Providing hygiene. e. Changing linens. f. Changing briefs or assisting with toileting. g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters. h. Wound care: any skin opening requiring a dressing. 3.) R32's modification of admission MDS (minimum data set) with an assessment reference date of 4/20/25 has a BIMS (brief interview mental status) score of 6 which indicates severe cognitive impairment. R32 is assessed as requiring partial/moderate assistance for toileting hygiene and is always incontinent of urine and bladder. On 5/19/25, at 1:49 p.m., Surveyor observed Certified Nursing Assistant (CNA)-X in R32's room. R32 is sitting in a wheelchair and informed CNA-X that R32 made a mess. CNA-X placed a bath blanket on R32's bed, informed R32 she was going to get help and left R32's room. On 5/19/25, at 1:52 p.m., CNA-X & CNA-M entered R32's room and put gloves on. CNA-X and CNA-M assisted R32 to bed. R32 took a couple steps, then CNA-X & CNA-M lowered R32's pants and R32 sat on the edge of the bed. CNA-M removed the gait belt, moved the wheelchair away from R32's bed and swung R32's legs so R32 was laying flat in bed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 1:58 p.m, CNA-X unfastened R32's incontinence product & lowered the product between R32's legs. Surveyor noted a strong odor of BM (bowel movement). CNA-X washed under R32's abdominal fold to remove BM, squeezed water from the wash cloth onto R32's frontal perineal area and washed the frontal perineal area from front to back. CNA-X stated oh boy at least you are in bed and rewashed the frontal perineal area. CNA-X asked R32 if she could roll towards the wall and assisted R32 with rolling onto her side. CNA-X washed R32's rectal area to remove BM, removed the soiled incontinence product & placed this product in the garbage can. CNA-X folded the bath blanket over the BM to cover the BM. CNA-X rewashed R32's rectal area, squeezed water onto R32's buttocks and washed R32's buttocks and rectal area. After CNA-X finished washing R32's buttocks & rectal area, CNA-X did not remove her gloves. CNA-X removed silicone cream from the dresser, applied the cream on R32's buttocks, folded the bath blanket, moved R32's comforter and stated I know I had a brief. CNA-X placed an incontinence product under R32, R32 was assisted on her back and CNA-X rewashed R32's frontal perineal area. CNA-X applied silicone cream on R32's inner thighs, removed her gloves and washed her hands. Surveyor observed this is the first observation of CNA-X performing hand hygiene. CNA-X placed gloves on, assisted R32 with positioning on her side, and removed the bath blanket. R32 was positioned on her back, the incontinence product was fastened and R32 was covered with bedding. The head of R32's bed was elevated, the call light was placed in reach and R32's bed was lowered. At 2:09 p.m. CNA-X removed her gloves and washed her hands. On 5/21/25, at 10:32 a.m., Surveyor asked Infection Control/Registered Nurse (IC/RN)-T when staff are doing incontinence cares for resident who is incontinent of bowel, after they have finished washing the resident, before placing a new incontinence product on the resident should they remove their gloves and perform hand hygiene. IC/RN-T replied yes. Surveyor informed IC/RN-T of the observation with R32 & CNA-X. No additional information was provided. 4.) R50's significant change MDS (minimum data set) with an assessment reference date of 4/10/25 assesses R50 as being dependent for toileting hygiene & chair/bed to chair transfer. R50 is assessed as having a urinary indwelling catheter. On 5/19/25, at 10:54 a.m., Licensed Practical Nurse (LPN)-W entered R50's room wearing a gown that was not tied at the neck. LPN-W placed gloves on, removed a graduate from the bathroom and placed the graduate directly on the floor. LPN-W did not place a barrier on the floor. LPN-W asked R50 if he was having any pain in his stomach or bladder, which R50 indicated he wasn't. LPN-W informed R50 he was having the sediments & urine go down to the collection bag informing R50 the urine is looking really clear. At 10:59 a.m., LPN-W unclipped the spicket from the collection bag and drained the urine into the graduate. Surveyor observed there is still not a barrier on the floor. R50's representative moved LPN-W's gown towards the back as the gown was slipping off LPN-W's shoulders, placed the spicket back in the collection bag and placed the collection bag in the blue privacy bag. LPN-W informed Surveyor he removed 550 cc (cubic centimeters) of urine. (continued on next page)

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	525242	A. Building B. Wing	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Kensington	1810 Kensington Dr Waukesha, WI 53188

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 11:01 a.m. LPN-W removed his gloves and placed gloves on. Surveyor observed LPN-W did not perform hand hygiene prior to placing gloves on. LPN-W removed syringe kit from R50's dresser, placed a towel under R50's upper leg, poured sodium chloride 0.9% into the container & withdrew 60 cc. LPN-W unclamped the tubing and flushed R50's urinary catheter. At 11:06 a.m. LPN-W collected the garbage, removed his gloves & gown and washed his hands. On 5/20/25, at 7:29 a.m., Surveyor observed Med Tech-Y and Certified Nursing Assistant (CNA)-Z entered R50's room and placed gloves on. Surveyor observed neither Med Tech-Y or CNA-Z were wearing a gown. Surveyor observed R50 is sitting on the edge of the bed. The height of R50's bed was raised, a sling was placed around R50 & connected to the hoyer lift. R50 was raised off the bed, R50's pants were pulled up and R50 was lowered into the bed. Med Tech-Y unhooked the sling from the lift & removed the sling from R50. CNA-Z removed the draw sheet from R50's bed and informed R50 she was going to help change his shirt. Med Tech-Y removed her gloves, washed her hands, and left R50's room. CNA-Z stated to R50 she was going to help you pull your shirt over your head and removed R50's shirt. CNA-Z handed R50 deodorant which R50 applied. CNA-Z placed a shirt & sweater on R50, informed R50 she is going to wash his glasses & she needs a weight. CNA-Z then washed R50 glasses. After washing R50's glasses, CNA-Z removed her gloves and washed her hands. At 7:45 a.m. Surveyor observed CNA-Z enter R50's room with a flat sheet. Surveyor observed CNA-Z is not wearing any PPE (personal protective equipment). CNA-Z placed the flat sheet on R50's bed and made R50's bed. On 5/21/25, at 7:14 a.m. Surveyor noted the EBP sign located on the right side of R50's doorframe, which has been on the doorframe since the beginning of the survey on 5/18/25, documents Providers and staff must also wear gloves and gowns for high contact resident care activities, dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assist with with toileting device care or use: central line, urinary catheter, feeding tube, tracheostomy. Wound care any skin opening requiring a dressing. On 5/21/25, at 10:32 a.m., Surveyor asked Infection Control/Registered Nurse (IC/RN)-T when emptying an urinary collection bag should the graduate be placed directly on the floor. IC/RN-T replied no. Surveyor asked when staff removes their gloves should they perform hand hygiene before placing new gloves on. IC/RN-T replied yes. Surveyor asked how does staff know a resident is on enhanced barrier precautions. IC/RN-T informed Surveyor there is signage on the door, they are informed by their nurse and upon hire they are educated. Surveyor asked IC/RN-T when staff are transferring a resident or making their bed & the resident is on enhanced barrier precautions should they wear a gown. IC/RN-T replied yes they should be wearing a gown based on the EBP sign. Surveyor informed IC/RN-T of the observations with R50.5.) R9 was admitted to the facility on [DATE] with pertinent diagnoses that include unstageable pressure ulcer of sacral region (a severe pressure sore that's difficult to stage because the base of the wound is obscured by slough or eschar, making it impossible to determine the true depth of tissue damage. The sacral region is located at the base of the spine), type 2 diabetes mellitus (happens when the body cannot use insulin correctly and sugar builds up in the blood), morbid obesity (body mass index (BMI) of 40 or higher), and chronic pain syndrome (a condition characterized by persistent pain that lasts for more than three months). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/20/25, at 01:24 PM, Surveyor observed Licensed Practical Nurse (LPN)-L perform wound care on R9's left posterior thigh pressure injury. LPN-L put on a face mask, gown, washed hands and applied gloves. Surveyor observed LPN-L take the existing wound cover off R9's wound. LPN-L cleaned the wound with gauze and normal saline. Next LPN-L applied the Silver sulfadiazine with a cotton tip applicator. LPN-L then folded an abdominal pad into thirds, dated and initialed it and applied it over the Silver sulfadiazine and wound with tape. Surveyor observed LPN-L then remove gloves and wash hands. Surveyor noted that LPN-L did not change gloves change after taking the existing wound cover off, cleaning the wound or touching and applying the new wound cover. According to the Pennsylvania Department of Health gloves should be changed after the old dressing is removed and discarded immediately, dirty gloves removed and discarded. Hand hygiene should be performed properly before accessing clean supplies. Clean gloves donned. Then wound cleaned using aseptic non-touch technique. Wound treatment completed using aseptic non-touch technique. Dirty supplies discarded in trash receptacle. Gloves removed and hand hygiene performed properly after dressing change is complete. On 05/20/25, at 03:19 PM, during the end of day exit meeting with the facility, Surveyor shared concern that while watching wound care, LPN-L did not perform handwashing and a glove change between dirty and clean tasks. No additional information was provided regarding handwashing and glove changes. Based on observations, interviews, and record review, the facility did not establish and maintain an infection prevention and infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections during 5 (R12, R44, R32, R50 & R9) of 8 resident care and treatment observations. * Surveyor observed a staff member empty R12's ileostomy bag (small abdominal opening to allow waste discharge from the small bowel). After empting the ileostomy bag, Surveyor observed the staff member not remove their gloves and did not wash their hands prior to turning on R12's radio. * Surveyor observed a staff member walk into R44's enhanced barrier precaution room and leave R44's enhanced barrier precaution room without performing hand hygiene as required for posted enhanced barrier precaution rooms. * Surveyor observed a staff member not remove their gloves or wash their hands after providing incontinence care to R32. * Staff was observed not wearing a gown when caring for R50 whom was on enhanced barrier precautions. * During Surveyor's observation of R9's wound care, Licensed Practical Nurse-L was observed not washing hands and changing gloves between dirty and clean procedures. Findings include: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Enhanced Barrier Precaution signs on the resident's door frames document: Everyone Must: Clean their hands, including before entering and when leaving the room. Providers and staff must also: Wear gloves and a gown for the following high contact resident care activities. dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assist with toileting device care or use: central line, urinary catheter, feeding tube, tracheostomy, Wound care any skin opening requiring a dressing. The facility's policy dated as revised 2/2025 and titled, Hand Hygiene documents: Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Definitions: Hand Hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of antiseptic hand rub, also known as alcohol-based hand rub (ABHR). Policy explanation and Compliance Guidelines: 1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. 2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. 3. Alcohol-based hand rub with 60 to 95 % alcohol is the preferred method for cleaning hands in most clinical situations. Wash hands with soap and water whenever they are viably dirty, before eating, and after using the restroom 6. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. b. Bar soap is approved for a resident's personal use only. Keep bar soap clean and dry in protective containers (i.e. plastic case or bag). c. Liquid soap reservoirs must be discarded when empty. If refillable, dispensers must be emptied and cleaned, rinsed and dried according to manufacturer instructions Findings include: 1.) R12 was admitted to the facility on [DATE] with diagnoses that included Urinary Retention and Ileostomy. On 05/20/25, at 09:56 AM, Surveyor observed R12's ileostomy bag being emptied of fecal material by CNA-G during R12's cares. Surveyor noted that R12 is in enhanced barrier precautions with an enhanced barrier precaution sign located outside of R12's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor observed CNA-G wash hands and don gloves and gown prior to CNA-G performing cares on R12. Surveyor observed CNA-G empty R12's Ileostomy bag and then place contents from R12's ileostomy bag into a closed bag and then double bag the fecal contents of the bag. Surveyor observed R12 then request that CNA-G turn on R12's stereo. Surveyor observed CNA-G walk over to R12's radio while still wearing the gown and gloves used during the emptying of R12's ileostomy bag and turn on R12's radio. Surveyor observed CNA-G then remove CNA-G's gown and gloves and wash CNA-G's hands and leave R12's room. On 05/21/25, at 12:50 PM, Surveyor informed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B Surveyor's concerns of CNA-G touching R12's radio without removing CNA-G's contaminated gloves and performing hand hygiene after emptying R12's ostomy bag of fecal material. No additional information was provided. 2.) R44 was admitted to the facility on [DATE] with diagnoses that included Urinary Incontinence with an Indwelling Catheter and Cancer. On 5/19/25, at 08:05 AM, Surveyor observed Certified Nursing Assistant (CNA)-H walk from a meal cart down the hall into a room occupied by R44. Surveyor observed CNA-H place a mask on and bring a meal tray into R44's room and set it down in front of R44. Surveyor watched CNA-H pick up the meal tray and not perform hand hygiene when CNA-H left R44's enhanced barrier precaution room. Surveyor watched CNA-H walk back to meal cart and pick up another tray and return to R44's enhanced barrier precaution room and set the new tray down in front of R44. Surveyor watched CNA-H only perform hand hygiene when leaving R44's enhanced barrier precaution room after the second tray was delivered. Surveyor was positioned outside of R44's room and could see in the room because the door to R44's room was left open. On 05/21/25, at 12:50 PM, Surveyor informed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B Surveyor's concerns during the 5/19/25 incident when CNA-H did not perform hand hygiene when leaving R44's enhanced barrier precaution room. No additional information was provided.