STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525266	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Park Nursing and Rehab Center	718 Jupiter Drive Madison, WI 53718

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that each resident received treatment and care in accordance with professional standards of practice (N6, Wisconsin Nurse Practice Act) for 1 out of 19 residents (R74) reviewed for change of condition.R74 had orders to update the physician with pulse greater than 119. R74 had a pulse of 140 and the facility did not complete a nursing assessment, recheck the pulse, consult with the physician, or complete ongoing monitoring of R74. R74 was found pulseless and non-breathing. The facility's failure to recognize a change in condition and perform a thorough nursing assessment along with ongoing assessments and monitoring of a resident created a finding of immediate jeopardy that began on [DATE]. Surveyor notified the NHA A (Nursing Home Administrator) of the immediate jeopardy on [DATE] at 2:03 PM. The immediate jeopardy was removed on [DATE]; however, the deficient practice continues at a scope/severity of D (potential for more than minimal harm/isolated) as the facility continues to implement its action plan. Evidenced by:The facility's Change in a Resident's Condition or Status policy, dated 2/2021, states in part: Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., (example) changes in level of care, billing/payments, resident rights, etc.). Policy Interpretation and Implementation 1. The nurse will notify the resident's attending physician or physician on call when there has been a(an): .d. significant change in the resident's physical/emotional/mental condition; e. need to alter the resident's medical treatment significantly;.i. specific instruction to notify the physician of changes in the resident's condition.3. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR (Situation, Background, Assessment, and Recommendation-a standardized tool used by nurses to communicate critical patient information to other healthcare providers) Communication Form.8. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.According to the Wisconsin Nurse Practice Act, N6.03(1), An R.N. (Registered Nurse) shall utilize the nursing process in the execution of general nursing procedures in the maintenance of health, prevention of illness or care of the ill. The nursing process consists of the steps of assessment, planning, intervention, and evaluation. This standard is met through performance of each of the following steps of the nursing process: (a) Assessment. Assessment is the systematic and continual collection and analysis of data about the health status of a patient culminating in the formulation of a nursing diagnosis. (b) Planning. Planning is developing a nursing plan of care for a patient which includes goals and priorities derived from the nursing diagnosis. (c) Intervention. Intervention is the nursing action to implement the plan of care by directly administering care or by directing and supervising nursing acts delegated to L.P.N.s (Licensed Practical Nurse) or less skilled assistants. (d) Evaluation. Evaluation is the determination of a patient's progress or lack of progress toward goal achievement which may lead to modification of the nursing diagnosis.R74 was admitted to the facility on [DATE] with diagnoses to include Other Cardiomyopathies (a disease of the heart muscle which causes the heart to have a harder time pumping blood to the rest of the (continued on next page)

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

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	body); Type 2 Diabetes Mellitus with ketoacidosis without coma (a condition when the body can't make enough insulin to regulate blood sugars which can cause heart concerns due to electrolyte imbalances); morbid obesity; and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life.)R74's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident is cognitively intact. R74's Physician's Orders include:*Order date [DATE] CPR (cardiopulmonary resuscitation-indicating full code status; a medical directive instructing healthcare providers to perform life saving measures in the event of a cardiac or respiratory arrest.)R74's Hospital Discharge summary dated [DATE], states in part: PHMx (past medical history).s/p (status post-a condition after a specific past event) cardiac arrest (when the heart suddenly and unexpectedly stops beating) with defibrillator in place (a device that provides electric shock to the heart).primary familial cardiomyopathy (a genetic heart condition where the heart muscle thins and weakens, causing inefficient pumping).R74's Progress Note dated [DATE] at 12:34 PM, states in part: Elevated heart rate noted when obtaining VS (vital signs). Apical pulse rate (pulse point on the chest at the tip of the heart) is 105 and regular.called the on-call.advised that patient be evaluated in the ER (Emergency Room) with previous cardiac history, resident refused x3 (three times), education of importance was provided, resident still declined.R74's Physician's Orders include: Order date [DATE] VS every shift for monitoring.R74's Progress notes include:*[DATE] 11:26 am message left with NP (Nurse Practitioner) regarding continued elevated HR (heart rate) 110. Continues to deny heart palpations, SOB (shortness of breath), or chest pain.*[DATE] 11:39 am NP updated and meeting with resident today. *[DATE] 2:56 am . update left with NP of elevated HR of 114 and need for parameters of when to call MD.R74's Physician's Orders include:*Order date [DATE] Update NP in 1 week with heart rates one time only for Tachycardia (a condition where the heart beats abnormally fast, over 100 beats a minute) start date [DATE]*Order date [DATE] VS every shift, update provider for HR > (greater than) 119 and/or HR>100 with other symptoms, every shift for tachycardia*Order date [DATE] Update provider for HRs sustained >119 (for HR in 120s) or HR>100 with associated symptoms [dyspnea (difficulty breathing), CP (chest pain), dizziness, diaphoresis (sweating) and/or palpitations (sensation of feeling your heart beat abnormally)] every shift for TachycardiaR74's Weights and Vitals Summary for Pulse includes:*[DATE] 12:34 PM 105 bpm (beats per minute)*[DATE] 3:33 PM 102 bpm*[DATE] 5:06 AM 115 bpm*[DATE] 10:40 AM 110 bpm*[DATE] 3:14 PM 113 bpm*[DATE] 11:48 PM 114 bpm*[DATE] 7:59 AM 116 bpm*[DATE] 4:40 PM 111 bpm*[DATE] 12:10 AM 115 bpm*[DATE] 9:04 AM 117 bpm*[DATE] 8:56 PM 109 bpm*[DATE] 11:34 PM 116 bpm*[DATE] 10:38 AM 116 bpm*[DATE] 4:57 PM 115 bpm*[DATE] 2:45 AM 102 bpm*[DATE] 2:35 PM 108 bpm*[DATE] 9:17 PM 88 bpm*[DATE] 2:15 AM 99 bpm*[DATE] 1:52 PM 103 bpm*[DATE] 3:58 PM 104 bpm*[DATE] 9:17 PM 105 bpm*[DATE] 12:14 AM 102 bpm*[DATE] 9:32 AM 100 bpm*[DATE] 2:18 PM 100 bpm*[DATE] 9:35 PM 140 bpmImportant to note: there are no pulses documented on the vitals record after [DATE] at 9:35 PM. Additionally, there are no further cardiorespiratory assessments of R74 despite a pulse of 140. R74's Medication Administration Record (MAR) for the evening shift of [DATE] indicates a pulse of 140.R74's Progress Notes include:*[DATE] 6:55 AM Resident deceased *[DATE] 7:35 AM writer entered patient's room at approximately 4:30am.found pt pulseless and not breathing. Pt full code, writer and CNA (Certified Nursing Assistant) pulled pt from bed to floor where writer began chest compressions and CNA called 911. EMS (Emergency Medical Services) arrived, took over compressions.EMS attempted compressions for approximately 40 min when decision was made to cease attempts.Important to note: There are no progress notes or nursing assessments documented on [DATE] or [DATE] prior to R74's death.On [DATE] at 9:01 AM, Surveyor interviewed CNA U (Certified Nursing Assistant) and asked if anything had been shared about R74's pulse in shift report on [DATE]. CNA U stated no, but I had told the nurse a week or so earlier as I had noticed an elevated pulse .anything above 110 you are supposed to notify. If I remember right R74 was like 140 or something. Actually, I remember R74 being (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	147 .I had never seen anyone with a heart rate that high when resting.I could understand if they were in a marathon. CNA U indicated telling the nurse about the pulse and the nurse telling CNA U to recheck. CNA U stated the next pulse check was just as high.not higher, maybe 3 points less. CNA U indicated no recollection of who the nurse was or if there was any intervention for resident following the report of continued high pulse.On [DATE] at 9:50 AM, Surveyor interviewed LPN R (Licensed Practical Nurse) who indicated no recollection of R74. Surveyor asked if LPN R had any recollection of a resident having a pulse of 140. LPN R stated no. Reviewed the documentation of R74's VS report and MAR. LPN R stated no, that must be a typo.if a resident had a pulse of 140 I would notify the doctor.On [DATE] at 2:53 PM, Surveyor interviewed NP T (Nurse Practitioner) and asked if continued monitoring would be expected for a resident with a pulse of 140. NP T stated yes, vital signs with heart rate and monitoring for dizziness, shortness of breath, and altered mental status. NP T stated that if a resident refused to go to the ER, NP T would question the refusal and contact the resident/family to discuss risks and benefits.On [DATE] at 3:20 PM, Surveyor interviewed RN V (Registered Nurse) who indicated that no information had been shared at shift change regarding R74, but there were tasks in the charting regarding watching R74's pulse. RN V indicated peeking at resident at change of shift but having no contact with R74 until finding R74 pulseless/non-breathing, stating that R74 didn't like to be disturbed and preferred to call for assist as needed.On [DATE] at 11:55 AM, Surveyor interviewed IDON B (Interim Director of Nursing) and asked about interpretation of an order to update physician for sustained pulse >119. IDON B stated it would be dependent on the resident's activity level at the time of the pulse. If the resident was active, they may be elevated. Staff would need to recheck in a few minutes to see if it was an anomaly (something that deviates from what is normal/expected). After the recheck, if still above, call the physician. IDON B indicated being unfamiliar with R74 and would need to review. At 5:05 PM, IDON B stated that no documentation of assessment or physician update was found regarding the pulse of 140 and IDON B would have expected there to be.On [DATE] at 1:31 PM, Surveyor interviewed MD Q (Medical Director) and asked about a pulse of 140. MD Q stated that at 140, that is real tachycardia. MD Q stated this is abnormal and would need to be investigated: EKG (electrocardiogram-a non-invasive test that records the electrical activity of the heart), blood work, VS every 10-15 minutes; may need to call 911. MD Q stated we expect staff to document, that is unacceptable.The failure to complete a nursing assessment and implement continued monitoring created a reasonable likelihood for serious harm which created a finding of immediate jeopardy. The facility removed the immediate jeopardy on [DATE]; however, the deficient practice continues at a scope/severity of D (potential for more than minimal harm/isolated) as the facility continues to implement the following action plan: * A house sweep of all current residents to identify any changes of condition within the last 24 hours that require MD notification, and one resident was noted to have a change of condition, however standard of nursing practice and proper notification procedure were followed.*Facility DON /NHA initiated education for all scheduled licensed nursing staff regarding:o Policies and procedures-change in a resident's condition or status, medication and treatment orders, charting and documentation, standards of nursing practice (nursing process, including assessment and evaluation). Education provided emphasized the importance of documentation, clear and concise communication, identifying a change in resident condition, provider notification, and clinical follow-up. o Provider notification, standards of practice are based on the facility policy. Notifications will be made within 24 hours of the change of condition, except in medical emergencies, or resident injury. Education on the Standards of Nursing Practice included the use of Einteract for comprehensive and concise communication. Education on assessments and change of condition included review of clinical protocol for resident change of condition, as well as focused nursing assessments.o All licensed nursing staff will receive the above mentioned education by [DATE] or before the start of their next shift. *The facility will contract with an outside consultant to monitor compliance with abatement strategies *Quality assessment and assurance to ensure ongoing compliance. *Director of (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Nursing/designee will complete audits on change of conditions [sic] including documentation, follow-up, and provider notification. These audits will occur 3 times weekly for 3 weeks, monthly for 4 months then randomly thereafter.*Results of these reviews will be reviewed by the facility Quality Assurance Performance Improvement committee for patterns, trends and continued recommendations for process monitoring and improvement.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility did not ensure a resident's environment remained free of accidents and hazards for 1 of 3 residents reviewed for falls (R48) and 1 of 3 residents reviewed for supervision (R37). R48 is being cited at severity level 3 (actual harm). R48 sustained three falls. The facility failed to identify a root cause analysis (RCA) or patterns with R48's three falls. Without identifying the RCA, the interdisciplinary team (IDT) did not implement resident specific interventions or identify patterns which could have contributed to her falls and/or prevent future falls, such as a plan to anticipate her toileting needs when she stated she was trying to go to the bathroom. R48 was found to have a C1 fracture (a break in the first vertebra or the cervical spine, located at the base of the skull) and left seventh rib fracture after the second fall. R48's third fall resulted in a closed fracture of her right femur. There was no evidence of an RN assessment prior to R48 being moved after the third fall. Surveyor observed R37 put crafting pom poms in his mouth during mealtime while unsupervised and observed chemicals, lotions, and aerosol cans in an unlocked cabinet on a R37's unit. R37 is known for wandering, being confused, and rummaging. This is evidenced by: Facility policy, titled Falls – Clinical Protocol, revised March 2018, states in part, .Cause Identification 1. For an individual who has fallen, the staff and practitioner will begin to try to identify possible causes within 24 hours of the fall. Treatment/Management 1. Based on the preceding assessment, the staff and provider will identify pertinent interventions to try to prevent subsequent falls and to address the risk of clinically significant consequences of falling . Facility policy, titled Falls and Fall Risk, Managing, revised March 2018, states in part, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling. Resident-Centered Approaches to Managing Falls and Fall Risk: .5. If falling recurs despite initial interventions, staff will implement additional or different interventions or indicate why the current approach remains relevant. 6. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable.8. Position-change alarms will not be used as the primary or sole intervention to prevent falls but rather will be used to assist the staff in identifying patterns and routines of the resident. The use of alarms will be monitored for efficacy and staff will respond to alarms in a timely manner. Monitoring Subsequent Falls and Falls Risk: .3. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending provider will help the staff reconsider possible causes that may not previously have been identified. Example 1 R48 initially admitted to the facility on [DATE] following a hospital stay for acute hypoxic respiratory failure and pneumonia. R48 had a left femur trochanteric fracture (a break in the bone that connects (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	the hip joint to the thigh) and left distal radius fracture (a break in the lower end of the long bone (thumb side) of the forearm) in 2/2025. R48 has diagnoses that include, in part: Other secondary Parkinsonism (condition that presents with symptoms such as tremors). R48's Minimum Data Set (MDS) with a reference date of 5/6/25, indicates R48's cognition is severely impaired, with a Brief Interview for Mental Status (BIMS) score of 7 out of 15. Section GG of this assessment indicated R48 uses a manual wheelchair for mobility and is dependent for chair/bed-to chair transfers, toilet transfers, and toileting hygiene. R48's admission Morse Fall Risk Assessment, dated 5/1/25, indicates R48 is at a high risk for falls, with a score of 75 (high risk is a score of 45 or higher). Section F. Mental Status states, Mental status measures the residents [sic] self-assessment of his/her own ability to ambulate. Ask the resident, 'Are you able to go to the bathroom alone, or do you need assistance?' Does the resident's response to the above indicate they know the limits of their abilities to ambulate safely? Response 1 is checked: Knows own limits.-It is important to note that R48 has a severe cognitive impairment; due to this, R48 may no longer be able to accurately judge her own limitations. R48's Care Plan, dated 5/1/25, states in part: .Focus: [R48] is at high risk for falls r/t (related to) impaired mobility secondary to Parkinson's Disease. Goal: [R48] will not sustain serious injury through the review date. Interventions/Tasks: All staff to monitor that [R48] is wearing appropriate footwear or non-skid socks when ambulating or mobilizing in w/c (wheelchair). Anticipate and meet [R48's] needs as much as possible to prevent unsafe self-initiation. Assess/observe regularly for a safe environment with even floors free from spills and/or clutter; adequate, glare-free light; personal items within reach. Be sure call light is within reach and encourage [R48] to use it for assistance as needed. Educate [R48], family, and her other caregivers about safety reminders and what to do if a fall occurs. Encourage [R48] to participate in activities that promote exercise, physical activity for strengthening and improved mobility. Follow fall protocol if a fall occurs. Pt (physical therapy) evaluate and treat as ordered or PRN (as needed). .Focus: Alteration in sleep pattern or sleep pattern disturbance.Interventions/Tasks: Encourage urination just before bedtime. .Focus: The resident has bladder incontinence r/t decreased mobility.Interventions/Tasks: Assist with routine and PRN toileting.Ensure the resident has an unobstructed path to the bathroom. .Focus: [R48] has impaired cognitive function or impaired thought processes – has activated HCPOA (Health Care Power of Attorney). SLUMS (St. Louis University Mental Status) score of 15/30 (examination for detecting cognitive impairment and dementia – a score of 0-20 indicates dementia).Interventions/Tasks: Ask yes/no questions to determine needs.Communication: Use the resident preferred name. Identify yourself at each interaction. Face [R48] when speaking and make eye contact. Reduce any distractions.The resident understands consistent, simple, directive sentences. Provide necessary cutes – stop and return if agitated. .Focus: [R48] has ADL (activities of daily living) self-care performance deficits.Interventions/Tasks: Ambulation: therapy only. Mobility/Locomotion: [R48] is mobile via manual wc (wheelchair) with assist of 1 staff. Toilet use: [R48] is able to perform stand pivot with 1A (one person assist) with grab bar or 2WW (two-wheeled walker). Fall #1:R48's Fall Un-Witnessed WITH Injury report, dated 6/4/25 at 5:00 AM, includes in part: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	.Nursing description: While doing rounds, CNA (certified nursing assistant) heard patient calling out 'help me, help me!' Upon entering patient's room, CNA found patient lying on the floor next to the wall across from the bathroom. Patient noted to have a large skin tear to left forearm that is actively bleeding but no other visible injuries noted. Patient c/o (complained of) chest and rib pain, telling writer it was hard to breathe. Writer offered to either have patient assisted back into bed or be sent to ER (Emergency Room) for further evaluation of the chest pain. It is this writer's opinion the skin tear did not warrant sutures.decision made to sent [sic] patient to.Hospital. Resident description: When queried regarding details of fall, patient tells writer, 'I tripped while on my way to the bathroom.'R48's Emergency Department after visit summary, dated 6/4/25, indicates that shoulder, elbow, and wrist x-rays were taken and a CT (computerized tomography) scan (an imaging procedure to look at cross-sectional images of the body) was completed. Discharge orders state, in part: .We found: Your fall did not result in any serious injuries; a comprehensive scan of your body (pan scan) showed no fractures or internal injuries. You were diagnosed with a urinary tract infection (UTI), for which you have been prescribed an antibiotic. Surveyor reviewed the Interdisciplinary Team (IDT) notes for R48's fall: 6/5/2025 24-hour note: IDT team reviewed this fall. Immediate intervention is to place reminders in resident's room to use call light when in need of assistance. CP (Care Plan) and CC (Care Card) updated. 6/9/2025 72-hour note: IDT team reviewed this intervention and found it to be effective. No additional falls were noted at this time. An updated Morse Fall Risk assessment was completed for R48 on 6/4/25. The updated assessment indicates R48 is at a high risk for falls, with a score of 80. Section F. Mental Status states, Mental status measures the residents [sic] self-assessment of his/her own ability to ambulate. Ask the resident, 'Are you able to go to the bathroom alone, or do you need assistance?' Does the resident's response to the above indicate they know the limits of their abilities to ambulate safely? Response 2 is checked: Overestimates or forgets limits. The following fall risk interventions/tasks were added to R48's care plan: Reminders placed in resident's room to use call light for assistance. Date initiated: 06/09/2025. [R48] will have a sign up in her room as a reminder to use her call light for assistance. Date initiated: 06/10/2025. It is important to note:-The fall report and the IDT review notes do not include documentation of a root cause. -Staff are educating R48 as an intervention for fall prevention, despite R48's BIMS score of 7 out of 15, indicating severe cognitive impairment, and her diagnosis of Parkinson's disease. Fall #2:R48's Fall Un-Witnessed WITHOUT Injury report, dated 6/11/25 at 6:00 AM, includes in part, .Nursing description: Writer called to resident room by CNA staff who reported resident was on the floor next to bed. She was sitting with [sic] floor with legs extended out. Resident unable to state why she was attempting to get out of bed on her own. VSS (vital signs stable), moves all extremities w/o (without) complaints of pain. No injuries observed. Resident description: Resident unable to give description.Immediate Action Taken – Description: DON (Director of Nursing), POA (Power of Attorney), and NP (Nurse Practitioner) updated. Resident encouraged to use call light for all transfers. R48's Progress Notes, dated 6/11/25, include in part:7:26 AM – RN (Registered Nurse): POA updated regarding unwitnessed fall. Resident reported that she had hit her head when she fell. Neuros and vitals WNL (within normal limits). POA did request for resident to be sent to hospital to be evaluated. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	8:30 AM – RN: Received orders to send resident out to ER for evaluation. Resident sent out.POA and DON updated. 3:44 PM - RN: Per report from POA, resident has a broken bone in her neck and ribs.resident will be transferred.for further evaluation. DON updated. Surveyor reviewed the IDT notes for R48's fall: 6/12/2025 24-hour note: IDT team reviewed this fall. Resident already had a care plan in place for low bed, however, she did not have fall mats. At this time the immediate intervention will be to add fall mats to the resident's interventions. CP and CC updated. 6/16/2025 72-hour note: Resident still remains in hospital at this time. IDT finished out this fall and intervention. An updated Morse Fall Risk assessment was completed for R48 on 6/11/25. The updated assessment indicates R48 is at a high risk for falls, with a score of 80. Section F. Mental Status states, Mental status measures the residents [sic] self-assessment of his/her own ability to ambulate. Ask the resident, 'Are you able to go to the bathroom alone, or do you need assistance?' Does the resident's response to the above indicate they know the limits of their abilities to ambulate safely? Response 2 is checked: Overestimates or forgets limits. The following fall risk interventions/tasks were added to R48's care plan: Low bed. Date initiated: 06/09/2025 / Cancelled date: 06/12/2025. Low bed and falls mat. Date initiated: 06/12/2025. Bed against wall for spatial awareness. Date initiated: 06/17/2025. [NAME] alarms (a monitoring system that uses sensors to track movements and sends a silent alert to staff members): restless in room, out of bed alarm. Date initiated: 06/17/2025. Soft touch disc call light to be placed by resident's thigh while in bed. Date initiated: 06/17/2025. R48's hospital inpatient Discharge summary, dated [DATE], indicates, in part: .Briefly, [R48] presented following a mechanical fall out of bed resulting in C1 fracture and L (left) 7th rib fracture. Recommended a PMT collar (neck brace) to allow C1 fracture to heal. R48's Progress Notes, dated 6/17/25, include in part:3:53 PM – RN: Resident arrived to unit at approximately 1315 (1:15 PM) .6:29 PM - RN: Resident's daughter conveyed concerns for resident's safety regarding risk for falls. She did not want to leave her mother as she felt she needed further monitoring in order to ensure she didn't fall from bed. Writer attempted to locate a bed mat (out of bed alarm) but was unable to find one in the closets or ancillary. Writer notified nurse of inability to find and to pass along to staff to request one tomorrow from the ancillary. Writer also left voicemail for ancillary requesting more mats. Writer reassured resident's daughter/POA that staff is doing everything they can to mitigate falls and make the environment as safe as possible. Writer was able to brainstorm a few ideas that helped the daughter feel more at ease with resident being in room tonight. Daughter agreed for resident to have bed against wall, low bed, fall mat, soft touch disc call light by thigh, and restless in room ([NAME] system) to be an adequate start to ensuring her mom's safety for tonight.Staff were told to try to pay close attention for the call light alerts from her room due to her high fall risk.It is important to note:-This is R48's second fall without using the call light for assistance.-The fall report and the IDT review notes do not address potential root causes of why R48 was trying to get out of bed at 6:00 AM.-Without a true root cause there is no way of knowing if these interventions are appropriate. -R48 indicated after her first fall on 6/4/25 at 5:00 AM that she was trying to go to the bathroom. There is no evidence the facility ruled out a potential relationship between toileting and this fall, as it occurred at a similar time of 6:00 AM.-When R48 was readmitted to the facility on [DATE], not all the equipment needed for the new interventions recommended by the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	IDT were available for use.-Staff are educating R48 as an intervention for fall prevention, despite R48's BIMS score of 7 out of 15, indicating severe cognitive impairment, and her diagnosis of Parkinson's disease. Fall #3:R48's Progress Notes, dated 8/2/25, include in part:1:14 AM – LPN (Licensed Practical Nurse): Writer was called by the CNA while conducting rounds in the skilled nursing to attend to Resident [R48] that fell. Upon arrival at the resident's room, writer found the resident lying on the floor. VS (vital signs) were obtained.and head to toe assessment was immediately completed. On assessment, the resident was found to have sustained a skin tear with active bleeding to her right elbow. Resident reported a severe pain (10/10) to her right hip. The resident stated she was attempting to transfer herself to the toilet when she lost balance and fell. With the assistance from the CNA, resident was safely transferred back to the bed with a Hoyer (type of full body lift). Writer contacted 911 due to resident's pain level and potential injury. Writer left a voicemail for the on-call nurse manager [ADON N] (Assistant Director of Nursing) .and resident's POA.was contacted and informed. Resident was transported via EMS (emergency medical services) to.hospital for further evaluation and treatment. It is important to note that the LPN left a message for the ADON and did not discuss moving R48 before getting her back into bed with a Hoyer lift. LPN's are not able to complete nursing assessments and can only gather data then must wait for further instructions from a RN or physician prior to moving a resident. R48's Fall Un-Witnessed WITH Injury report, dated 8/2/25 at 3:00 AM, was completed by ADON N. The time on the report is approximately two hours after the fall occurred. ADON N copied the progress note written by the LPN at 1:14 AM and pasted it into the incident description section on the fall report for both the nursing description and the resident description. R48's Progress Notes, dated 8/2/25, include in part: 8:59 AM - RN: Call placed to [Hospital]; resident admitted for closed fx (fracture) of right femur.Surveyor reviewed the IDT note for R48's fall, dated 8/3/2025. The note was text copied from the fall report summary. No root causes were identified for this fall.An updated Morse Fall Risk assessment was completed for R48 by ADON N on 8/2/25. The updated assessment indicates R48 is at a moderate risk for falls, with a score of 25 (moderate risk is a score from 25-44). (Of note: This assessment was completed after R48's third fall, 2 of 3 falls with fractures, and the score decreased from 80 to 25, indicating R48's fall risk as moderate and not high.) R48's hospital Discharge summary, dated [DATE] indicates, in part: Reason for Hospitalization: .Pt [patient] reports she has been residing in a rehab for her recent fall and reportedly tripped over her other foot landing on the right side. Imaging is remarkable for mildly displaced right femoral fracture.She reports pain in her right hip from the fall.Hospital Course: .Parkinson's disease .Suspect she has associated dementia and cognitive impairment which is becoming more obvious with acute stressors. R48's Progress Notes, dated 8/8/25, include in part:5:48 PM – LPN: Resident readmitted to facility from [hospital].A&O (alert and oriented) x 1.Resident able to make needs known. Educated/shown how to use call light, resident demonstrated back. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R48's Progress Notes, dated 8/9/25, include in part: 7:12 AM (staff position not listed in notes): Resident continues on skilled observations as ordered. NO acute events overnight. She noted [sic] to be restless and attempting to transfer from bed. Redirected and reoriented multiple times. Will continue monitoring for safety. An updated Morse Fall Risk assessment was completed for R48 on 8/8/25. The updated assessment indicates R48 is at a high risk for falls, with a score of 90. Section F. Mental Status states, Mental status measures the residents [sic] self-assessment of his/her own ability to ambulate. Ask the resident, 'Are you able to go to the bathroom alone, or do you need assistance?' Does the resident's response to the above indicate they know the limits of their abilities to ambulate safely? Response 2 is checked: Overestimates or forgets limits. No new fall risk interventions/tasks were added to R48's care plan. The following care area was added, and includes, in part: Focus: The resident has an alteration in musculoskeletal status r/t (related to) neck fracture (right femoral neck fracture – a break in the bone that connects the top of the thigh bone to the hip joint). Interventions/Tasks: Anticipate and meet needs. Be sure call light is within reach and respond promptly to all requests for assistance. Date initiated: 08/08/2025 . It is important to note:-This is R48's third fall without using the call light for assistance.-This is R48's second fall during the early morning hours where she indicated she was trying to get to the bathroom. The facility has not shown evidence of addressing toileting interventions with R48, given 2 of 3 falls were known to be related to toileting. There is no evidence of completion, for example, of a toileting diary, to look for patterns in R48's toileting needs and potentially decrease future falls. -The fall report and the IDT review notes do not include documentation of a root cause. -Without a true root cause there is no way of knowing if these interventions are appropriate. -Staff are educating R48 as an intervention for fall prevention, despite R48's BIMS score of 7 out of 15, indicating severe cognitive impairment, and her diagnosis of Parkinson's disease. -There is no evidence of an RN assessment/consult by the LPN prior to moving R48. On 8/26/25 at 3:42 PM, Surveyors interviewed DON B regarding R48's falls. DON B indicated he was unable to pick out the particular root cause of the falls without more information but said he would review IDT notes to see what was found. IDT notes are part of QAPI (Quality Assurance Performance Improvement) and not in residents' progress notes. DON B reviewed R48's fall on 6/4/25 along with the IDT notes. DON B pointed out this fall was related to trying to use the bathroom. DON B indicated the notes reflect that R48 not using the call light was the root cause of this fall and the 72-hour IDT fall review determined placing a call light reminder was effective because there were no more falls during that time frame. DON B reviewed R48's fall on 6/11/25 along with the IDT notes. DON B indicated the notes address injury reduction instead of the fall itself. DON B indicated that he would expect to see more information investigating why the fall happened, such as the position the resident was in after the fall and whether or not R48 had been toileted recently. DON B reviewed R48's fall on 8/2/25 along with the IDT notes. DON B pointed out R48 was attempting to transfer herself to the bathroom, had an injury, and was sent out for further evaluation. DON B indicated the IDT notes did not determine the root cause. DON B reviewed R48's care plan. He indicated the care plan addresses routine and PRN (as needed) toileting and having an unobstructed pathway. Having an unobstructed pathway to the bathroom is standard in all care plans. R48's care plan indicates she shouldn't transfer to the bathroom herself. DON B indicated there should be something more in the care plan to address her toileting needs. DON B stated that he has a concern with R48's falls and interventions not properly being put into place. DON B indicated the expectation (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	would be that the facility would have a clear indicator of what the root cause was for each fall. Surveyors asked DON B if educating the resident on call light use and placing signs in her room to remind her to use the call light are appropriate interventions, given her BIMS score indicates severe cognitive impairment. DON B indicated that educating R48 on using the call light is not an acceptable intervention. On 8/26/25 at 5:02 PM, Surveyors interviewed DON B and NHA A (Nursing Home Administrator). DON B and NHA A agreed that they would expect their team to determine the root cause for falls. NHA A indicated the facility consults with the medical director and pharmacist after three falls to discuss possible interventions. She said she would pull the records for review. On 8/27/25 at 5:31 PM, Surveyors interviewed DON B and NHA A. NHA A stated they had documentation from the facility's medical director stating that R48's falls were unavoidable. Surveyors reviewed the documentation from the facility's medical director pertaining to R48's falls that was signed and dated on 8/27/25. No further information was provided related to a pharmacist consult. NHA A also indicated interventions were put into place and they increased her [NAME] alarms, which track movements in resident rooms. It is important to note: The facility did not determine root causes for R48's falls and therefore it cannot be determined if the falls were unavoidable and/or if the interventions put into place were appropriate. Example 2 Facility policy, titled safety and Supervision of Residents, revised 7/2017, includes: Our facility strives to make the environment as free from accidents and hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. Implementing interventions to reduce accident risks and hazards shall include the following: communicating specific interventions to all relevant staff, assigning responsibility for carrying out interventions, providing training as necessary, ensuring that interventions are implemented, and documenting interventions. Monitoring effectiveness of interventions shall include the following: ensuring that interventions are implemented correctly and consistently, evaluating the effectiveness of interventions, modifying or replacing interventions as needed, and evaluating the effectiveness of new or revised interventions. R37 admitted to the facility on [DATE] with the following diagnoses: unspecified dementia, anxiety, and major depressive disorder. R37's Care Plan, initiated 1/28/22, includes: 1/28/22 Feeding assistants- do not assist due to high risk for choking/aspiration. 1/28/22 Monitor/document/report as needed any signs or symptoms of dysphagia, coughing, water eyes, runny nose, drooling, pocketing, choking, holding food in mouth, several attempts at swallowing, refusing to eat,. 5/2/23 needs assistance with meals. 3/25/24 R37 has potential for alteration in nutrition related to diagnoses including aftercare following fall, dementia, hypertension, chronic obstructive pulmonary disease, and a history of weight loss. R37 has potential for choking/aspiration related to chewing/swallowing difficulty and edentulous (no teeth) status and chooses not to wear dentures and history of not attempting to consume trial upgrades therefore interdisciplinary team in agreement for order consistency. 5/18/23 Provide supervision, cues, and physical assist as needed. 5/18/23 Encourage to come to dining room for (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	assist/supervision during meals. 3/25/24 R37 has difficulty self-feeding due to dementia and is able to maximize independence with dining by having foods in separate bowls. Speech Therapy Discharge, dated 6/22/22, includes diagnosis: Dysphagia- oral phase He demonstrates ability to safely swallow pureed solids and thin liquid diet using compensatory strategies from trained staff or caregivers demonstrating under 2 signs/symptoms of aspiration and greater than 80% oral clearance . Least restrictive diet is pureed . R37's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 8/8/25, indicates R37 is rarely or never understood in section C, but in section B it indicates R37 is understood by others and makes himself understood. (It is important to note the conflicting information in this one assessment. It is also important to note R37 resides on the memory care unit at the facility.) On 8/20/25 at 10:15 AM, Surveyor observed crafting supplies, aerosol cans, cleaner, and lotions in the activity cabinet on the unit. Activity Aide II began removing some of the items from the cabinet. During an interview, Activity Aide II indicated there are residents on the unit who wander and rummage in the cabinet and the lotions, aerosol cans, and cleaners should be locked up. On 8/20/25 at 12:58 PM, during the dining observation Surveyor observed that no staff were in the room while residents were eating meals. Two of the residents had pureed food in front of them, including R37. Surveyor observed R37 to have pureed food on his tray and two plastic covers. One of the plastic covers had crafting pom poms on it that appeared to be wet. The pom poms varied in size. Surveyor observed R37 place some of the pom poms in his mouth and Surveyor asked R37 what the pom poms were. R37 stated, I don't know, as he placed a few more in his mouth. Surveyor observed R37 take the plastic cover with the remaining pom poms and dump them into his mouth. RN W (Registered Nurse) entered the dining room and stood at her nurse cart with her back to the residents. Surveyor called to RN W and asked her if R37 should be eating crafting balls. RN W indicated he should not be and asked R37 to spit the pom poms out. R37 seemed confused by the request at first and hesitated, but with some encouragement by RN W R37 spit out 8 pom poms. On 8/20/25 at 1:16 PM, CNA M (Certified Nursing Assistant) indicated R37 has a history of placing nonfood items in his mouth. CNA M indicated she is not sure when the last time was that she saw R37 do this, but she sees him rummaging through drawers and cabinets at times. On 8/20/25 at 1:31 PM, DON B (Director of Nursing) indicated he is unsure if R37 has a history of placing nonfood items in his mouth. DON B indicated staff are to be supervising R37 while he is eating and they should have chemical cleaning products, aerosol cans, crafting supplies, and lotions in a locked cabinet because residents wander and rummage. On 8/20/25 at 3:13 PM, Activity Aide II stated, One time I laid out some sorting bears and he went to put them in his mouth. He does rummage through drawers. He could have gotten them (pom poms) out of here. I did pull some pom poms out of here today. Activity Aide II showed Surveyor a drawer at wheelchair height that R37 may have gotten the pom poms out of. On 8/20/25 at 3:22 PM, CNA FF indicated R37 rummages through drawers and cabinet that are at his reach. CNA FF also indicated staff are to supervise R37 when he is eating and offer cues, redirection, and/or assistance with meals. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 8/20/25 at 3:24 PM, Surveyor observed R37's room to have a bulletin board at wheelchair height with a sign pinned on it. The sign stated R37's name and around the name were glued on crafting pom poms. The sign also had glue spots with colored pom pom fuzz attached to it where pom poms were previously glued to the paper. On 8/20/25 at 3:40 PM, CNA GG stated, I see R37 rummaging in activity area and in dining room. I think those things he put in his mouth should be kept out of reach. Surveyor and CNA GG observed the sign in R37's room. Surveyor asked if R37 could have gotten the pom poms off of this sign. CNA GG indicated this was likely due to some of them being missing. On 8/20/25 at 3:44 PM, RN HH (Registered Nurse) stated R37 is known to rummage around looking for food. RN HH indicated staff should keep crafting supplies,

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility did not store, prepare, distribute, and serve food in accordance with professional standards for food service safety. This has the potential to affect 67 of 68 residents.Surveyor observed food that was not sealed or labeled with a use by date in the main kitchen freezer.Surveyor observed food that was not labeled or dated in a kitchenette refrigerator.Surveyor observed microwaves in the three kitchenettes to have several multi-colored dried on splatters and stains on the inside microwaves.The refrigerator and freezer temperatures in two of the kitchenettes are not being consistently monitored or recorded.Evidenced by:Example - Unsealed and unlabeled packages of food in main kitchen freezerFacility policy entitled, Food Receiving and Storage with a revision date of April 2019 states, in part: .8. All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date) .On 8/20/25 at 9:24 AM, during the initial tour of the kitchen, Surveyor and DM J (Dietary Manager) observed an opened bag of turkey sausage links and an opened bag of sliced salami in the walk-in freezer that weren't sealed or dated. Surveyor asked DM J if opened bags of food should be sealed and have a use by date; DM J stated yes. On 8/25/25 at 3:15 PM, Surveyor interviewed NHA A (Nursing Home Administrator), DON B (Director of Nursing), and RDM K (Regional Dietetic Manager). Surveyor asked if they would expect policies to be followed for food storage and labeling; they stated yes. Example - Unlabeled food in Kitchenette refrigeratorFacility policy entitled, Food Receiving and Storage with a revision date of April 2019 states, in part: .14. Food items and snacks kept on the nursing units must be maintained as indicated below: .b. All foods belonging to residents must be labeled with the resident's name, the item and the use by date.On 8/21/25 at 2:50 PM, Surveyor toured the kitchenette on the 100 hall. Surveyor observed a clear sandwich bag containing an opened package of sausage sticks and a snack pack of cheese cubes, nuts, and dried cranberries in the kitchenette refrigerator that did not have a name or date on it.On 8/21/25 at 3:02 PM, Surveyor interviewed CNA L (Certified Nursing Assistant) and asked if she knew whose food that was and how long it has been in the refrigerator. CNA L indicated she didn't know, couldn't tell because there was no name or date on it.On 8/25/25 at 2:32 PM, Surveyor interviewed DM J and AFSD I (Assistant Food Services Director) who indicated food in the kitchenette refrigerator should be labeled and dated. On 8/25/25 at 3:15 PM, Surveyor interviewed NHA A (Nursing Home Administrator), DON B (Director of Nursing), and RDM K (Regional Dietetic Manager). Surveyor asked if they would expect policies to be followed for food storage and labeling; they stated yes. Example - Kitchenette microwaves not being cleanedFacility policy entitled, Food Preparation and Service with a revision date of April 2019 states, in part: .4. Appropriate measures are used to prevent cross contamination. These include:.d. cleaning and sanitizing work surfaces and food-contact equipment between uses.On 8/20/25 at 12:22 PM, Surveyor toured the kitchenette on the 200 hall - Skilled (non-Memory Care) and observed multiple dried on substances of different colors inside the microwave.On 8/20/25 at 12:37 PM, Surveyor interviewed CNA M and asked who is responsible for cleaning the microwaves in the kitchenette. CNA M stated housekeeping cleans them. Surveyor showed CNA M the inside of the microwave on 200 hall (Skilled side) and CNA M indicated it was dirty and had several dried-on splatters on the inside.On 8/21/25 at 3:05 PM, Surveyor interviewed HKG O (Housekeeping Aide/CNA) and asked who is responsible for cleaning the microwaves in the kitchenettes. HKG O indicated housekeeping cleans the microwaves and kitchenette areas.On 8/21/25 at 2:50 PM, Surveyor toured the Kitchenette on the 100 hall and observed several multi-colored splatters on the inside of the microwave.On 8/21/25 at 3:02 PM, Surveyor interviewed CNA L and asked who was responsible for cleaning the microwave. CNA L stated housekeeping cleans it and CNA L observed microwave with Surveyor, and she indicated it was dirty with dried on splatters on it.On 8/21/25 at 3:05 PM, Surveyor interviewed HKG O and asked who is responsible for cleaning the microwaves in the kitchenettes. HKG O indicated housekeeping (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	cleans the microwaves and kitchenette areas. Surveyor showed HKG O the microwave and stated she had cleaned it earlier that morning, indicated it was dirty and began cleaning it while Surveyor was still present.On 8/21/25 at 3:10 PM, Surveyor toured the kitchenette on the Memory Care unit and observed the microwave to have several multi-colored dried on splatters, brown stains on the inside and some brownish-reddish spots on the inside of the door.On 8/21/25 at 3:17 PM, Surveyor interviewed RDM K (Regional Dietetic Manager) and asked her to look at the inside of the microwave. RDM K indicated housekeeping cleans the microwaves and verified the inside of the microwave looked dirty, should have been cleaned, and stated she thought the brown stains were burn marks and thought the spots on the inside of the door were rust. RDM K unplugged the microwave, pulled it away from the wall and said they would remove it and replace it. Surveyor observed a different microwave there the next visit to the kitchenette on 8/25/25.On 8/25/25 at 2:32 PM, Surveyor interviewed DM J (Dietary Manager) and AFSD I (Assistant Food Services Director) who indicated food in the kitchenette microwaves should have been clean.On 8/25/25 at 3:15 PM, Surveyor interviewed NHA A (Nursing Home Administrator), DON B (Director of Nursing), and RDM K (Regional Dietetic Manager). Surveyor asked if they would expect policies to be followed for food preparation and service; they stated yes. Example - Kitchenette refrigerator and freezer temperatures not being consistently monitored and recordedFacility policy entitled, Food Receiving and Storage with a revision date of April 2019 states, in part: .14. Food items and snacks kept on the nursing units must be maintained as indicated below:.c. Refrigerators must have working thermometers and be monitored for temperature according to state-specific guidelines.On 8/20/25 at 12:22 PM, Surveyor observed the temperature log for August 2025 for the refrigerator and freezer temperatures in the kitchenette on the 200 hall (Skilled). Surveyor observed only 2 days recorded for August: 8/5/25 and 8/12/25. Surveyor also reviewed the temperature logs for the months of May, June, and July 2025. May temperature log has the following days missing for both the refrigerator and freezer: May 1, 3, 4, 6, 9, 10, 13, 14, 24, and 25. June has the following days missing for temperature recording: June 9, 12, 16, 17, 20, 22, 23, 24, 25, 26, and 27.On 8/21/25 at 3:10 PM, Surveyor observed the temperature log for August 2025 for the refrigerator and freezer temperatures in the kitchenette on the Memory Care unit on the 200 hall. Surveyor observed only 4 days recorded for August: 8/5, 8/6, 8/11, and 8/12/25. Surveyor also reviewed temperature logs for the months of May, June, and July 2025. May temperature log has the following days missing for both the refrigerator and freezer: May 1, 4, 5, 9, 10, 13, 24, 25, 26, and 27. June temperature log has the following days missing for recording: June 7, 8, 9, 12, 16, 17, 20, 22, 23, 24, 25, 26, and 27. July log has the following day missing of temperature recording: July 6, 7, 11, 18, 19, 20, 21, 22, 23, 24, 25, 28, 29, 30, and 31.On 8/21/25 at 3:17 PM, Surveyor interviewed RDM K (Regional Dietetic Manager) and asked who is responsible to monitoring the temperatures of the refrigerator and freezer in the kitchenettes. RDM K stated she wasn't sure but indicated the temperatures should have been completed and indicated there were several dates missing on the August log.On 8/21/25 at 3:30 PM, Surveyor interviewed ADON N (Assistant Director of Nursing) and asked who was responsible for recording the temperatures of the refrigerator and freezer in the kitchenettes. ADON N stated the night shift nursing staff take the temperatures and record them. ADON N observed the August temperature log with Surveyor and verified there were several dates missing and stated they should have been filled out.On 8/25/25 at 2:32 PM, Surveyor interviewed DM J (Dietary Manager) and AFSD I (Assistant Food Services Director) who indicated kitchenette refrigerator and freezer temperatures should have been taken and recorded.On 8/25/25 at 3:15 PM, Surveyor interviewed NHA A (Nursing Home Administrator), DON B (Director of Nursing), and RDM K. Surveyor asked if they would expect policies to be followed for Food Receiving and Storage; they stated yes.

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Oak Park Nursing and Rehab Center	718 Jupiter Drive Madison, WI 53718

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. This had the potential to affect all 68 residents. Three staff members returned to work too soon after experiencing gastrointestinal (GI) symptoms. The facility's infection control line lists for staff and residents are incomplete and inaccurate. The facility did not ensure daily infection control surveillance for staff and residents. The facility failed to recognize commonalities with staff who called in with similar symptoms in February 2025 and did not rule out a GI or COVID-19 outbreak. The facility did not perform testing, per Centers for Disease Control and Prevention (CDC) guidelines, after a resident tested positive for COVID-19 at the facility in February 2025. The facility had COVID-19 outbreaks in February 2025 and April 2025 and did not have complete outbreak summaries. The laundry room was observed to be dirty. Surveyor observed a staff member handling R45's indwelling catheter bag without utilizing Enhanced Barrier Precautions (EBP) or performing proper hand hygiene. This is evidenced by: The facility policy, Employee Work Exclusion Policy, effective 7/19/24, states in part: .Purpose: It is the policy of [Facility Name] to exclude healthcare workers that put patients/residents at risk due to their infection status in accordance with the CDC guidelines, and state and federal regulations. For the purposes of this policy, healthcare workers include all employees to reduce the spread of infection. Universal Source Control Measures: Universal source control is to be implemented on a unit or area of the facility experiencing SARS-CoV-2 (COVID-19) outbreak if an unknown source with prevalent high-risk exposure could impact safety AND contact tracing cannot be reliably completed. Contact Tracing Source Control Measures: If contact tracing is conducted immediately following discovery of a positive case of SARS-CoV2 then source control is to be implemented only by those persons identified in contact tracing. Disease / Exclusion/Work Restriction Duration: Diarrheal disease (i.e. (for example) Norovirus or other GI illness) / Exclude until 48 hours after symptoms resolve. The facility policy, Infection Prevention and Control Program, revised in December 2023, states in part: Policy Statement: An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the transmission of communicable diseases and infections. Elements of the IPCP: .3. Surveillance and reporting: a. Process surveillance (adherence to infection prevention and control practices) and outcome surveillance (incidence and prevalence of healthcare acquired infections) are used as measures of the IPCP effectiveness. b. Surveillance tools are used for identifying the occurrence of (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring employee infection, monitoring adherence to infection prevention and control practices, and detecting unusual pathogens with infection control implications. 5. Data Analysis: a. Data gathered during surveillance is used to oversee infections and spot trends. 6. Outbreak Management a. Outbreak management is a process that consists of: (1) determining the presence of an outbreak; (2) managing the affected residents; (3) preventing the spread to other residents; (4) documenting information about the outbreak; (5) reporting the information to appropriate public health authorities; (6) educating the staff and the public; (7) monitoring for recurrences; (8) reviewing the care after the outbreak has subsided; (9) recommending new or revised policies to handle similar events in the future. 7. Prevention of infection a. Important facets of infection prevention include: (1) identifying possible infections or potential complications of existing infections. (5) screening for possible significant pathogens. (8) following established general and disease-specific guidelines such as those of the Centers for Disease Control (CDC) . The facility policy, Outbreak of Communicable Diseases, revised in September 2022, states in part: Policy Statement: Outbreaks of communicable diseases within the facility are promptly identified and managed. Policy Interpretation and Implementation: 1. An outbreak is defined as one of the following:. c. Occurrence of three (3) or more cases of the same infection over a specified period of time and in a defined area. 6. The infection preventionist and director of nursing services are responsible for: a. managing surveillance data; b. monitoring ill residents and staff; c. initiating transmission-based precautions, as appropriate; and d. communicating with the medical director and the attending physicians. ADON N (Assistant Director of Nursing) is the facility's Infection Preventionist and had worked in this position for approximately a month from the date of this survey. DON B (Director of Nursing) has been helping her acclimate to this role. Example 1: Surveyors reviewed the staff line list provided by the facility for the past three months (June, July, and August 2025) and for February 2025 and April 2025, when COVID-19 outbreaks occurred at the facility. The line list has columns labeled as follows: Employee Name / Title/Dept (Department) / Date of Call In / Date of Symptom Onset / Time of Symptom Onset (if known) / Date of Last Symptom / Time of Last Symptom / Date Allowed to Return / Time allowed to return (48 hr (hours) after last symptom of NVD (nausea, vomiting, or diarrhea) or 24 hr after fever w/o (without) medication) / COVID/Flu/RSV (respiratory syncytial virus) Exposure: Yes/No / COVID/Flu/RSV Testing Needed? The list also has columns with symptoms that can be checked (examples: nausea, vomiting, diarrhea, fever, chills.) Surveyors noted several staff members with nausea, vomiting, and/or diarrhea symptoms had a date allowed to return to work that was the day after the date of last symptom. Surveyors requested timecards for five of these staff members to see when they returned to work. Three of the five staff members returned to work in a time frame that was less than 48 hours after the last symptom of nausea, vomiting, and/or diarrhea. MAA Z (Medication Administration Aide): Symptoms: vomiting and diarrhea; Date of call in: 2/5 for 2/6; Date of symptom onset: 2/5/2025; Time of symptom onset: 11:20 p (PM); Date of last symptom: 2/6/2025; Time of last symptom: noon; Date allowed to return to work: 2/7/2025; Time allowed to return to work: after noonMAA Z's timecard indicated he worked on 2/7/25 from 3:00 PM to 6:30 PM. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	DA BB (Dietary Aide): Symptom: diarrhea; Date of call in: 4/20/2025; Date of symptom onset: 4/17/2025; Time of symptom onset: AM; Date of last symptom: late 4/20; Time of last symptom: 11:30 p; Date allowed to return: 4/21/2025; Time allowed to return: AM DA BB's timecard indicated he worked on 4/21/25 from 5:42 AM to 2:54 PM. Additionally, the line list notes that the date of symptom onset was 4/17/25, but DA BB's timecard also shows that he worked on 4/17, 4/18, and 4/19. Housekeeper AA: Symptom: diarrhea; Date of call in: 6/3/2025; Date of symptom onset: 6/3/2025; Time of symptom onset: 4 AM; Date of last symptom: 6/4/2025; Time of last symptom: AM; Date allowed to return: 6/5/2025; Time allowed to return: blank Housekeeper AA's timecard indicated she worked on 6/5/25 from 5:48 AM to 2:18 PM. On 8/26/25 at 4:48 PM, Surveyors interviewed DON B and asked how long staff members with GI symptoms should be off work. DON B reviewed the facility's policy and indicated staff should be off for 48 hours after the time of the last symptom. Surveyors identified staff members who returned to work too soon. DON B stated, That would be a concern if they're coming back to work the next day. Example 2: Surveyors reviewed the staff and resident line lists provided by the facility for the past three months (residents: May, June, and July 2025 / staff: June, July, and August 2025) and for February 2025 and April 2025, when COVID-19 outbreaks occurred. The staff line lists contain the following columns: Employee Name / Title/Dept (Department) / Date of Call In / Date of Symptom Onset / Time of Symptom Onset (if known) / Date of Last Symptom / Time of Last Symptom / Date Allowed to Return / Time allowed to return (48 hr (hours) after last symptom of NVD (nausea, vomiting, or diarrhea) or 24 hr after fever w/o (without) medication) / COVID/Flu/RSV (respiratory syncytial virus) Exposure: Yes/No / COVID/Flu/RSV Testing Needed? The list also has columns with symptoms that can be checked (examples: nausea, vomiting, diarrhea, fever, chills.)The logs do not indicate when staff members worked last or what unit or shift they were on. Staff February log indicates:5 occurrence dates that have no explanation or symptoms listed.9 occurrence dates that have no date or time of last symptom listed. Two of these are listed as ongoing.7 occurrence dates that have no date allowed to return to work listed.4 occurrence dates that have nausea, vomiting, and/or diarrhea symptoms checked, but the date/time allowed to return to work is less than 48 hours after the date/time of last symptom. Staff April log indicates:2 occurrence dates that have no explanation or symptoms listed.5 occurrence dates that have no date or time of last symptom listed.1 occurrence date that has no date allowed to return to work listed.2 occurrence dates that have nausea, vomiting, and/or diarrhea symptoms checked, but the date/time allowed to return to work is less than 48 hours after the date/time of last symptom. Staff June log indicates:1 occurrence date that has no explanation or symptoms listed.3 occurrence dates that have no date or time of last symptom listed.1 occurrence date that has no date allowed to return to work listed.4 occurrence dates that have nausea, vomiting, and/or diarrhea symptoms (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	checked, but the date/time allowed to return to work is less than 48 hours after the date/time of last symptom. Staff July log indicates:3 occurrence dates that have no date or time of last symptom listed.2 occurrence dates that have nausea, vomiting, and/or diarrhea symptoms checked, but the date/time allowed to return to work is less than 48 hours after the date/time of last symptom.The resident line lists contain the following columns: Resident name, MRN (medical record number), Most recent/relevant admission date, Location in facility, Antibiotic start date, Symptom onset date, Data U/A (urinalysis) ordered, Type of infection criteria met, Other: identify infection type, CAI/HAI (community-acquired infection / hospital-acquired infection), Culture result, Specimen collection date, Organism 1, Organism 2, MDRO (multidrug-resistant organism) type,.Signs and Symptoms, Antibiotic(s) prescribed, Indication/dose/duration documented, Provider name, Antibiotic verified after culture, Precautions type, Precautions start, Precautions end, Additional notes. Resident February log indicates :26 occurrences listed: no admission dates are listed, CAI/HAI column is not completed, only 3 occurrences verify the type of infection criteria was met, 9 occurrences are missing residents' location in facility. On 8/27/25 at 2:45 PM, Surveyors interviewed DON B. Surveyors went over the February line lists and asked if all the blanks should be filled in. DON B said yes. DON B indicated line lists should be complete or they should not be on there at all. DON B indicated staff members on the line list were being mixed up with staff members who called in for reasons such as family emergencies. DON B stated the facility has a new tracking system that is better and cleaner. Resident COVID line list:R62: Onset date: 2/7/25, Positive lab test: 2/7/25. Droplet isolation placed: 2/7/25. Notes: admitted to hospital 2/7R93: Onset date: 2/12/25, Positive lab test: 2/12/25. Droplet isolation placed: 2/8/25. Notes: Sent to ED (emergency department) and returned 2/8 at 1:00 AM, tested positive at hospital On 8/27/25 at 3:01 PM, Surveyors interviewed DON B and NHA A (Nursing Home Administrator). Surveyors reviewed the February 2025 line list and asked about the information on the list for R93, as it did not match information in her health record. DON B confirmed R93 did not go to the hospital on 2/8 and she tested positive for COVID on 2/12, so the droplet isolation date on the list was also wrong. DON B indicated the information on the line for R93 matched information for R62, who was listed on the line above. DON B stated, This is a mess. DON B indicated, my biggest concern is we have all of these pieces and none of them are communicating. Surveyors asked if line lists should be accurate. DON B said yes, they should be. Example 3: Surveyors reviewed the staff and resident line lists provided by the facility for the past three months (residents: May, June, and July 2025 / staff: June, July, and August 2025) and for February 2025 and April 2025, when COVID-19 outbreaks occurred. The facility completed separate COVID line lists for residents in February and April 2025. Surveyors compared these line lists to the infection-tracking maps provided by the facility for February 2025 and April 2025. The maps have the following labels: Respiratory, Skin mucosal, UTI (urinary tract infection), GI, Blood, Bone, Other. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The February 2025 map had five rooms on the second floor highlighted in blue, which indicated a respiratory infection. The April 2025 map had one room on the first floor and four rooms on the second floor highlighted in blue, which indicated a respiratory infection On 8/26/25 at 11:34 AM, Surveyors interviewed ADON N (Assistant Director of Nursing) and DON B (Director of Nursing). ADON N indicated maps are tracked in real time, so nothing is missed. February COVID-19 line list vs. map:-Six residents tested positive for COVID-19 in February 2025 but were not tracked on the facility's surveillance map for having a respiratory illness: R93, R94, R66, R95, R14, and R96. April COVID-19 line list vs. map:-Six following residents tested positive for COVID-19 in April 2025 but were not tracked on the facility's surveillance map for having a respiratory illness: R37, R97, R57, R38, R17, and R65. On 8/26/25 at 4:48 PM, Surveyors interviewed DON B and showed him the discrepancies between the maps and line lists. DON B agreed that there were discrepancies. DON B indicated the facility has recently switched to a new infection control program in July 2025 that tracks residents and staff members together. They are still working on learning the new system. -Staff February log:2/2: Call in with symptoms of nausea and diarrhea / Onset date:2/22/2: Call in with symptoms of vomiting / Onset date: 2/22/4: Call in with nausea / Onset date: 2/32/5: Call in with vomiting and diarrhea / Onset date: 2/52/6: Call in with vomiting and diarrhea / Onset date: 2/69 occurrence dates do not have a yes or no response to the COVID/Flu/RSV exposure column.10 occurrence dates do not have a yes or no response to the COVID/Flu/RSV testing needed? column. On 8/27/25 at 2:45 PM, Surveyors interviewed DON B. Surveyors pointed out the pattern of staff members that had CDC-listed COVID symptoms when they called in, yet they were not listed as needing to be tested. DON B indicated they try to identify if there was a significant exposure. When staff members call in, they are asked if they've had a COVID exposure, as testing is not recommended for everyone. Surveyors pointed out that the list does not say what unit staff members worked on and when they worked last. They suggested this might make surveillance easier. DON B indicated it would be easier if all the information was in one place. On 8/27/25 at 5:31 PM, Surveyors interviewed NHA A (Nursing Home Administrator) and DON B. Surveyors asked if people have GI symptoms that are similar, would this be a commonality? DON B replied yes. Surveyor asked if DON B would expect commonalities to be looked at if staff members are calling in with the same symptoms. DON B replied yes. Surveyors asked once this was identified, should the facility have done contact tracing or broad-based testing? DON B indicated this would have warranted further testing and the facility should have done tracking and trending. The facility did not perform testing, per CDC (Centers for Disease Control and Prevention) guidelines, after a resident tested positive for COVID-19 at the facility in February 2025. -Resident July log: No MDROs were documented on any of the resident logs until July 2025. On 8/26/25 at 11:34 AM, Surveyors interviewed DON B and ADON N. Surveyors asked how the facility (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	tracks MDROs. ADON N indicated MDROs are in resident care plans. The new tracking list the facility is using has a column for that. -Summary by infection category lists 0 Urinary tract/kidney infections On 8/26/25 at 11:34 AM, Surveyors interviewed DON B and ADON N. Surveyors had noted that R48 had a UTI in July 2025 but noted that the infection category summary on the facility's infection surveillance monthly report was showing the facility had no UTIs in July 2025. DON B pointed out that R48 was listed on the report. Under the Infection category for R48, Unknown was listed, so it didn't show up on the summary. DON B indicated they are still working on learning the new system. On 8/27/25 at 5:31 PM, Surveyors interviewed NHA A and DON B. Surveyors commented that the facility's infection control program wasn't able to be looked at in a comprehensive way. DON B agreed with this statement and indicated that the overall program was being treated as three or four separate programs, when it should have been treated as one. Example 4: The CDC lists symptoms of COVID-19 on their website: https://www.cdc.gov/covid/signs-symptoms/index.html. The list was last updated on 3/10/25. Symptoms include: fever or chills, cough, shortness of breath or difficulty breathing, sore throat, congestion or runny nose, new loss of taste or smell, fatigue, muscle or body aches, headache, nausea or vomiting, and diarrhea.Surveyors reviewed the February 2025 resident line list. According to the line list, the facility's first COVID-positive resident (R62) was identified on 2/8. On 8/27/25 at 3:01 PM, Surveyors interviewed NHA A (Nursing Home Administrator) and DON B. DON B indicated the R62 tested positive while she was out at the hospital and the facility was notified upon her return to the facility. Surveyors asked what the facility's protocol is when a resident tests positive for COVID. DON B indicated staff is to call the DON, which was done. Surveyors asked if isolation and PPE (personal protective equipment) are used. DON B indicated enhanced droplet precautions are put into place with an N-95 mask. DON B and NHA A indicated all staff and resident testing was initiated on 2/12 after three residents were found to be COVID-positive. Surveyors asked if the facility does house-wide or contact tracing. DON B indicated the facility attempts to do contact tracing. On 8/27/25 at 5:31 PM, Surveyors interviewed NHA A and DON B. Surveyors stated there was no evidence of broad-based testing or contract tracing being done after the first resident in the facility tested positive for COVID. DON B indicated this should have been done, but they do not have any evidence showing that it was done.Surveyors reviewed the staff line list for February 2025:2/2: Call in with symptoms of nausea and diarrhea / Onset date:2/22/2: Call in with symptoms of vomiting / Onset date: 2/22/4: Call in with nausea / Onset date: 2/32/5: Call in with vomiting and diarrhea / Onset date: 2/52/6: Call in with vomiting and diarrhea / Onset date: 2/62/6: Call in with no symptoms listed / Onset date: 2/6 – date of last symptom listed as ongoing2/7: Call in with nausea and chills / Onset date: 2/7 (Of note: Nausea, Vomiting and Diarrhea in 3 or more staff or residents within 72 hours would meet criteria for an outbreak. These symptoms can be due to Gastrointestinal (GI) illness or COVID-19. Neither of which were ruled out for the staff indicated above.) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/27/25 at 2:45 PM, Surveyors interviewed DON B. Surveyors pointed out the pattern of staff members that had CDC-listed COVID symptoms when they called in, yet they were not listed as needing to be tested. DON B indicated they try to identify if there was a significant exposure. When staff members call in, they are asked if they've had a COVID exposure, as testing is not recommended for everyone. Surveyors pointed out that the list does not say what unit staff members worked on and when they worked last. DON B indicated it would be easier if all the information was in one place. DON B was asked what date would be considered the start of the facility outbreak. DON B reviewed the information and indicated he would guess it started on 2/7. Surveyors asked if staff should be considered when determining an outbreak. DON B answered yes. Surveyors pointed out that staff members were on the line list in early February with COVID symptoms, but they were not tested. Surveyors asked what symptoms require testing. DON B indicated cold symptoms and respiratory symptoms and indicated they test for nausea, diarrhea, and vomiting if the CDC recommends it. DON B indicated testing everyone is not recommended. Surveyors asked if the facility should be testing based on symptoms alone. DON B indicated they probably should be. Surveyors asked if the facility can determine the actual start date for the outbreak without knowing if staff members were positive for COVID. DON B indicated the facility would not know for sure. On 8/27/25 at 5:31 PM, Surveyors interviewed NHA A (Nursing Home Administrator) and DON B. Surveyors asked why the facility was not doing COVID-19 testing for all symptoms that are listed on the CDC's website (such as nausea, vomiting, diarrhea). DON B indicated that COVID testing should be done if symptoms are not easily explained by another reason. Surveyors asked if people have GI symptoms that are similar, would this be a commonality? DON B replied yes. Surveyor asked if DON B would expect commonalities to be looked at if staff members are calling in with the same symptoms. DON B replied yes. Surveyors asked once this was identified, should the facility have done contact tracing or broad-based testing? DON B indicated this would have warranted further testing and the facility should have done tracking and trending. Example 5: On 8/26/25 at 11:34 AM, Surveyors interviewed ADON N and DON B. Surveyors asked if the facility had any outbreaks. ADON N and DON B indicated there had been no outbreaks in the last few months.After reviewing the facility's infection surveillance maps, Surveyors requested line list documentation from February 2025 and April 2025. The February 2025 map had five rooms on the second floor highlighted in blue, which indicated a respiratory infection. The April 2025 map had one room on the first floor and four rooms on the second floor highlighted in blue, which indicated a respiratory infection. On 8/26/25 at 3:42 PM, Surveyors interviewed DON B. DON B indicated they had discovered there was a COVID-19 outbreak in February 2025 and in April 2025 after looking at the line lists for those months. DON B and NHA A (Nursing Home Administrator) provided the facility summaries for both months. The facility completed separate COVID line lists for residents in February and April 2025. The line list contained the following information for residents: Room number, Resident with COVID signs/symptoms, Onset date, Positive lab test, Symptoms, Last symptom date, Droplet isolation placed, Date resolved, Notes. The February summary listed the following information for residents: Date, Event – [NAME] (opportunistic pathogen) timeline COVID-19, Response/Action. A separate resident summary was not provided for April. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility noted no staff members had tested positive for COVID during the February 2025 outbreak. The summary listed the following information for staff members in April 2025: Date, Event – [NAME] timeline COVID-19, Response/Action. Nothing in the summaries included an overall description of the facility's response or lessons learned. It was not obvious when each outbreak started or ended. Surveyors wouldn't have known about the outbreaks if they hadn't asked for the line lists for February and April. On 8/27/25 at 2:45 PM, Surveyors interviewed DON B. DON B was asked what date would be considered the start of the facility outbreak. DON B reviewed the information and indicated he would guess it started on 2/7. Surveyors asked if staff should be considered when determining an outbreak. DON B answered yes. Surveyors pointed out that staff members were on the line list in early February with COVID symptoms, but they were not tested. Surveyors asked what symptoms require testing. DON B indicated cold symptoms and respiratory symptoms and indicated they test for nausea, diarrhea, and vomiting if the CDC recommends it. DON B indicated testing everyone is not recommended. Surveyors asked if the facility should be testing with the symptoms alone. DON B indicated they probably should be. Surveyors asked if the facility can determine the actual start date for the outbreak without knowing if staff members were positive for COVID. DON B indicated the facility would not know for sure. On 8/27/25 at 3:01 PM, Surveyors interviewed DON B and NHA A. NHA A indicated the facility called an outbreak on 2/12. NHA A indicated when staff call in with nausea, vomiting, and/or diarrhea, they ask if they've had a COVID exposure. If they haven't, they do not require testing. Surveyors asked how long the facility continues to test residents during an outbreak. NHA A indicated until there are 14 days of no positive tests. DON B indicated the end of the February outbreak was 3/4. Surveyors pointed out that a staff member had called in at the end of February with nausea and vomiting but had not been tested. Surveyors asked if she should have been tested, and would this have changed the end date of the outbreak? DON B responded, possibly. Example 6: On 8/25/25 at 11:10 AM, Surveyors toured the laundry room with HD CC (Housekeeping Director). Surveyors noted a thick layer of dust on top of the pipes above the clean laundry folding area. Some of the dust was hanging down from the pipes and there was air circulating in the room, causing it to blow. The positioning of the pipes created the potential for dust to fall on the clean laundry being folded. On 8/26/25 at 2:20 PM, Surveyors toured the laundry room again. Two housekeeping staff members were working in the laundry room. Surveyors pointed out the dust on top of the pipes above the clean laundry folding area and asked who oversees cleaning the pipes. Both staff members indicated they didn't know who cleans the pipes. On 8/26/25 at 3:39 PM, Surveyors interviewed HD CC and told her about the dust on the pipes in the laundry room. HD CC indicated the maintenance department oversees cleaning pipes and the vents around the facility. HD CC stated she would put a request in to have the laundry room pipes cleaned. Example 7: The facility policy titled, Catheter Care, Urinary, dated 2001, states, in part: Purpose: The purpose of (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	this procedure is to prevent urinary catheter-associated complications, including urinary tract infections. Infection Control: 1. Use aseptic technique when handling or manipulating the drainage system. The facility policy titled, Handwashing/Hand Hygiene, dated 2001, with a Revision Date of October, 2023, states, in part: Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. Policy Interpretation and Implementation: Administrative Practices to Promote Hand Hygiene . 2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents and visitors . Indications for Hand Hygiene: 1. Hand Hygiene is indicated: . c. after contact with blood, body fluids, or contaminated surfaces . 4. Single-use disposable gloves should be used: . c. when in contact with a resident, or the equipment or environment of a resident, who is on contact precautions . R45 was admitted to the facility on [DATE] with diagnoses that include, in part: Other Neuromuscular Dysfunction of Bladder. R45's Comprehensive Care Plan, dated 8/11/25, states, in part: Focus: Resident is on Enhanced Barrier Precautions related to (r/t) indwelling catheter. Goal: Enhanced Barrier Precautions will be followed when coming into contact with. catheter. Interventions: Utilize gown and gloves when coming into contact with. catheter. On 8/20/25 at 12:44 PM, Surveyor observed R45 in the dining room eating lunch with his catheter bag uncovered. On 8/20/25 at 12:51 PM, Surveyor interviewed RN H (Registered Nurse) about R45's catheter bag not being covered. RN H indicated that they do have catheter bags in the facility, and that she would get one to cover R45's catheter bag. Surveyor observed while RN H went to a storage closet in the hallway and retrieved a catheter bag. Surveyor observed RN H return to the dining room and proceed to cover R45's catheter bag with the privacy bag. RN H did not wear gloves, or gown, or perform any hand hygiene before or after handling R45's catheter bag. Surveyor asked RN H if R45 was on Enhanced Barrier Precautions. RN H stated that he was. Surveyor asked RN H what Enhanced Barrier Precautions should be in place for someone that had a catheter. RN H stated that she should have worn gloves and performed hand hygiene after handling R45's catheter bag. On 8/26/25 at 3:17 PM, Surveyor interviewed DON B (Director of Nursing) and shared the observation of R45's catheter bag being handled without Enhanced Barrier Precautions or proper hand hygiene. Surveyor asked DON B if it was his expectation that staff followed Enhanced Barrier Precautions for a resident with an indwelling catheter. DON B stated yes, that was his expectation and that it was concerning that a staff member handled a catheter bag without gloves or performing hand hygiene.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure each resident had a safe, clean, comfortable and homelike environment or ensure housekeeping provided necessary services to maintain a sanitary, orderly and comfortable area for 3 of 22 sampled residents (R33, R37, and R47), 4 supplemental residents (R57, R76, R26, R30) and 1 of 4 units.R33 and R26 voiced concerns related to the cleanliness of the unit.Surveyor observed R33's, R37's, R57's, R76's, and R30's rooms to be unclean with dirt and debris build up in the corners, urine dried around floor and bottom of toilet, and food and paper particles spattered on floor throughout room.Surveyor and staff observed dried dripping substance on the walls and the ceiling, dirt and debris gathered in the corners, in the windowsills, along the baseboards, and behind doors in the hallways of the unit, in the activity room, and in the dining room.Surveyor observed R47's wheelchair armrest to have the padding and leather/plastic covering to be peeled away and/or missing, exposing the hard structure and screws. Staff indicated they were aware of this concern but thought it was the family's responsibility to fix and did not attempt to put anything in place to make the chair comfortable for R47 while she used it.Surveyor observed R37's wheelchair to have hardened and black colored food on it throughout survey.Evidenced by:Facility policy, titled Resident Room Cleaning Procedure, undated, includes: . Spray the outside of the toilet with (named cleaner) . wipe down horizontal surfaces with (named cleaner) . dust on Wednesdays . sweep the entire floor- floors should we swept corner to corner in a circle around the room and ending in the bathroom . mop the entire floor- be sure to place wet floor signs before beginning . Floor should be mopped corner to corner . Example 1R33 admitted to the facility on [DATE] with the following diagnoses: major depressive disorder, anxiety, type 2 diabetes mellitus, and acute and chronic respiratory failure with hypoxia.R33's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 4/6/25 indicates R33's ability to express needs and wants is understood by others and her ability to understand others is she understands with clear comprehension.On 8/20/25 at 9:52 AM, R33 stated, They could do a better job at cleaning my room. There is dirt in the corners and corn on the floor in the bathroom that has been there a couple days. Surveyor observed debris, hair, and dirt to be gathered in the corners, along the baseboard, and next to the heating register. Surveyor observed 3 pieces of dried corn on the floor near where the floor and shower meet and dried urine on the bottom of R33's toilet.On 8/25/25 at 9:54 AM, Surveyors observed R33's room to still have dirt, dust, debris, and hair built up in the corners of her room, next to her register, behind the doors, and along the baseboards. R33 indicated someone did come in and clean up the hard dried corn after she showed it to them, but they haven't done much to get the floor cleaned in other places.On 8/25/25 at 10:07 AM, Housekeeper EE and Surveyor walked together observing R33's room and bathroom. Surveyor and Housekeeper EE observed dirt and debris built up in the corners, along the baseboards, next to the register, behind the doors, and urine splatters around the base of R33's toilet. I can definitely do better. Sometimes I don't do my best because I have so many rooms to do. Housekeeper EE indicated he only deep cleans the room when someone asks or there is a discharge/room change.On 8/25/25 at 10:36 AM, Housekeeping Manager CC and Surveyor observed R33's room noting dirt and debris built up in the corners, along the baseboards, and along the register. Housekeeping Manager CC and Surveyor observed R33's wall to have brown dried dripping marks on it near the garbage can and observed the bathroom. Housekeeping Manager CC indicated R33's bathroom should not have dirt built up in the corners and urine splatters on the floor and on the bottom of the toilet from last week. Housekeeping Manager CC indicated she would educate and get staff cleaning these areas as soon as possible. Housekeeping Manager CC indicated there is no set schedule for deep cleaning, but they are to do it upon discharges. Housekeeping Manager CC indicated there should be a schedule for deep cleaning the rooms for the long term care residents.Example 2R26 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	admitted to the facility on [DATE] with the following diagnoses: alcohol abuse, major depressive disorder, generalized anxiety, and chronic pain.R26's most recent MDS with ARD of 6/10/25, indicates her ability to express needs and wants is understood by others and her ability to understand others is she understands with clear comprehension.On 8/20/25 at 10:03 AM, R26 indicated she has a concern that the housekeeping staff do not come on the weekends to clean.Example 3 R37 admitted to the facility on [DATE].R57 admitted to the facility on [DATE].R76 admitted to the facility on [DATE].R30 admitted to the facility on [DATE].On 8/20/25 from 9:52 AM until 1:14 PM, Surveyors observed R37's, R57's, R76's, and R30's rooms to have dust, hair, and debris built up in the corners, behind the doors, along the baseboards, and in the windowsills. Surveyors observed R76's bathroom to have urine on and around the bottom of the toilet and a dirty mop head to be lying on the floor. Surveyor observed a dried gray spill mark next to R37's bed.On 8/25/25 at 9:54 AM, Surveyors observed R37's room, R57's room, R76's room, and R30's room to still have dust, debris built up in the corners, behind the doors, and along the baseboards. Surveyors observed R76's bathroom to still have urine splatter on the floor and bottom of his toilet. Surveyor observed the same gray dried on liquid spill mark next to R37's bed.On 8/25/25 at 10:07 AM, Housekeeper EE observed R37's, R57's, R76's, and R30's rooms, noting dust, hair, and debris built up in the corners, behind the doors, along the baseboards, in the windowsills, and urine splatters around the toilet in R76's room. Housekeeper EE stated, I can definitely do better. Sometimes I don't do my best because I have so many rooms to do. On 8/25/25 at 10:36 AM, Housekeeping Manager CC indicated she oversees several buildings and is not always at this location. Housekeeping Manager CC indicated the department has two open positions and the current staff is working short staffed. Housekeeping Manager CC and Surveyor walked through the unit together noting in rooms (R33's, R57's, R76's, R37's) dirt and debris built up in the corners, in the windowsills, and along the baseboards. Housekeeping Manager CC indicated the cleanliness of the unit does not meet her expectations. Housekeeping Manager CC indicated she will re-educate the housekeeping staff on the issues. Housekeeping Manager CC indicated it is not homelike to have dried brown dripping on the ceilings, walls, or doors. Housekeeping Manager CC indicated staff should clean spills on the spot, when they happen. Housekeeping Manager CC indicated there should not be cobwebs, paper debris, food debris, and dried dripping in the windowsills. Housekeeping Manager CC observed along the baseboards, in the corners, and behind the doors in R37's room, R57's room, R76's room, and R30's room. Housekeeping Manager CC indicated these areas are unclean and they should be cleaned. Example 4On 8/20/25 from 9:52 AM, Surveyors observed on the memory care unit brown dried liquid dripping down the walls in the hallway, activity room, and the dining room. Surveyors observed brown dried liquid on the ceiling in the activity room and on two doors in the activity room. Surveyors observed cobwebs, dust, hair, and debris in the windowsills of the activity room.On 8/25/25 at 9:54 AM, Surveyors observed the same units walls to still have brown dried liquids dripping on them in multiple areas, dust and debris to be gathered in the corners of the activity room and the dining room, and along the baseboards in the hallway, in rooms, in activity room, and in dining room. Surveyors observed a brown substance dripping on two doors in the activity room, and dust, cobwebs, hair, and debris to be gathered in the windowsills of the activity room.On 8/25/25 at 10:07 AM, Housekeeper EE and Surveyor walked together observing the unit. Housekeeper EE indicated he sees a brown liquid dried to the walls and ceiling in the dining room and activity room. Housekeeper EE indicated there are cobwebs, hair, food wrappers, and dried spills in the windowsills of that activity room. Housekeeper EE indicated he sees brown dried substance dripping down two doors in the activity room and brown dried substance dripping in several areas in the hallway. Housekeeper EE indicated the nursing staff could also assist in cleaning up the spills when they happen, but they do not always do this. Housekeeper EE indicated the department is working short staffed as they have 2 positions not filled. Housekeeper EE stated, I can definitely do better. Sometimes I don't do my best because I have so many rooms to do. On 8/25/25 at 10:36 AM, Housekeeping Manager CC indicated she oversees several buildings and is not always at this location. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Housekeeping Manager CC indicated the department has two open positions and the current staff is working short staffed. Housekeeping Manager CC and Surveyor walked through the unit together noting the following: In the dining room- dust and debris built up along the baseboards and behind the door, brown dried dripping on the walls in multiple areas and on the doors. In the activity room- dust and debris built up along the baseboards and in the corners and brown dried dripping on the doors, ceiling, and walls in multiple areas, and dried spills on the floor. In the hallways of the unit- brown dried dripping in multiple areas, dust gathered in the corners, along the baseboards, in doorways, and behind doors. Housekeeping Manager CC indicated the cleanliness of the unit does not meet her expectations. Housekeeping Manager CC indicated she will re-educate the housekeeping staff on the issues. Housekeeping Manager CC indicated it is not homelike to have dried brown substance dripping on the ceilings, walls, or doors. Housekeeping Manager CC indicated staff should clean spills on the spot, when they happen. Housekeeping Manager CC indicated there should not be cobwebs, paper debris, food debris, and dried substance dripping in the windowsills of the shared activity room. Housekeeping Manager CC observed along the baseboards, in the corners, and behind the doors in the activity room, dining room, and indicated she would have staff come and clean these areas.Example 5R47 admitted to the facility on [DATE] with diagnoses including schizophrenia, anxiety disorder, macular degeneration, glaucoma, and major depressive disorder.R47's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 6/25/25 indicates R47 requires assistance to meet her needs in the following areas: toileting, bathing, dressing, putting on footwear, rolling in bed, and transfer.On 8/21/25 at 12:30 PM, Surveyor observed R47's wheelchair armrest to have a hard plastic structure and a screw exposed. Surveyor observed the leather/plastic casing that used to cover the structure to be hanging alongside the armrest and missing the padding. R47 had a short-sleeved shirt on and was propelling herself on the unit, rubbing the inside of her elbow along the exposed hard structure. Surveyor observed R47's arm and did not observe an injury. On 8/21/25 at 12:57 PM, RN W (Registered Nurse) indicated R47's wheelchair armrest is ripped and folded over. RN W indicated R47's wheelchair has been like this for several days and it is the family's responsibility to maintain the chair because they own in. Surveyor asked RN W if there was potential for R47 to get an injury due to the exposed hard plastic structure or screws. RN W indicated there is potential for this as R47 propels herself on the unit. Surveyor asked RN W if R47's chair in this condition is safe and homelike. RN W indicated it is not.On 8/21/25 at 1:01 PM, DON B (Director of Nursing) indicated he was unaware of R47's chair being damaged and the facility should put something in place on R47's wheelchair arm rest to prevent R47 from obtaining an injury. DON B indicated the broken armrest of R47's wheelchair is not safe and homelike. DON B indicated the facility would get her a different wheelchair until her family can repair hers.Example 6R37 admitted to the facility on [DATE] with the following diagnoses: unspecified dementia, anxiety, and major depressive disorder.On 8/20/25 at 12:58 PM, Surveyor observed R37's wheelchair to have hardened food substance on it that resembled hardened brown candle wax. The substance was on the arm of his chair, the side of his chair, in the braking mechanism of the chair, on the seat of his chair and on the bars underneath the chair. Surveyor observed R37 drop food from his mouth onto the chair including orange pureed fruit and a red and white pudding/cheesecake dessert. During an interview, RN W indicated it is the night shift CNAs (certified nursing assistants) who clean wheelchairs. RN W indicated R37's wheelchair needs to be cleaned.On 8/25/25 at 10:07 AM, Surveyor and Housekeeper EE observed R37's wheelchair noting the brown, white, red, and orange substances that are layered on the arm, side, seat, on the braking mechanism, and on the bars. Housekeeper EE indicated the nursing department is responsible for cleaning resident wheelchairs. On 8/25/25 at 10:36 AM, Housekeeping Manager CC indicated it is the nursing department's responsibility to clean the wheelchairs and R37's wheelchair needs to be cleaned. Housekeeping Manager CC indicated R37's wheelchair has not been cleaned in some time.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interviews, and record review, the facility did not ensure Minimum Data Set (MDS) assessment information accurately reflected resident's status for 3 residents (R) of 19 sampled residents (R8, R23, R37) and 1 supplemental resident (R48).R8's, R23's, R37's, and R48's MDS (Minimum Data Set) assessments have conflicting data and are inaccurate as section C indicates they are rarely or never understood, while section B indicates they are understood, have clear speech, and make themselves understood by others.R48's MDS indicates she discharged with return anticipated and that she had a fall with major injury. R48's emergency department notes indicate she had a fall with fracture. Her reentry assessment indicates she did not have a fall with major injury.Evidenced by:The facility did not provide a policy related to the completion of resident MDS.Example 1R8 admitted to the facility on [DATE] Type 2 diabetes, hypothyroidism (a condition in which the thyroid gland does not produce enough thyroid hormone), chronic kidney disease, gastro-esophageal reflux disease (a digestive disease in which stomach acid or bile irritates the food pipe lining), and depressive episodes (periods of intense sadness),On 8/20/25 at 10:14 AM, Surveyor interviewed R8. R8 was able to have a complete conversation and spoke about the food at the facility, the residents who live at the facility, and her experience with previously being sent out to the hospital. She spoke clearly and was able to make herself understood.R8's most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 8/21/25 indicates in section B that R8's speech is clarity is clear, her ability to hear is adequate, she makes herself understood, and she understands others with clear comprehension. R8's section C indicates R8 is rarely or never understood.(It is important to note that section B and section C do not support each other, and the assessment does not accurately reflect R8's cognition.)Example 2R23 admitted to the facility on [DATE] with the following diagnoses: Type 2 Diabetes Mellitus, congestive heart failure, hyperlipidemia (a condition in which there are high levels of fat in the blood), dementia, and depression.On 8/20/25 at 12:55 PM, Surveyor observed R23 interact with staff members and residents during lunch. Surveyor noted that R23 speaks fluent Spanish. Some staff members were able to communicate in Spanish back to her. Surveyor also noted that R23 can point and use her hands to makes her needs known if staff members are unable to understand Spanish.R23's most recent MDS, with ARD of 8/6/25, indicates in section B that R23 makes herself understood, has clear speech with distinct intelligible words, and understands others. R23's MDS, section C indicates that she is rarely to never understood.(It is important to note that R23 is assessed to be understood and to understand and to rarely or never be understood. This is contradicting and does not reflect R23's cognitive status.)Example 3R48 admitted to the facility on [DATE] with the following diagnoses: polyneuropathy (peripheral nervous system disorder that impacts nerve function), chronic obstructive pulmonary disease, and chronic kidney disease.On 8/20/25 at approximately 1:00 PM, Surveyor observed R48 interact with staff members and residents during lunch. Surveyor was able to communicate with R48 and asked how lunch was going. R48 spoke clearly and was able to make herself understood.On 8/27/25 at 11:25 AM, Surveyors interviewed NHA A (Nursing Home Administrator) regarding R48. NHA A indicated R48 can articulate and have conversations with staff members.R48's MDS, with ARD of 8/13/25, indicates in section B that R48 has clear speech with distinct intelligible words, adequate hearing, has the ability to make herself understood, and has the ability to understand others with clear comprehension.(It is important to note the discrepancy recorded within this assessment.)Example 4R37 admitted to the facility on [DATE] with the following diagnoses: emphysema (condition of the lung marked by abnormal enlargement), unspecified dementia, anxiety, major depressive disorder, and chronic kidney disease stage 3.R37's MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 8/8/25, indicates R37 is rarely or never understood in section C, but in section B it indicates R37 is understood by others and makes (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	himself understood.(It is important to note the conflicting information in this one assessment.)Example 5Minimum Data Set 3.0 Resident Assessment Instrument, includes in part: Steps for Assessment The period of review is 180 days (6 months) prior to admission, looking back from the resident's entry date (A1600). 1. Ask the resident and family or significant other about a history of falls in the month prior to admission and in the 6 months prior to admission. This would include any fall, no matter where it occurred. 2. Review inter-facility transfer information (if the resident is being admitted from another facility) for evidence of falls. 3. Review all relevant medical records received from facilities where the resident resided during the previous 6 months; also review any other medical records received for evidence of one or more falls. Coding Instructions for J1700A, Did the Resident Have a Fall Any Time in the Last Month Prior to Admission/Entry or Reentry? Code 0, no: if resident and family report no falls and transfer records and medical records do not document a fall in the month preceding the resident's entry date item (A1600). Code 1, yes: if resident or family report or transfer records or medical records document a fall in the month preceding the resident's entry date item (A1600). Code 9, unable to determine: if the resident is unable to provide the information or if the resident and family are not available or do not have the information and medical record information is inadequate to determine whether a fall occurred. DEFINITION FALL Unintentional change in position coming to rest on the ground, floor or onto the next lower surface (e.g., onto a bed, chair, or bedside mat). The fall may be witnessed, reported by the resident or an observer or identified when a resident is found on the floor or ground. Falls include any fall, no matter whether it occurred at home, while out in the community, in an acute hospital or a nursing home. Falls are not a result of an overwhelming external force (e.g., a resident pushes another resident). An intercepted fall occurs when the resident would have fallen if they had not caught themself or had not been intercepted by another person - this is still considered a fall. CMS understands that challenging a resident's balance and training them to recover from a loss of balance is an intentional therapeutic intervention and does not consider anticipated losses of balance that occur during supervised therapeutic interventions as intercepted falls. CMS's RAI Version 3.0 Manual CH 3: MDS Items [J] October 2024 Page J-32 J1700: Fall History on Admission/Entry or Reentry (cont.) Coding Instructions for J1700B, Did the Resident Have a Fall Any Time in the Last 2-6 Months prior to Admission/Entry or Reentry? Code 0, no: if resident and family report no falls and transfer records and medical records do not document a fall in the 2-6 months prior to the resident's entry date item (A1600). Code 1, yes: if resident or family report or transfer records or medical records document a fall in the 2-6 months prior to the resident's entry date item (A1600). Code 9, unable to determine: if the resident is unable to provide the information, or if the resident and family are not available or do not have the information, and medical record information is inadequate to determine whether a fall occurred. Coding Instructions for J1700C. Did the Resident Have Any Fracture Related to a Fall in the 6 Months prior to Admission/Entry or Reentry? Code 0, no: if resident and family report no fractures related to falls and transfer records and medical records do not document a fracture related to fall in the 6 months (0-180 days) preceding the resident's entry date item (A1600). Code 1, yes: if resident or family report or transfer records or medical records document a fracture related to fall in the 6 months (0-180 days) preceding the resident's entry date item (A1600). Code 9, unable to determine: if the resident is unable to provide the information, or if the resident and family are not available or do not have the information, and medical record information is inadequate to determine whether a fall occurred. page 31: Steps for Assessment 1. If this is the first assessment/entry or reentry (A0310E = 1), review the medical record for the time period from the admission date to the ARD. 2. If this is not the first assessment/entry or reentry (A0310E = 0), the review period is from the day after the ARD of the last MDS assessment to the ARD of the current assessment. 3. Review all available sources for any fall since the last assessment, no matter whether it occurred while out in the community, in an acute hospital, or in the nursing home. Include medical records generated in any health care setting since last assessment. 4. Review nursing home incident reports, fall logs and the medical record (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	comprehension. R48's MDS also indicates R48 had no falls since entry, reentry, or prior scheduled PPS or OBRA assessment. On 8/26/25 at 2:37 PM, MDS Coordinator JJ indicated falls are only counted if they occurred after the reentry. MDS Coordinator JJ indicated if section B states resident is understood by others and understands others then section C should be completed with an interview.On 8/26/25 at 3:15 PM, DON B (Director of Nursing) stated, They need to be accurately filled out. We will have to educate. If sections are completed with interview we should be able to do section C. DON B indicated staff should follow the RAI manual instructions for entering data.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure that each resident receives food and drink that is palatable and at a safe and appetizing temperature. This has the potential to affect 4 (R82, R51, R3 and R1) of 19 sampled residents and residents eating in 1 of 3 dining rooms (10 residents out of a census of 68). R82 and R51 voiced concerns with hot foods not being hot. R3 and R1 voiced concerns regarding food temperatures. Surveyor conducted 1 test tray for the dining room which was not palatable. Evidenced by: Example 1 On 8/20/25 at 2:38 PM, Surveyor interviewed R82 during the initial screening process. During the interview R82 was asked if there were any concerns with meals. R82 indicated about 5 times a week the food is dry, tasteless, has no spices and the hot foods are not hot. Example 2 On 8/21/25 at 9:16 AM, Surveyor interviewed R51 during the initial screening process. During the interview R51 was asked if there were any concerns with meals. R51 indicated that about 5 times a week the hot foods are not hot. Example 3 R3 admitted to the facility on [DATE]. Her most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/4/25 indicates R3's cognition is intact with a Brief Interview of Mental Status (BIMS) score of 15 out of 15. On 8/20/25 at 11:48 AM, Surveyor interviewed R3 about the food at the facility. R3 stated that the food was terrible. R3 indicated that the food was not hot and very often she has to eat cold eggs in the morning. R3 stated that she eats breakfast in her room, and that she usually doesn't get her breakfast tray until 9:00 o'clock. Of note: the posted mealtimes provided by the facility indicate that breakfast for the hallway that R3 resides in is 7:40 AM. Example 4 R1 admitted to the facility on [DATE]. Her most recent MDS with an ARD of 7/30/25 indicates R1's cognition is intact with a BIMS score of 15 out of 15. On 8/20/25 at 12:05 PM, Surveyor interviewed R1 about the food at the facility. R1 stated that she eats in her room, and that the food is not always hot. R1 indicated that the majority of the time the (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	food is cold, and that while she loves oatmeal for breakfast, when she gets hers in the morning it is cold. R1 stated that she doesn't like cold oatmeal. Surveyor asked R1 if the staff would warm up her oatmeal for her so she wouldn't have to eat it cold. R1 stated that they would, but that she has gotten tired of asking them to warm it up every day. Example 5 Facility policy, entitled Food Preparation and Service with a revision date of April 2019 states, in part: .Food Preparation, Cooking and Holding Time/Temperatures 1. The danger zone for food temperatures is between 41- and 135-degrees Fahrenheit.PHF (Potentially Hazardous Foods) must be maintained below 41 degrees Fahrenheit or above 135 degrees Fahrenheit. On 8/21/25 at 12:55 PM, Surveyor conducted a test tray from the 200 Skilled Unit dining room. Surveyor took the temperature of the items on the tray. The temperatures were as follows: Hamburger on a bun– 126.7 degrees Fahrenheit Sweet Potato fries – 122.8 degrees Fahrenheit Dill pickle spear – 115 degrees Fahrenheit Milk – 38.9 degrees Fahrenheit Water – 42.9 degrees Fahrenheit Surveyor tasted the food and drink on the tray. The hamburger and fries were not as hot as they should have been. The pickle was very warm from sitting on the plate from preparation to service and should have been a cold item. The tray was not palatable and at a safe and appetizing temperature. On 8/25/25 at 2:32 PM, Surveyor interviewed DM J (Dietary Manager) and AFSD I (Assistant Food Service Director) who indicated the hot food should have been above 135 degrees and the cold food should be below 41 degrees Fahrenheit. On 8/25/25 at 3:15 PM, Surveyor interviewed NHA A (Nursing Home Administrator), DON B (Director of Nursing), and RDM K (Regional Dietetic Manager). Surveyor asked if they would expect policies to be followed for food preparation and service; they stated yes.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility did not ensure that residents were ensured a dignified existence and self-determination for 2 of 17 sampled residents (R45 and R37). R45 voiced concerns that his catheter bag was not covered, including when he went to the dining room for meals. R37's wheelchair was observed to be dirty and undignified. As evidenced by: The facility policy titled, Resident Rights, dated 2001, states, in part: .Policy Interpretation and Implementation: 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; b. to be treated with respect, kindness, and dignity. e. self-determination. h. be supported by the facility in exercising his or her rights. The facility policy titled, Dignity, dated 2001, states, in part: Policy Statement: Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Policy Interpretation and Implementation: 1. Residents are treated with dignity and respect at all times. 2. The facility culture supports dignity and respect for residents by honoring residents goals, choices, preferences. 5. When assisting with care, residents are supported in exercising their rights. For example, residents are: a. groomed as they wish to be groomed. e. provided with a dignified dining experience. 12. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents; for example: a. helping the resident to keep urinary catheter bags covered. Example 1 R45 was admitted to the facility on [DATE]. R45's Minimum Data Set (MDS) dated [DATE] indicates, in part: a Brief Interview of Mental Status (BIMS) score of 6 out of 15, indicating R45 has a severe cognitive impairment. R45's Comprehensive Care Plan, dated 1/14/25, states, in part: .Focus: The resident has a Suprapubic catheter related to (r/t) Neuro muscular dysfunction of bladder. Intervention: Position catheter bag and tubing below the level of the bladder and away from entrance room door or cover for privacy. On 8/20/25 at 10:59 AM, Surveyor interviewed R45 in his room and noted that he had a catheter bag that was uncovered. Surveyor asked R45 about his catheter bag. R45 stated that he didn't mind it being uncovered while in his room, but that he liked it to be covered when he was out of his room. On 8/20/25 at 12:44 PM, Surveyor observed R45 eating lunch in the dining room with his catheter bag uncovered. Surveyor interviewed R45 about his catheter bag, who stated that that there should be a black or blue bag covering it. R45 indicated that his catheter bag should be covered and that he likes it to be covered when he is out of his room. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/20/25 at 12:51 PM, Surveyor interviewed RN H (Registered Nurse) and asked her about R45's catheter bag not being covered. RN H stated that they do have catheter bags and that she would get him one. Surveyor asked RN H if she would consider the catheter bag uncovered to be a violation of R45's dignity. RN H stated yes, she considered the uncovered catheter bag to be a dignity issue. On 8/20/25 at 12:57 PM, Surveyor interviewed CNA D (Certified Nursing Assistant) and asked her about R45's catheter bag. CNA D stated that she didn't think that R45 had a bag to cover his catheter, but that some of the other residents have them. Surveyor asked CNA D if she would consider the catheter bag uncovered to be a violation of R45's dignity. CNA D stated yes, that possibly R45 would feel bad if he wanted it covered and it wasn't. On 8/25/25 at 8:18 AM, Surveyor observed R45 in the dining room eating breakfast again with his catheter bag not covered. On 8/26/25 at 3:16 PM, Surveyor interviewed DON B (Director of Nursing) and shared with him the observations of R45's catheter bag being uncovered in the dining room. Surveyor asked DON B if he would consider the catheter bag uncovered to be a violation of R45's dignity. DON B stated that yes, if a resident is requesting their catheter bag to be covered and it wasn't, then he would consider that to be a violation of their dignity. Example 2 On 8/20/25 at 12:58 PM, Surveyor observed R37 sitting in his wheelchair. Surveyor observed R37's wheelchair to have dried brown, yellow, red, and orange food substance on the arm of the chair, in the braking mechanism, along the side of the chair, and on the edge of the seat of the wheelchair. Some of the food substance had hardened into a brown wax-like form representing a dripping candle. Other food substance was colorful and could be identified by the menu for the week, including cheesecake/Jello desert and mandarin oranges. On 8/21/25 at 12:52 PM, RN W (Registered Nurse) and Surveyor observed R37's wheelchair. RN W stated, This is not clean. There is food on here from more than one meal. RN W indicated the night shift CNAs (Certified Nursing Assistants) are to clean the residents' wheelchairs. On 8/25/25 at 10:07 AM, Housekeeper EE and Surveyor observed R37's wheelchair while he was seated in it, in the unit's dining/activity room, noting the food substance to be hardened like candle wax and in the form of a spill with dripping patterns. Housekeeper EE indicated it is the nursing department's responsibility to clean resident wheelchairs. Housekeeper EE indicated the food appears to have fallen at different times with the oldest food being brown in color and the newer food to be hardened but still holding some color. Housekeeper EE indicated R37's wheelchair was not clean, and it should be. Surveyor observed R37's wheelchair to have the same food substance on it as last week, noting brown hardened food substance dripping down the side of the wheelchair on the arm, the side panel, in and on the braking handles, and on the seat of the wheelchair. The food varied in color from white, red, orange, brown, and it varied in hardness (some of the food could be wiped off while others were hardened onto the chair). On 8/25/25 at 10:36 AM Housekeeping Manager CC indicated cleaning of spills is everyone's responsibility, not just housekeeping department. Housekeeping Manager CC observed R37's wheelchair and indicated it is dirty, and nursing should clean this. Housekeeping Manager CC indicated R37's chair should be cleaned regularly, but it has not been.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not document a thorough investigation and did not resolve grievances as outlined in the facility policy for 1 of 1 Residents (R2) reviewed for grievances. R2 had voiced a concern to a staff member and the facility failed to follow their grievance policy by thoroughly investigating, following up, and documenting the concern.Evidenced by: The facility policy, Grievances/Complaints, Recording and Investigating indicates, in part: Policy Statement: All grievances and complaints filed with the facility will be investigated and corrective actions will be taken to resolve the grievance(s). Policy Interpretation and Implementation: 1. The administrator has assigned the responsibility of investigating grievances and complaints to the grievance officer. 2. Upon receiving a grievance and complaint report, the grievance officer will begin an investigation into the allegations.4. The investigation and report will include, as applicable: a. the date and time of the alleged incident; b. the circumstances surrounding the alleged incident; c. the location of the alleged incident; d. the names of any witnesses and their accounts of the alleged incident; e. the resident's account of the alleged incident; g. accounts of any other individuals involved (i.e., employee's supervisor, etc.); and h. recommendations for corrective action. 5. The grievance officer will record and maintain all grievances and complaints on the Resident Grievance Complaint Log.6. The Resident Grievance/Complaint Investigation Report Form will be filed with administrator within five (5) working days of the incident. 7. The resident, or person acting on behalf of the resident, will be informed of the findings of the investigation, as well as any corrective actions recommended, within (of note, there is a line in the policy and nothing is written on the line) working days of the filing of the grievance or complaint.9. A copy of the Resident Grievance/Complaint Investigation Report Form must be attached to the Resident Grievance/Complaint Form and filed in the business office. 10. Copies of all reports must be signed and will be made available to the resident or person acting on behalf of the resident.R2 was admitted to the facility on [DATE] with diagnoses that include, in part: Chronic Obstructive Pulmonary Disease (A group of lung diseases that block airflow to and from the lungs, making it hard to breathe), Other spondylosis with radiculopathy, lumbosacral region (A medical diagnosis for degenerative changes in the lower spine that cause nerve compression, leading to symptoms like pain, numbness, or weakness in the lower back and legs), and Polyneuropathy (a condition where multiple peripheral nerves (nerves outside the brain and spinal cord) are damaged, leading to various symptoms such as weakness in extremities, difficulty walking or standing, and numbness, tingling, or burning in the hands, feet, legs, or arms.R2's most recent Minimum Data Set (MDS), target date 8/10/25, indicates R2 has a Brief Interview for Mental Status (BIMS) score of 6, indicating R2 has a severe cognitive impairment.Section GG Functional Abilities and Goals indicates that R2 is dependent (Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.) in using her wheelchair (w/c). R2's Kardex indicates for Mobility/Locomotion that R2 is mobile via manual w/c with assist of 1 staff. On 8/21/25 at 11:01 AM, Surveyors completed the Resident Council task as part of the survey process. During this meeting a concern was brought forward by R2, R59, and R51 regarding R2 being left in the dining room, after trays are picked up, and not being helped back to her room. These residents indicated it generally happens after lunch and supper. R51 indicated he has had to go to the nurse's station and get someone to help R2. R59 indicated she has had to get help for R2 about 4 times a week after the lunch meal. R2 indicated she has fallen asleep while waiting to get assistance, it happens almost every night, and it makes her feel embarrassed. On 8/26/25, Surveyors reviewed R2's electronic health record, in part, and noted the following: 8/16/25 7:32 PM, Author: LPN Y (Licensed Practical Nurse), Note Text: Writer heard resident yelling out help. Writer followed voice and found resident in dinning [sic] room. Resident was (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	crying and stated staff always forgets her everyday [sic] in dinning [sic] room. Resident also voiced concerns of wanting to know why this is happening and if she did anything wrong for this to keep happening. Writer apologized to resident and stated nothing is her fault and this should not be happening.Writer will be notifying DON (Director of Nursing) of concerns.8/16/25 7:40 PM, Author: LPN Y, Note Text: Resident stated wanted to report it because she is tired of it happening.ADON notified of concerns.On 8/26/25 at 11:11 AM, Surveyor interviewed LPN Y via telephone. LPN Y indicated on 8/16/25 when she found R2 in the dining room that she had texted the ADON that [Room Number] had been left in the dining room and wanted it reported. LPN Y indicated she texted ADON at 7:40 PM and received a response within minutes that said, Oh wow, thank you.Surveyors reviewed the July and August Grievance Log and did not find an entry for R2.On 8/27/25 at 8:30 AM, Surveyor interviewed ADON N (Assistant Director of Nursing) and reviewed the 8/16/25 notes above regarding R2 being left in the dining room. Surveyor asked ADON N what action she took after being notified that R2 was left in the dining room. ADON N indicated she personally has been going in there and making sure that R2 is not in there alone. ADON N indicated that the nurse, staff member, or CNA (Certified Nursing Assistant) needs to stay with the residents at all times and that no one should be leaving residents unattended in the dining room. ADON N indicated that even if the residents are done eating and trays have been taken there should still be a staff member that remains in the dining room with residents and that no one is to be left unattended in the dining room. Surveyor asked ADON N if she completed a grievance or investigation. ADON N indicated she reported the incident to the DON (Director of Nursing) and believed the DON completed a grievance, but she could not say for sure. ADON N indicated that she did not personally complete a grievance. ADON N indicated the DON at the time of the incident no longer works at the facility. Surveyor asked ADON N what the expectation is if someone reports a grievance to her. ADON N indicated she reports it to the administrator who will instruct her to write up the grievance and then she follows the administrator's guidance from there. Surveyor asked ADON N if she discussed this grievance with NHA A (Nursing Home Administrator). ADON N indicated she could not recall if she had, that it was on a weekend, she worked the floor that Monday and saw the previous DON doing education, so she thought the previous DON took care of it. Surveyor asked ADON N if a grievance/investigation should have been completed, and she indicated it should have.On 8/27/25, at approximately 12:13 PM, Surveyor interviewed NHA A and reviewed the notes for 8/16/25 above from R2's electronic health record. NHA A indicated that the incident of R2 being left in the dining room should have been written up as a grievance. Surveyor reviewed the interview with ADON N with NHA A and NHA A indicated she would have expected the previous DON to follow-up with her about the concern. NHA A indicated she is the grievance officer and did not recall anyone reporting this information to her. On 8/27/2025 at 3:55 PM, NHA A provided surveyors with an attendance record from a staff in-service dated 8/16/25 and titled, Staff Education: Mealtime Procedures. The education included, in part: Post-Meal Assistance: Once a resident has finished dining, please offer assistance if they wish to return to their room or move to another location. There are 26 names listed on the attendance record. The employee list provided by the facility contained 119 nursing staff. NHA A indicated she was not able to locate documentation of a grievance form, an investigation, recommendations for corrective action, or information that anyone followed up with R2 regarding a resolution.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that all alleged violations involving misappropriation of resident funds/personal property are reported immediately to the administrator of the facility, the State agency, and to other officials, including local law enforcement, in accordance with State law through established procedures for 1 of 22 sampled residents (R48) reviewed for abuse. The facility did not report allegations of abuse to the state agency in accordance with facility policy and federal regulations for an incident involving R48.Evidenced by:Facility policy, titled Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating, revised 9/2022, includes, in part: All reports of resident abuse, neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and other officials according to state law. Immediately is defined as within 2 hours of an allegation involving abuse or result in serious bodily injury; or within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.R48 admitted to the facility on [DATE]. R48's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 8/13/25, indicates R48's hearing is adequate with no difficulty in normal conversations, social interactions, and listening to television, R48's MDS also indicates her speech clarity is clear with distinct intelligible words and her ability to express ideas and wants is understood by others. R48's MDS indicates her ability to understand others or understand verbal content is understands with clear comprehension.R48's Nurse Notes, dated 8/9/25 at 10:09 AM: Resident appeared to be tearful this morning upon arrival to activity room. Resident was well dressed and was cleaned up appropriately for the day, however said to writer, Why would you pinch me and jolt me out of bed? Writer asked resident if she knows that writer was her nurse and that this was their first interaction of the day. Resident responded, Yes, I know you are (named nurse), why would you do that? Resident kept asking writer where her daughter and grandkids were and if they were okay. Writer re-assured resident that her daughter and grandkids were at home safely, and that resident was here for her hip rehabilitation. Writer also re-assured that writer has not seen resident yet until she came into the activity room and offered to help her with her pain medication. Resident calmed down and acknowledged that. Resident was resistant to medication. Writer assisted resident in calling her daughter per resident request and initiated 2 assist personal cares due to resident increased confusion. (It is important to note the allegation by R48 that this nurse or someone pinched her and jolted her out of bed.)R48's Nurse Notes, dated 8/9/2025 at 3:08 PM, includes Resident's daughter came into unit around 2:20 PM requesting to speak with writer. Writer went in to speak with resident and resident's daughter. Daughter told writer that resident was stating that staff member named [name] got her up this morning and was rough with her. Writer spoke to daughter regarding resident's increased confusion, orientation status of 1, and about the confusion that occurred this morning when resident told writer that writer was the one who jolted her out of bed this morning. Writer explained to daughter that resident had increased pain this morning due to her hip, and that writer had not had a chance to pre-medicate resident before morning get up. Writer explained how increased pain with morning activity may have caused some distress. Daughter was not satisfied with this response and wanted to know specifically which CNA (Certified Nursing Assistant) helped with the morning get up. Writer re-assured daughter that the writer's nursing student witnessed the morning get up when resident and CNA were in the bathroom and did witness staff being appropriate and gentle with cares with resident. Daughter was still unsatisfied with this. Writer offered to update the administrator, and care plan with resident to be 2 assist for resident (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	safety. Daughter was agreeable to this. During the entirety of the interaction between daughter and writer, resident continued to insist that [name] was rough with her when prompted by daughter even though resident was reminded about twice in the conversation that there was no [name] on staff. (It is important to note the allegation of a staff member being rough with R48.)On 8/26/25 at 11:25 AM, NHA A (Nursing Home Administrator) indicated the expectations of the facility is to report all allegations of abuse immediately within 2 hours or 24 hours. NHA A and Surveyor reviewed R48's Nurse Notes, dated 8/9/25 at 10:09 AM and 3:08 PM. NHA A indicated this could be two allegations of abuse, but R48 was confused. NHA A indicated she did not report the allegations to the state agency. NHA A indicated there is potential for a confused resident to have been abused and the facility takes all allegations seriously. NHA A indicated a confused resident could provide some accurate information along with confused details such as mixing up names of staff members or thinking another resident is a staff member. NHA A indicated RN X (Registered Nurse) was not removed from resident care upon gaining knowledge of the allegation of her pinching and jolting resident out of bed. NHA A indicated two staff with or without a student could abuse a resident and upon voicing the allegation the facility should have followed the abuse policy to ensure resident is protected, supported, and to rule in or out abuse.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that in response to allegations of abuse, neglect, exploitation or mistreatment, that all alleged violations are thoroughly investigated and residents are protected pending a thorough investigation for 1 of 22 residents reviewed (R48). The facility did not thoroughly investigate R48's allegations of abuse by a staff member. The facility did not remove the alleged staff from patient care to protect residents while conducting a thorough investigation.Evidenced by:Facility policy, titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, revised 9/2022, includes, in part: All reports of resident abuse, neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for protection of resident. All allegations are thoroughly investigated. The administrator initiates investigations. Investigations may be assigned to an individual trained in reviewing, investigating, and reporting such allegations. Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete. The individual conducting the investigation at a minimum: reviews documentation and evidence, reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident, observes the alleged victim, including his or her interactions with staff and other residents, interview persons reporting the incident, interview any witnesses to the incident, interview the residents as medically appropriate or the resident's representative, interview the resident's attending physician as needed to determine the resident's condition, interview staff members on all shifts who have had contact with the resident during the period of the alleged incident, interview the resident's roommate/family member/ and visitors, interview other residents whom the accused employee provides care or services, review all events leading up to the alleged incident, and document the investigation completely and thoroughly.R48's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 8/13/25, indicates R48's hearing is adequate with no difficulty in normal conversations, social interactions, and listening to television, R48's MDS also indicates her speech clarity is clear with distinct intelligible words and her ability to express ideas and wants is understood by others. R48's MDS indicates her ability to understand others or understand verbal content is understands with clear comprehension.R48's Nurse Notes, dated 8/9/25 at 10:09 AM, Resident appeared to be tearful this morning upon arrival to activity room. Resident was well dressed and was cleaned up appropriately for the day, however said to writer, Why would you pinch me and jolt me out of bed? Writer asked resident if she knows that writer was her nurse and that this was their first interaction of the day. Resident responded, Yes, I know you are (named nurse), why would you do that? Resident kept asking writer where her daughter and grandkids were and if they were okay. Writer re-assured resident that her daughter and grandkids were at home safely, and that resident was here for her hip rehabilitation. Writer also re-assured that writer has not seen resident yet until she came into the activity room and offered to help her with her pain medication. Resident calmed down and acknowledged that. Resident was resistant to medication. Writer assisted resident in calling her daughter per resident request and initiated 2 assist personal cares due to resident increased confusion.(It is important to note the allegation by R48 that this nurse or someone pinched her and jolted her out of bed.)R48's Nurse Notes, dated 8/9/2025 at 3:08 PM, includes: Resident's daughter came into unit around 2:20 PM requesting to speak with writer. Writer went in to speak with resident and resident's daughter. Daughter told writer that resident was stating that staff member named [name] got her up this morning and was rough with her. Writer spoke to daughter regarding (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's increased confusion, orientation status of 1, and about the confusion that occurred this morning when resident told writer that writer was the one who jolted her out of bed this morning. Writer explained to daughter that resident had increased pain this morning due to her hip, and that writer had not had a chance to pre-medicate resident before morning get up. Writer explained how increased pain with morning activity may have caused some distress. Daughter was not satisfied with this response and wanted to know specifically which CNA helped with the morning get up. Writer re-assured daughter that the writer's nursing student witnessed the morning get up when resident and CNA were in the bathroom and did witness staff being appropriate and gentle with cares with resident. Daughter was still unsatisfied with this. Writer offered to update the administrator, and care plan with resident to be 2 assist for resident safety. Daughter was agreeable to this. During the entirety of the interaction between daughter and writer, resident continued to insist that [name] was rough with her when prompted by daughter even though resident was reminded about twice in the conversation that there was no [name] on staff.(It is important to note the allegation of a staff member being rough with R48.)On 8/26/25 at 11:25 AM NHA A (Nursing Home Administrator) indicated the expectations of the facility is to report all allegations of abuse immediately within 2 hours or 24 hours. NHA A and Surveyor reviewed R48's Nurse Notes, dated 8/9/25 at 10:09 AM and 3:08 PM. NHA A indicated this could be two allegations of abuse, but R48 was confused. NHA A indicated she did not conduct a thorough investigation regarding the allegations to rule out abuse. NHA A indicated she only interviewed R48, R48's daughter, and RN X (Registered Nurse) and did not interview other staff, students, or residents regarding the incidents alleged. NHA A indicated there is potential for a confused resident to have been abused and the facility takes all allegations seriously. NHA A indicated a confused resident could provide some accurate information along with confused details such as mixing up names of staff members or thinking another resident is a staff member. NHA A indicated RN X was not removed from resident care upon gaining knowledge of the allegation of her pinching and jolting resident out of bed. NHA A indicated two staff with or without a student could abuse a resident and upon voicing the allegations the facility should have followed the abuse policy to ensure resident is protected, supported, and to rule in or out abuse.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not provide the proper discharge documentation for 3 of 4 residents reviewed for discharge (R2, R5, and R73). R2 was transferred to the hospital, and no bed hold notice was provided. R5 was not provided a bed hold. R73 was transferred to the hospital, and no bed hold notice was provided. Evidenced by: The facility policy, Bed-Holds and Returns includes, in part: Policy Statement: Residents and/or representatives are informed (in writing) of the facility and state (if applicable) bed-hold policies. Policy Interpretation and Implementation: All residents/representatives are provided written information regarding the facility and state bed-hold policies, which addresses holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Resident's, regardless of payer source, are provided written notice about these policies at least twice: a. notice 1: well in advance of any transfer (e.g., in the admission packet); and b. notice 2: at the time of transfer (or, if the transfer was an emergency, within 24 hours) . Example 1 R2 was admitted to the facility on [DATE] with diagnoses that include, in part: Chronic Obstructive Pulmonary Disease (A group of lung diseases that block airflow to and from the lungs, making it hard to breathe), and Other spondylosis with radiculopathy, lumbosacral region (A medical diagnosis for degenerative changes in the lower spine that cause nerve compression, leading to symptoms like pain, numbness, or weakness in the lower back and legs. R2's Progress Notes include, in part: 4/4/25 at 8:40 AM.Reports SOB (Shortness of Breath) and chest pain, 911 called.911 transported to [Hospital Name] . Surveyor reviewed R2's electronic medical record and could not find evidence a bed hold was provided to R2 or her representative for the 4/4/25 transfer to the hospital. On 8/26/25 Surveyor requested bed hold information for R2 from the facility. On 8/26/2025 at 2:23 PM, RDM K (Regional Dietary Manager) reported to surveyor that the bed hold for R2 could not be located and that one should have been completed. On 8/26/25 at 11:58 AM Surveyor interviewed NHA A (Nursing Home Administrator) regarding bed holds. During the interview NHA A indicated that the facility has blue packets for any transfers out of the facility and part of that packet includes the bed hold. NHA A indicated the bed hold is given when the resident is leaving. NHA A indicated if the resident is unable to sign it, they have a UDA (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(User-Defined Assessment) that would be completed on what their wishes were for the bed hold and that would be triggered and completed by the nurses. NHA A indicated the nurses are responsible for ensuring the bed hold is completed and then the IDT (Interdisciplinary Team) should be checking to ensure it was completed for anyone transferred out. Surveyor asked NHA A if she would have expected a bed hold to be completed for R2's transfer to the hospital. NHA A indicated she would. Example 2 R5 was admitted to the facility on [DATE] with diagnoses that include: Bell's Palsy (weakness in muscles in one half of the face), cardiomegaly (enlarged heart), encounter for attention to gastrostomy (opening to the stomach from abdominal wall for introduction of food), gastrostomy malfunction, spinal stenosis (spinal narrowing), glaucoma, aphasia (inability to speak), anxiety disorder, mild cognitive impairment, and anemia. R5's most recent Minimum Data Set (MDS) assessment dated [DATE] indicates a Brief Interview of Mental Status (BIMS]) score of 00, indicating R5's cognition is severely impaired. R5 has an activated Power of Attorney. R5 was transferred to the hospital on 6/16/25 after experiencing a change of condition. R5 was discharged from the hospital and returned to the facility on 7/2/25. R5 was also transferred to the hospital on 7/3/25 after experiencing another change of condition and returned to the facility on 7/8/25. Surveyor conducted a review of R5's medical record and could not locate any evidence that R5 or their representative were given the required bed hold notice information in writing at the time of each hospitalization transfer. Surveyor requested bed hold notices for each of the hospitalizations. The facility provided Surveyor one bed hold and storage agreement which was signed by R5's representative and dated 7/14/25. (This is 6 days after R5 was re-admitted to the facility after the second hospitalization). Example 3 R73 admitted to the facility on [DATE] with diagnoses that include cerebral infarction due to occlusion or stenosis of small artery (a stroke caused by the blockage or narrowing of a small blood vessel in the brain) R73's Progress Notes include: *7/6/25 2:23 PM Res was seen having seizure activity.EMS (emergency medical service) arrived, and resident taken out to hospital. On 8/27/25 at 10:32 AM, Surveyor interviewed RN W (Registered Nurse) and asked about information shared with resident/resident representative at time of a transfer to the hospital. RN W stated there is a packet that lists everything that needs to go with the resident to the hospital. RN W stated that in the packet there is a bed hold agreement to review and if the resident is unable to complete the bed hold, family will be contacted. If family is unable to be reached by the floor nurse, the ADON (Assistant Director of Nursing) or the social worker is made aware. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/27/25 at 10:38 AM, Surveyor interviewed ADON N and asked about bed hold notice for R73. ADON N stated there was documentation stating that the Power of Attorney had been notified of hospitalization, but not if there had been discussion of a bed hold. ADON N stated there was no bed hold notice in R73's chart and there should have been. On 8/27/25 at 11:45 AM, Surveyor interviewed IDON B (Interim Director of Nursing) who stated that there should be a bed hold notice for any resident who is transferred out.

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure that a resident who requires dialysis receives such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 1 sampled resident (R1) reviewed for dialysis.The facility failed to provide ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility. The facility staff were not fluent in the emergency plan for a resident bleeding from their dialysis fistula site.This is evidenced by:The facility's policy titled Hemodialysis Catheters - Access and Care Of, dated 2001, with a Revision Date of February 2023, states, in part: . Care of Arterio-venous fistula (AVF)s. 4. To prevent infection and/or clotting: a. Keep the access site clean at all times. d. Check for signs of infection (Warmth, redness, tenderness or edema) at the access site when performing routine care and at regular intervals. g. Check the color and temperature of the fingers, and the radial pulse of the access arm when performing routine care and at regular intervals. H. Check patency of the site at regular intervals. Palpate the site to feel the thrill, or use a stethoscope to hear the whoosh or bruit of blood flow through the access. Care Immediately Following Dialysis Treatment: . 4. If there is major bleeding from site (post-dialysis), apply pressure to insertion site and contact emergency services and dialysis center. Verify that clamps are closed on lumens. This is a medical emergency. Do not leave resident alone until emergency services arrive. According to Clinical Journal of the American Society of Nephrology article titled Diagnosis, Treatment, and Prevention of Hemodialysis Emergencies dated February 2017, .Vascular Access Hemorrhage: Hemorrhage from an AV access is an uncommon but potentially fatal complication if it is not recognized promptly and acted on with an appropriate intervention. Most fatal vascular access hemorrhages occur outside of the dialysis facility, but occasionally, they rupture at the dialysis unit (120). Patients and their families should be educated about the recognition and emergent management of a bleeding AV access . In the event of bleeding from vascular access site, direct continuous pressure with a finger for 15-20 minutes is the most effective method of controlling the bleeding. In the event of rupture of a PSA or aneurysm away from dialysis unit or hospital, direct pressure with a finger at the site of bleeding is the best method of controlling bleeding. Patients should be advised to continue holding direct pressure until emergency medical help arrives and avoid applying a tourniquet, towel, or BP cuff to the extremity . Diagnosis, Treatment, and Prevention of Hemodialysis Emergent .: Clinical Journal of the American Society of NephrologyR1 was admitted to the facility on [DATE] with diagnoses that include, in part: Dependence on Renal Dialysis and End Stage Renal Disease.R1's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/30/25 states that R1 has a Brief Interview of Mental Status (BIMS) score of 15 out of 15, indicating that R1 is cognitively intact.R1's care plan initiated on 6/28/25 with a revision date of 7/9/25, includes goals and interventions for nutritional needs related to comorbidities including end stage renal disease, but does not include a dialysis focus, goal, or any interventions or tasks related to dialysis services, assessment of the vascular access port, monitoring of complications, or steps for staff to take if R1 is bleeding from her dialysis fistula.R1's Physician Orders include, in part: Dialysis Monday, Wednesday, and Friday at [Dialysis Center Name] . Monitor Hemodialysis (HD) catheter site for bleeding. If bleeding noted, apply pressure and call 911, every shift.On 8/20/25 at 11:29 AM, Surveyor interviewed R1 about her dialysis care. R1 stated that she goes out to dialysis three times a week. Surveyor asked R1 how often the facility monitored her access port for bleeding or infection. R1 indicated that she wasn't sure, but that staff were not checking it after every dialysis appointment.On 8/21/25 at 7:53 AM, Surveyor interviewed CNA D (Certified Nursing Assistant) and asked her if she had received any training on caring for residents on dialysis. CNA D stated no, she hadn't. Surveyor asked CNA D what kinds of things she would have to monitor for someone on dialysis. CNA D stated (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	no one had ever told her anything to be monitoring for with R1. Surveyor asked CNA D what she would do if she walked in and saw a resident bleeding from their dialysis fistula. CNA D stated she would call the nurse.On 8/25/25 at 3:58 PM, Surveyor interviewed CNA C (Certified Nursing Assistant) and asked her if she had received any training on caring for a resident on dialysis. CNA C stated she had not received any training specifically on dialysis residents. Surveyor asked CNA C what kinds of things she would have to monitor for someone on dialysis. CNA C stated that she would watch R1's output and what she was eating. Surveyor asked CNA C what she would do if she walked in and saw a resident bleeding from their dialysis fistula. CNA C stated she would go get the nurse, she would run and get her or put R1's assist light on or yell for help.On 8/26/25 at 9:44 AM, Surveyor interviewed CNA E and asked her if she had received any training specifically on dialysis residents. CNA E stated she had not received any training on that. Surveyor asked CNA E what kinds of things she would have to monitor for someone on dialysis. CNA E stated usually the nurse would do that as she was not qualified to do that. Surveyor asked CNA E what she would do if she walked in and saw a resident bleeding from their dialysis fistula. CNA E stated she would tell the nurse.On 8/26/25 at 10:39 AM, Surveyor interviewed LPN F (Licensed Practical Nurse) and asked what kind of care they provide to residents receiving dialysis. LPN F stated that they monitor when R1 goes to dialysis and make sure there is no excessive bleeding when R1 returns from her dialysis appointments. Surveyor asked LPN F if monitoring of R1's dialysis treatments should be on her care plan. LPN F stated yes, dialysis care should be on R1's care plan.On 8/26/25 at 3:18 PM, Surveyor interviewed DON B (Director of Nursing) about R1's dialysis care. Surveyor asked DON B if it was his expectation that staff know how to care for, monitor for complications, and know what to do in the case of a dialysis emergency. DON B answered yes, that was his expectation. Surveyor asked DON B if R1's dialysis care and monitoring should be on her care plan. DON B stated yes, it was his expectation that dialysis care would be on R1's care plan.R1 is receiving dialysis services three times per week. R1's care plan does not indicate how to handle an emergency situation with R1's dialysis port and staff were not able to appropriately verbalize what to monitor for or how to handle an emergency situation.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that it was free of medication error rates of 5% or greater. There were 2 errors in 28 opportunities that affected 2 out of 6 residents (R53 & R16) included in the medication pass task, which resulted in an error rate of 7.14%. R53 received Lasix (Furosemide) 10 mg tablet outside of the medication administration window. R16 received Metoprolol Extended Release (ER) 25 mg tablet that had been crushed. Evidenced by: The facility policy entitled, Administering Medications, dated 2001, states, in part: Policy Statement: Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation: . 4. Medications are administered in accordance with prescriber orders, including any required time frame. 7. Medications are administered withing one (1) hour of their prescribed time, unless otherwise specified. Example 1 R53 was admitted to the facility on [DATE] and has diagnoses that include, in part: Chronic Atrial Fibrillation, unspecified (a common heart rhythm disorder where the upper chambers of the heart irregularly). R53's Physician Orders include, in part: Lasix Oral Tablet (Furosemide). Give 10 mg (milligrams) by mouth one time a day for edema. Start Date: 5/20/25. No end date. R53's Medication Administration Record (MAR) for August 2025 indicates, in part: Lasix Oral Tablet (Furosemide). Give 10 mg (milligrams) by mouth one time a day for edema. Schedule Time: 7:00 AM. Administration time: 8:40 AM. Documented Time: 8:41 AM. On 8/25/25 at 8:40 AM, Surveyor observed LPN F (Licensed Practical Nurse) administer R53's morning medications, including Lasix (Furosemide) 10 mg tablet. On 8/25/25 during medication reconciliation, Surveyor noted that R53's Lasix (Furosemide) was scheduled to be given at 7:00 AM. On 8/25/25 at 1:49 PM, Surveyor interviewed LPN F about R53's morning medication pass. Surveyor asked LPN F when medications are to be given. LPN F stated medications should be given an hour before or after they are scheduled. Surveyor asked LPN F what the administration window would be for a medication that was scheduled for 7:00 AM. LPN F stated that medication should be given between 6:00 AM and 8:00 AM. Surveyor shared with LPN F that R53's MAR indicated that her Lasix (Furosemide) was to be administered at 7:00 AM. LPN F stated that she was going to be calling R53's practitioner and have that changed since it shouldn't be set at a scheduled time. Surveyor asked LPN F if R53 getting her Lasix (Furosemide) outside of the administration window, would that be considered a medication error. LPN F stated that yes, that would be considered a late medication error. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/26/25 at 3:15 PM, Surveyor interviewed DON B (Director of Nursing) about the observation of morning medication pass. Surveyor asked DON B what the window was for administering medications on time. DON B stated that the window was an hour before or after. Surveyor asked DON B what the administration window would be for a medication scheduled at 7:00 AM. DON B indicated that medication should be given between 6:00 AM and 8:00 AM. Surveyor asked DON B if a medication that was scheduled at 7:00 AM and administered at 8:40 AM, would that be considered a medication error. DON B stated that yes, he would consider that to be a late medication. Example 2 The facility policy, Adverse Consequences and Medication Errors, revised in February 2023, states in part, .Medication Errors – 1. A 'medication error' is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. 2. Examples of medications errors include: .h. Failure to follow manufacturer's instructions and/or accepted professional standards (e.g.crushing a medication on the 'do not crush list' without an order). R16 was admitted to the facility on [DATE] with diagnoses that include essential (primary) hypertension (high blood pressure) and nonrheumatic aortic valve disorder (a condition affecting the aortic valve of the heart). R16's Physician Orders, dated 10/30/23, include in part, the following medication: Metoprolol Succinate ER oral tablet extended release 24-hour 25 mg – Give 1 tablet by mouth for HTN (hypertension). Hold if pulse is below 50. On 8/25/25 at 8:34 AM, Surveyor observed RN X (Registered Nurse) prepare to crush eight of R16's medications, one of them being a Metoprolol Succinate ER 25 mg tablet. Surveyor interrupted RN X and asked if an extended-release medication should be crushed. RN X said there is an order for all R16's medications to be crushed and indicated that R16 is on hospice, so it's fine to crush them. RN X proceeded to crush all eight medications, including the Metoprolol Succinate ER tablet, and administer them to R16 with applesauce. It is important to note extended-release medications are not to be crushed. According to drugs.com, Extended-release tablets may be scored or divided; however, do not crush or chew, swallow whole (https://www.drugs.com/tips/metoprolol-succinate-er-patient-tips). Extended-release medications dissolve slowly in the body to ensure a longer therapeutic effect. Metoprolol helps to lower blood pressure and causes the heart to pump slower. If the medication is crushed and absorbed quickly, it could cause a dangerously low blood pressure or slow heart rate. On 8/25/25 at 8:39 AM, Surveyor interviewed DON B (Director of Nursing) and asked if R16's Metoprolol Succinate ER tablet should have been crushed. DON B stated it depends on how it's absorbed - if it's sprinkles in a capsule or a solid pill. He indicated he would have to look at the medication to see. Surveyor asked RN X to look at the medication. The Metoprolol Succinate ER tablet was solid. Surveyor noted the banner on R16's chart stated that she takes her medications crushed, but there was no specific order to crush the Metoprolol Succinate ER tablet. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON B printed R16's Medication Administration Record (MAR) on 8/25/25 at 11:38 AM. Surveyor reviewed the MAR and noted that R16's Metoprolol Succinate ER tablet had been discontinued by the provider on 8/25/25 at 10:55 AM and replaced with Metoprolol Tartrate 25 MG – 0.5 tablet two times a day (note: this is not an extended-release medication).

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure residents are free of significant medication errors, for 1 of 6 residents reviewed in the medication administration task (R16).R16 received a Metoprolol Succinate Extended Release (ER) 25 mg tablet (a medication used to treat high blood pressure and chest pain) that had been crushed.This is evidenced by:The facility policy, Adverse Consequences and Medication Errors, revised in February 2023, states in part, .Medication Errors - 1. A ?medication error' is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. 2. Examples of medications errors include: .h. Failure to follow manufacturer's instructions and/or accepted professional standards (e.g.crushing a medication on the ?do not crush list' without an order).R16 was admitted to the facility on [DATE] with diagnoses that include essential (primary) hypertension (high blood pressure) and nonrheumatic aortic valve disorder (a condition affecting the aortic valve of the heart). R16's Physician Orders, dated 10/30/23, include in part, the following medication:Metoprolol Succinate ER oral tablet extended release 24-hour 25 mg - Give 1 tablet by mouth for HTN (hypertension). Hold if pulse is below 50.On 8/25/25 at 8:34 AM, Surveyor observed RN X (Registered Nurse) prepare to crush eight of R16's medications, one of them being a Metoprolol Succinate ER 25 mg tablet. Surveyor interrupted RN X and asked if an extended-release medication should be crushed. RN X said there is an order for all R16's medications to be crushed and indicated that R16 is on hospice, so it's fine to crush them. RN X proceeded to crush all eight medications, including the Metoprolol Succinate ER tablet, and administer them to R16 with applesauce.It is important to note extended-release medications are not to be crushed. According to drugs.com, Extended-release tablets may be scored or divided; however, do not crush or chew, swallow whole (https://www.drugs.com/tips/metoprolol-succinate-er-patient-tips). Extended-release medications dissolve slowly in the body to ensure a longer therapeutic effect. Metoprolol helps to lower blood pressure and causes the heart to pump slower. If the medication is crushed and absorbed quickly, it could cause a dangerously low blood pressure or slow heart rate.On 8/25/25 at 8:39 AM, Surveyor interviewed DON B (Director of Nursing) and asked if R16's Metoprolol Succinate ER tablet should have been crushed. DON B stated it depends on how it's absorbed - if it's sprinkles in a capsule or a solid pill. He indicated he would have to look at the medication to see. Surveyor asked RN X to look at the medication. The Metoprolol Succinate ER tablet was solid. Surveyor noted the banner on R16's chart advised that she takes her medications crushed, but there was no specific order to crush the Metoprolol Succinate ER tablet.DON B printed R16's Medication Administration Record (MAR) on 8/25/25 at 11:38 AM. Surveyor reviewed the MAR and noted that R16's Metoprolol Succinate ER tablet had been discontinued by the provider on 8/25/25 at 10:55 AM and replaced with Metoprolol Tartrate 25 MG - 0.5 tablet two times a day (note: this is not an extended-release medication).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility did not ensure drugs and biologicals are stored in accordance with currently accepted professional standards for 1 of 2 medication rooms reviewed for medication storage. The medication room on the first floor contained an expired single-dose COVID vaccine and 4 urinary catheter kits that were expired. This is evidenced by: Facility policy entitled, Medication Labeling and Storage with a revision date of February 2023 states, in part. Medication Storage.3. If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. On [DATE] at 10:36 AM, Surveyor conducted medication storage observation of the medication room on the first floor with RN P (Registered Nurse). Surveyor found a Spikevax single-dose COVID vaccine in the medication room refrigerator with an expiration date of [DATE] and 4 urinary catheter insertion tray kits in the cupboard with expiration dates of [DATE]. Surveyor asked RN P to read the expiration dates on the packages, RN P indicated they were all expired and removed them. On [DATE] at 11:12 AM, Surveyor interviewed DON B (Director of Nursing) regarding medication storage and expiration dates. DON B indicated medication in storage should not be expired and expired medication should not be given.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on observation, interview, and record review, the facility did not ensure snacks were offered at bedtime daily when there is more than 14 hours between the evening meal and breakfast for 1 resident (R3) of total census of 68 reviewed for snacks.R3 voiced concerns of snacks not being offered at bedtime.The facility is not offering all residents nourishing snacks at bedtime when their supper meal and breakfast meal are more than 14 hours apart.Evidenced by:Facility policy, titled Frequency of Meals, dated 2001, states, in part: . Policy Interpretation and Implementation: 1. The facility will serve at least three (3) meals or their equivalent daily at scheduled times. There will not be more than a fourteen (14) hour span between the evening meal and breakfast. 5. Nourishing snacks will be available for the residents who need or desire additional food between meals. 6. Evening snacks will be offered routinely to all residents. 7. Residents will also be offered nourishing snacks if the time span between the evening meal and the next day's breakfast exceeds fourteen (14) hours.Facility's posted mealtimes for first floor dining room are as follows:Breakfast 7:40 AMLunch 12:15 PMSupper 5:50 PMOn 8/20/25 at 11:48 AM, Surveyor interviewed R3 who stated that they don't get served breakfast until 9:00 AM most days and that breakfast is often late. Surveyor asked R3 if they receive a nighttime snack. R3 stated they are not offered a nighttime snack, and if they want one, they can ask but it would only be Jello, pudding, or saltine crackers.On 8/25/25 at 4:06 PM, Surveyor observed the snack cart near the elevator on the first-floor skilled nursing unit. Surveyor observed Jello, cookies, saltine crackers, and pudding on the cart.On 8/26/25 at 7:51 AM, CNA D (Certified Nursing Assistant) stated that this section of the hallway does not receive breakfast trays until around 8:30 AM. Surveyor asked CNA D if residents are offered a nighttime snack. CNA D indicated staff do not offer all residents a snack at bedtime, but they have snacks available if a resident should ask.On 8/26/25 at 8:33 AM, Surveyor asked R3 when she received dinner the previous evening. R3 stated she received her dinner tray around 5:45 PM.On 8/26/25 at 8:35 AM, Surveyor observed R3's breakfast tray being delivered to her room.On 8/26/25 at 12:15 PM, Surveyor asked LPN F (Licensed Practical Nurse) if residents are offered a nighttime snack. LPN F indicated she doesn't normally work at bedtime, but that the snack cart was always available to residents who wished to have a snack.On 8/26/25 at 12:19 PM, Surveyor asked CNA E if residents are offered a nighttime snack. CNA E indicated that staff do not always offer every resident a snack, but they do have them available if they ask.On 8/26/25 at 2:28 PM, Surveyor observed the snack cart near the elevator on the first-floor skilled nursing unit. Surveyor observed Jello, oatmeal bars, saltine crackers, and pudding on the cart.On 8/26/25 at 2:47 PM, Surveyor interviewed AFSD I (Assistant Food Service Director) and asked about the snacks that were offered to residents. AFSD I stated that they keep a cart on each floor by the elevators that are re-stocked daily. AFSD I stated that the snacks offered included pudding, Jello, granola bars, cookies, veggie crisps, crackers, shortbread cookies and sugar-free snacks. Surveyor asked AFSD I if snacks were being offered to the residents at bedtime. AFSD I stated that they would be offered to the diabetic residents but he didn't know about the other residents. Surveyor asked AFSD I when breakfast trays were normally delivered to the skilled nursing unit. AFSD I stated that breakfast would be delivered to the dining room at 7:45 AM and they hall trays would be delivered within 10 minutes later. Surveyor shared with AFSD I the observation of R3's breakfast tray being delivered at 8:35 AM this morning. Surveyor asked AFSD I if he knew how long the time frame should be for the residents between dinner and breakfast. AFSD I stated he didn't remember off the top of his head but that they try to push dinner out as late as possible so they are within that window. Surveyor asked AFSD I if there was greater than 14 hours between dinner and breakfast, should residents be offered a nutritious snack. AFSD I indicated that yes, residents should be offered a snack in that instance.R3 went nearly 15 hours between dinner and breakfast without being offered a snack.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure the resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza and/or pneumococcal immunization; and (B) That the resident either received the influenza and/or pneumococcal immunization or did not receive the influenza and/or pneumococcal immunization due to medical contraindications or refusal. This affected 1 of 5 residents (R33) reviewed for immunizations.R33 signed a consent form to receive the 2024-2025 influenza vaccine but never received it.This is evidenced by:The facility policy entitled Influenza Vaccine, with a revision date of March 2022, states in part: Policy Statement: All residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccines against influenza.Policy Interpretations and Implementation:1. Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents and employees, unless the vaccine is medically contraindicated or the resident or employee has already been immunized.Example 1R33 was admitted to the facility on [DATE].R33 had documentation for an influenza vaccine administered on 2/9/24.R33 signed a vaccine consent and administration record form on 10/21/24 indicating that she received education about the influenza vaccine and would like to receive it for the 2024/2025 season.R33 did not have an influenza vaccine listed in her Electronic Health Record (EHR) for the 2024/2025 influenza season.On 8/26/25 at 11:34 PM, Surveyors interviewed DON B (Director of Nursing) and ADON N (Assistant Director of Nursing) regarding facility immunizations. ADON N indicated R33 should have received her influenza vaccine and would look for documentation.On 8/26/25 at 4:48 PM, DON B indicated he could not find documentation that R33 had received the influenza vaccine for the 2024-2025 season. DON B also confirmed that he did not see it listed on the Wisconsin Immunization Registry.