STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525271	A. Building B. Wing	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Estates of Countryside, Inc	1130 Collins Road Jefferson, WI 53549

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 3.) R64 was admitted to the facility on [DATE], with diagnoses including Anxiety Disorder, Chronic Kidney Disease, encounter for fitting and adjustment of Urinary Device. R64's comprehensive Minimum Data Set (MDS), dated [DATE], indicates a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. R64 has an indwelling catheter and no trial of a toileting program. R64's Care Plan, date initiated 5/13/25, documents, a focus area of Bowel and Bladder support is required. The goal is R64 will maintain current of bowel incontinence and R64 will show no complications secondary to catheter use. Interventions document, in part, .Keep drainage bag covered to promote privacy. R64's Physician orders, dated 5/12/25, documents, CATHETER: INDWELLING URINARY CATHETER CARE DAILY AND PRN (as needed) every night shift related to ENCOUNTER FOR FITTING AND ADJUSTMENT OF URINARY DEVICE AND as needed related to ENCOUNTER FOR FITTING AND ADJUSTMENT OF URINARY DEVICE (sic). On 06/09/25 at 10:15 AM, Surveyor observed R64 in her room, resting in her recliner, with the door open. R64 has an indwelling catheter, and the catheter bag attached to walker did not have a privacy cover. R64's catheter bag could be seen from the hallway. On 06/10/25 at 12:37 PM, Surveyor observed R64 in her room, resting in her recliner, with the door open. R64's catheter bag was attached to walker and did not have a privacy cover. R64's catheter bag could be seen from the hallway. On 06/11/25 at 08:01 AM, Surveyor observed R64 eating breakfast in the dining room with other residents. R64's catheter bag was attached to her wheelchair and did not have a privacy cover. On 06/11/25 at 08:07 AM, Surveyor interviewed Registered Nurse (RN)-FF, asking what is the practice for privacy covers. RN-FF stated that drainage bags should always be covered with a blue privacy covering. Surveyor stated that R64 does not have a privacy cover on her catheter drainage bag and RN-FF stated, she should. RN-FF immediately notified Certified Nursing Assistant (CNA)-QQ and CNA-QQ wheeled R64 back to R64's room and placed a privacy cover on R64's catheter drainage bag. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/11/25 at 08:11 AM, Surveyor interviewed R64 and asked R64 about the cover on the catheter bag. R64 stated, if she goes out of out or if she goes to therapy or other places in facility. R64 stated her drainage bag it is not always covered wherever she goes in the building but sometimes it is. On 06/12/25 at 03:09 PM, Surveyor notified Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B of concern regarding R64's dignity due to no privacy cover on R64's catheter drainage bag, observed on three different occasions. Based on observation and interviews, the facility did not ensure each Resident is treated with dignity and respect that promoted maintenance or enhancement of quality of life. This occurred for 3 (R95, R94, R64) of 23 Residents reviewed for dignity. *R95 was observed by Surveyor to be fed by staff while standing over resident. R95 was observed in dining area sleeping face down in lap with food noted all around R95's bowl on the table while seated with other diners, in dining room. *Surveyor observed staff call across dining room referring to R94 as a feeder. Surveyor observed R94 alone at a table with R94's food still sitting in front of R94. *R65 was observed by Surveyor with catheter bag exposed without privacy cover for 3 days. Finding include: Facility Policy titled; Dignity dated 06/23. A. Policy: The facility will promote care for residents in a manner that promotes and enhances their sense of well-being, level of satisfaction with life, and feelings of self-worth and esteem. B. Procedure: 1. Residents should be treated with dignity and respect. 2. The facility's culture supports dignity and respect by honoring resident goals, choices, preferences, values and beliefs. 3. Individual needs and preferences are assessed upon admission and quarterly thereafter on the activity assessment. 4. Residents may exercise their rights without interference or coercion, discrimination or reprisal from any person or entity associated with the facility. 5. When assisting with care, residents are supported in exercising their rights. 6. Residents' private space and property should be respected, unless there is a reasonable suspicion to believe there is property that may pose a risk of harm to the resident or others in the facility. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. Residents' rights to personal privacy will be respected. 8. Residents will be dressed in a manner that preserves dignity, which includes wearing garments that are not over revealing. 1.) R95 was initially admitted to the facility on [DATE] with diagnoses (dx) that included Unspecified Dementia (a decline in mental ability severe enough to interfere with daily life, affecting memory, thinking, language, and judgment), Vitamin D deficiency (nutritional deficiency of vitamin D), and Deficiency of other specified group B vitamins (nutritional deficiency of B vitamins). R95's Quarterly Minimum Daily Set (MDS) with an assessment reference date of 3/13/25 documents Under Section C cognitive patterns a Brief Interview for Mental Status score of 6 indicating R95 having severe cognitive impairment. Under section GG Functional abilities and goals documents R95 as being independent with eating. R95's GG (functional abilities and goals) screener dated 6/10/25 documents that R95's eating ability as resident completes activity. Assistance may be provided throughout the activity or intermittently. R95's hearing loss care plan documents: R95 is noted to have hearing loss in the right ear. Date Initiated: 03/05/2025. R95's intervention section documents: Face R95 when speaking. Date Initiated: 03/05/2025. R95's impaired cognition care plan documents R95 has Impaired cognition due to dx of dementia. Date Initiated: 11/30/2024. R95's intervention section documents: When speaking to resident, establish and maintain eye contact, reduce environmental distractions, and use resident's preferred name to maintain attention. Date Initiated: 12/03/2024. On 06/10/25, at 08:28 AM, Surveyor observed R95 sitting bent way over with their head in R95's lap sleeping at a table during the breakfast meal. Surveyor observed other diners around R95 including residents seated at R95's table. Surveyor observed R95's cereal all over table surrounding R95's cereal bowl. Surveyor observed there were no staff by R95's table helping R95. Surveyor observed R95 had no adaptive spoons or 2 handled cups to assist in R95's meal as recommended by occupational therapy on 5/30/25. On 06/10/25, at 0829 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-I about R95's current condition. Surveyor asked LPN-I if R95 needed help in the dining room. LPN-I informed Surveyor that R95 is not speaking much today and that the family is looking at hospice for R95. LPN-I informed Surveyor that R95 has declined in abilities recently. Surveyor asked LPN-I if R95 needed help eating. LPN-I informed Surveyor it depends on R95's cognitive abilities for the day, but often R95 will feed herself with set up. LPN-I informed Surveyor that R95 is weaker today. On 06/10/25, at 12:20 PM, Surveyor observed lunch on the 400 unit. Surveyor observed Certified Nursing Assistant (CNA)-N initially helping R95 eat and drink. Surveyor observed CNA-N was standing over R95 while helping R95 eat the meal. Surveyor observed that CNA-N the only one helping in the dining area. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/11/25, at 09:09 AM, Surveyor interviewed Resident Care Coordinator (RCC)-E about what education the staff receive on dignity and assisting the residents with eating. Surveyor asked RCC-E if RCC-E did the education for the certified nursing assistants (CNA). RCC-E informed Surveyor the RCC-E did the education for the CNA's and other staff. Surveyor asked if it was appropriate for staff to stand over residents while they are assisting to feed them or should staff sit next to them at eye level. RCC-E informed Surveyor the staff need to be at eye level and sit by them to maintain dignity. Surveyor asked RCC-E who does the training on feeding assistance for residents. RCC-E informed Surveyor that RCC-E does the training for staff regarding feeding assistance and that staff are taught by RCC-E to sit at Resident level. RCC-E clarified to Surveyor definitely at the eye level of the resident. RCC-E informed Surveyor that is what RCC-E teaches. On 06/11/25, at 11:26 AM, Surveyor interviewed R95. Surveyor attempted to question R95 about R95 needing assistance eating. R95 became teary and informed Surveyor I am okay. R95 provided Surveyor no other information. On 06/11/25, at 03:20 PM, Surveyor informed NHA-A, DON-B, of Surveyors concerns with dignity issues of staff standing over a resident while assisting in feeding, leaving food in front of resident who is unable to feed themselves. Surveyor informed NHA-A during an interview, RCC-C informed Surveyor that this was appropriate resident treatment. NHA-A informed Surveyor the NHA-A agreed it was not appropriate resident treatment. 2.) R94 was initially admitted to the facility on [DATE] with diagnosis that included Cerebral Infarction (a condition where blood flow to the brain is blocked causing brain tissue damage), Aphasia (a language disorder from damage to areas of the brain), Dysphagia oropharyngeal phase (difficulty swallowing that occurs in the mouth or throat). R94's Quarterly Minimum Daily Set (MDS) with an assessment reference date of 4/25/25 documents Under Section C cognitive patterns a Brief Interview for Mental Status score of unable to complete assessment rarely or never understood indicating R94 has severe cognitive impairment. Under section GG Functional abilities and goals documents R94 as being completely dependent on staff with eating (Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident). R94's restorative eating care plan documents R94 is in a program secondary to requiring assistance to eat meals. Difficulty focusing on task. Date Initiated: 04/11/25. R94's intervention section documents: Position resident at the dining room table. Provide napkin or other clothing protection per resident reference. Date Initiated: 04/11/2025. Prompt and cue resident to remain seated throughout the meal. Date Initiated: 04/11/2025. Prompt and encourage resident to maintain intake. Date Initiated: 04/11/2025. R94's activities of daily living (ADL) care plan documents that R94 has an ADL Functional Performance Deficit r/t (related to) cerebral infarction, expressive and receptive aphasia, poor (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cognition, weakness, is unable to follow direction of staff, and is in need of extensive assist with cares. Res has dentures however does not utilize and Family is in agreement that this is fine, collaboration with Hospice to ensure that resident is comfortable, and Hospice CNAs visits occur as well. Uses Broda chair for comfort Date Initiated: 10/22/2024. R94's intervention section documents: Assist/prompt resident to bring cup to mouth for drinking during meals. Date Initiated: 11/04/2024. Assist/prompt resident to bring food to mouth during meals. Date Initiated: 11/04/2024 On 06/10/25, at 12:38 PM, Surveyor observed during the lunch meal Licensed Practical Nurse (LPN)-M calling across the room to Certified Nursing Assistant (CNA)-P asking if there were any feeders the staff still needed help with. Surveyor observed CNA-P reply to LPN-M she's a feeder over here pointing to R94. LPN-M walked over to table and sat down by R94. On 06/10/25, at 12:58 PM, Surveyor returned to dining room and observed R94 sitting at the table alone with R94's food set out in front of R94. Surveyor asked CNA-Q if R94 was supposed to be alone at a table with food in front of R94. CNA-Q informed Surveyor R94 is a total assist with feeding and dependent on staff to eat. CNA-Q informed Surveyor CNA-Q did not know why the food is placed it in front of R94 and why R94 was left alone. CNA-Q stated R94 sitting alone with food was not appropriate because R94 cannot feed herself and R94 needs supervision and assistance at meals. Surveyor observed CNA-Q sit down to finish assisting R94 to eat the lunch meal. Surveyor observed that R94 continued to eat R94's meal with CNA-Q's help. On 6/16/25, at 11:55 AM, Surveyor observed R94 at the dining table with a family member waiting for lunch. On 06/11/25, at 09:09 AM, Surveyor interviewed Resident Care Coordinator (RCC)-E about what education the staff receive on dignity and assisting the residents with eating. Surveyor asked RCC-E if it was appropriate that staff should call across the room and ask if there are feeders over there. RCC-E informed Surveyor it is not appropriate to call residents who need assistance to be fed by staff as feeders. RCC-E asked Surveyor what staff did that and that RCC-E would talk to them because that was inappropriate for staff to refer to residents in that manner. RCC-E informed Surveyor that is not what we teach the staff, we teach them to maintain dignity and respect. On 06/11/25, at 03:20 PM, Surveyor informed NHA-A and DON-B, of staff leaving food in front of resident who is unable to feed themselves, calling residents feeders across the dining room.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure residents were free from abuse affecting 2 (R67 and R513) of 3 residents reviewed for abuse concerns. R513 had behaviors of agitation, wandering, and physical behaviors toward others. On 4/5/2025, R513 entered R67's room and was hitting and kicking R67 after R67 had fallen to the ground. Supervision of R513 was not increased with the heightening of behaviors to prevent abuse to R67. Findings include: The facility policy and procedure titled Abuse Policy dated 9/2020 documents: POLICY: . This facility is committed to protecting our residents from abuse by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, and staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals. ABUSE PREVENTION PROGRAM . 3. Prevention: The facility desires to prevent abuse, neglect and theft by establishing a resident sensitive and resident secure environment. d. As part of the social service assessment, staff will identify residents with increased vulnerability for abuse or who have needs and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals and approaches which would reduce the chances of mistreatment for these residents. Staff will continue to monitor the goals and approaches on a regular basis. R67 was admitted to the facility on [DATE] with diagnoses of congestive heart failure, adjustment disorder with mixed anxiety and depressed mood, atrial fibrillation, hypertension, and mitral valve insufficiency. R67's Annual Minimum Data Set (MDS) assessment dated [DATE] documented R67 had moderate cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 10 with no behaviors. R67's Activities of Daily Living Care Plan initiated on 3/4/2024 documented R67 was independent with ambulation and R67's At Risk for Falls Care Plan initiated on 3/4/2024 documented R67 was at risk for falls due to weakness and a history of falls. R67 had an activated Power of Attorney (POA). R67's At Risk for Abuse Care Plan was initiated on 3/12/2024 due to R67's incapacitated status, impaired cognition, and mental health diagnosis of adjustment disorder with depressed and anxious mood with the following interventions: -At onset of behavior, calmly and firmly attempt to redirect to socially acceptable behaviors. -Check and assure physical comfort. -Compliment (R67) for appropriate social interactions. -Consider past patterns, personal and medical/psych history, interests, family/friends accounts to past incidents. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Consider possible antecedents: fear, fatigue, loss of control over a situation. -Determine preferred setting and approach and then offer health care accordingly. -Encourage (R67) to participate in activities. -Encourage/reassure/redirect/repeat as needed. -Investigate accusation. -Maintain a calm soothing approach/environment and smile/pay compliments to promote feelings of belonging and importance with (R67). -Monitor and report signs/symptoms of abuse. -Remind other to try to let comments/loud repetitive noises go in one ear and out the other, to ignore, to move away from. -Respond with reassurance; do not argue. -Simplify tasks, reduce stimulation, give more time or space if showing signs of feeling too challenged. R513 was admitted to the facility on [DATE] with diagnoses of Alzheimer's disease, severe dementia with other behavioral disturbance, major depressive disorder, anxiety disorder, and cognitive communication deficit. R513's Annual MDS assessment dated [DATE] documented R513 was severely cognitively impaired with a BIMS score of 3 and had the following behaviors during the 7-day lookback period: delusions, physical behaviors toward others daily, verbal behaviors toward others 1-3 days, rejection of care 4-6 days, and wandering daily. R513's Cognitive Loss/Dementia Care Area Assessment (CAA) and Behavioral Symptoms CAA documented R513 has diagnoses of Alzheimer's Disease and Dementia with behavioral disturbance. R513 has mental health diagnoses as well that could contribute to behaviors. A care plan would be developed to address cognition and behaviors. R513 had an activated POA. R513's Psychotropic Medication Care Plan was initiated on 7/10/2021 for the use of the antipsychotic quetiapine and antidepressant duloxetine with the following pertinent interventions in place on 4/5/2025: -Attempt dosage reduction gradually as able. -Delusions interventions: 1. Redirection. 2. One-on-one interaction. 3. Encouragement from staff. -Hallucinations interventions: 1. Redirection. 2. One-on-one interaction. 3. Encouragement from staff. 4. Reality orientation to things in the present and in the environment. -Physically resistive to care interventions: 1. Redirect. 2. Reapproach. 3. Anticipate needs. 4. Two staff to provide cares as able. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R513's At Risk for Abuse Care Plan was initiated on 7/12/2021 due to R513's major depressive disorder and dementia as well as behaviors with the following interventions in place on 4/5/2025: -At onset of behavior, calmly and firmly attempt to redirect to socially acceptable behaviors. -Check and assure physical comfort. -Compliment (R513) for appropriate social interactions. -Consider past patterns, personal and medical/psych history, interests, family/friends accounts to past incidents. -Consider possible antecedents: fear, fatigue, loss of control over a situation. -Determine preferred setting and approach and then offer health care accordingly. -Encourage (R513) to participate in activities. -Encourage/reassure/redirect/repeat as needed. -Investigate accusation. -Maintain a calm soothing approach/environment and smile/pay compliments to promote feelings of belonging and importance with (R513). -Monitor and report signs/symptoms of abuse. -Regularly assess (R513) for possible thoughts of self-harm. -Remind other to try to let comments/loud repetitive noises go in one ear and out the other, to ignore, to move away from. -Respond with reassurance; do not argue. -Simplify tasks, reduce stimulation, give more time or space if showing signs of feeling too challenged. Surveyor noted R513's At Risk for Abuse Care Plan interventions were the same as R67's interventions and not personalized to the individual. R513's At Risk for Elopement Care Plan was initiated on 4/1/2024 due to exit-seeking and wandering behavior with the interventions: -Check and assure physical comfort. -Consider past patterns, personal and medical/psych history, interests, family/friends accounts to past incidents. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Consider potential variables: boredom, thirst, hunger, need for toileting, pain, exercise, companionship, exhaustion and over stimulation. -Determine preferred setting. -Encourage/reassure/redirect/repeat as needed. -For wandering: 1. Redirection. 2. Check and ensure (R513) safety. 3. Calmly and positively guide (R513) back to (R513's) room/unit or towards whichever activity (R513) may be currently attending. 4. Assess (R513's) mood and address any mood related issues that may be occurring. 5. Provided one-on-one interaction with encouraging, uplifting comments. -If (R513) shows agitation regarding the Wanderguard, remind (R513) it is in place for safety due to night terror and sleepwalking. -May initiate frequent checks and supervision. -Monitor behaviors. -Offer alternative activities of daily living that may be engaging. -Utilize Wanderguard as appropriate. -Wanderguard on wheelchair for exit seeking behaviors; check for placement and function as required. Surveyor noted R513 did not have a care plan to address the aggressive behaviors exhibited by R513 towards staff and potentially other residents. On 3/29/2025 at 2:06 PM in R513's progress notes, a Registered Nurse (RN) documented R513 opened a fire door and was redirected immediately back into the facility. Management and R513's POA was notified. On 3/30/2025 at 7:58 PM in R513's progress notes, a Licensed Practical Nurse (LPN) documented R513 was agitated throughout the shift. R513 went to the front desk often stating R513 was waiting for a cab and leaving, many times trying to go outside. When the LPN was called, the LPN offered to take R513 outside. R513 would refuse, get upset, and raise voice at the LPN. The LPN called R513's POA after three separate incidences and the POA told the LPN to sit in a chair in R513's way and wait for R513 to get tired. On the fourth attempt at R513 trying to leave, the LPN sat next to R513 in a chair and R513 immediately hit the LPN, began to kick the LPN, and attempted to push the chair over that the LPN was sitting in. R513 was very agitated that the LPN would not leave R513 alone and get R513 a cab to go home. The LPN attempted to reorient R513 without success, informing R513 that it was Sunday and that the cabs stop running at 7:00 PM and it was now 7:45 PM. Eventually R513 got tired and went back to the room with another nurse. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/3/2025 at 10:16 PM in R513's progress notes, an LPN documented R513 was increasingly combative with staff while wandering. Management was notified and was advised to call the on-call physician. An order for Trazadone 50 mg to be given one time was received. Trazadone is an antidepressant used to treat depression and anxiety. R513 refused the medication and was currently calm and sleeping. On 4/5/2025 at 5:17 PM in R513's progress notes, RN-KK documented R513 was behavioral at that time. Attempts were made to call R513's POA and R513's son but was unsuccessful. An order was received to give R513 the scheduled dose of Seroquel 50 mg, an antipsychotic, at that time instead of in the evening as ordered. On 4/5/2025 at 5:40 PM in R513's progress notes, the on-call physician documented R513 was agitated and trying to elope out of the facility. R513 was trying to bite other residents and refusing to take medications. The physician documented the restlessness and agitation were worsening due to progressive dementia and ordered the Seroquel to be given early. On 4/5/2025 at 9:42 PM in R513's progress notes, the on-call physician documented per the facility nurse, R513 went into another resident's room, hit the resident on the back of the left shoulder and kicked the other resident. Per the nurse, the other resident (R67) does not have any injuries, and the resident denies being hit or kicked by R513. R513's POA was with R513 at that time and R513 is more calm. On 4/5/2025 at 10:35 PM in R513's progress notes, RN-KK documented R513 was very combative throughout the shift this afternoon/evening. R513 would not be redirected by staff despite many attempts to do so. R513 wheeled about the facility, going onto every unit. R513 would kick, hit, and even pull staff members' hair when they attempted to take R513 back to R513's unit. R513 also made several unsuccessful attempts to leave the facility. R513 required continuous monitoring from staff. Several attempts had been made by RN-KK to contact R513's POA to come to the facility to be with R513. R513's POA would come to the facility whenever asked. R513's POA was not answering the phone. Finally, R513's POA answered the phone and arrived at the facility at 8:00 PM and stayed with R513 until R513 went to sleep. On 4/5/2025 at 10:38 PM in R67's progress notes, the on-call physician documented R67 lost their balance while attempting to get another resident to leave R67's room. Per the nurse, R67 got up independently and was sitting on the bed when staff arrived. R67 sustained a skin tear to the left shin. Per the nurse, another resident came into R67's room and hit R67 on the back of the left shoulder and kicked R67. R67 did not recall where R67 was kicked. No signs of injury were found post altercation. On 4/6/2025 at 3:18 PM in R67's progress notes, an LPN documented R67 was telling staff that a resident came into R67's room and was kicking R67. R67 stated three staff members came in when R67 yelled for help and took the other resident out of R67's room. R67 stated R67 was fine and was talking with peers and laughing. On 4/7/2025 at 11:01 AM in R67's progress notes, RN-Y documented the interdisciplinary team (IDT) met to review R67's incident on 4/5/2025. The root cause of R67's fall was most likely R67 stood up and lost balance and fell. R67 was startled as another resident entered R67's room. The immediate intervention was to ensure R67 was safe and remove the other resident from R67's room. R67's care plan was updated. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R67's Impaired Cognitive Functioning Care Plan was revised on 4/7/2025 with the intervention to remind R67 that R67 is safe when feeling anxious or scared. Surveyor noted the IDT met and the care plan was updated two days after the incident. R513 continued to have agitation, elopement attempts, and physical behaviors until R513 was transferred to a memory care facility on 5/12/2025. R513's care plan was not revised with any interventions after the physical altercation with R67. Supervision was not increased to protect other residents from R513. The facility reported the incident to the State Agency. The facility investigation of the event included a recap of the incident and interviews with staff members that were working in the facility on 4/5/2025. Nursing Home Administrator (NHA)-A wrote the recap of the event: R513 wandered into R67's room and when R67 stood up to redirect R513, R67 lost their balance and fell. While R67 was on the ground, R513 wheeled over and began hitting and kicking at R67. The residents were immediately separated and R67 was assessed for the fall and incident. R513 was supervised until R513's POA was able to come and sit with R513 to assist with calming R513 down. After some time, R513 did settle down and went to sleep. The staff statements showed R513 had been agitated all day with wandering into other resident rooms. -CNA-LL's statement indicated after 6:00 PM, a family member of a resident on the 300 unit told CNA-LL there was someone in the resident's room. CNA-LL went in and attempted to redirect R513 out of the room. CNA-LL touched R513's shoulder and R513 immediately tried to scratch CNA-LL. CNA-LL called for the nurse to assist. The nurse came and grabbed the back of the wheelchair while CNA-LL moved things out of the way so R513 could not throw anything. Together they removed R513 from the unit and called the 600 unit to come and retrieve R513. At about 7:30 PM or 8:00 PM, CNA-LL was in the hallway about to put someone in bed when CNA-LL heard R67 yell out for help. R513 was in R67's room at the foot of R67's bed. CNA-LL asked R513 to leave and R513 started to kick at CNA-LL. R513 followed CNA-LL to the doorway where CNA-LL was able to grab the front of the wheelchair to pull R513 out of the room. CNA-LL shut the door behind R513 and R513 followed CNA-LL towards the kitchen. CNA-LL attempted to make a phone call to the 600 unit. When CNA-LL turned to see if R513 was behind CNA-LL, R513 was not there. CNA-LL ran to R67's room and found R67 on the floor with the feet by the closet and the face facing the bed. R513 was in front of R67 attempting to kick R67. CNA-LL could not see if R513 kicked R67. CNA-LL grabbed R513's chair and again got R513 out of R67's room. CNA-LL ran and grabbed the nurse and DON-B. They helped get R513 off the unit and contacted the 600 unit to get R513. -An LPN statement indicated R513 was wandering the facility and entered the 300 unit and into another resident's room. The LPN had to assist a Certified Nursing Assistant (CNA) to get R513 out of that room and was brought to the community wing area. While continuously trying to redirect R513, R513 was hitting, kicking, grabbing, and pulling at the nurses and CNAs. R513 wandered into the conference room and the LPN returned to the unit. The CNA from the 600 unit was with R513 and requested assistance as R513 was throwing trash, the trash can and pulling cords. R513 wandered to the outside of the 400 unit. The LPN contacted the charge nurse and the 600 unit nurse to come help redirect R513. There were four staff attempting redirection. R513 was kicking and swinging arms and grabbed the 600 unit CNA's ponytail. After the situation deescalated, the LPN returned to their unit. Later in the shift around 7:30 PM, R513 was again wandering the facility and ended up entering the 300 unit with staff at 7:40 PM unsuccessfully redirecting R513. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A CNA statement indicated R513 was seen on the 200 unit around 4:00 PM entering resident rooms. Staff redirected R513 into the dining room where R513 attempted to open the patio door. Staff tried to redirect but R513 was able to open the door and set off the alarm. The 600 unit staff was called to come and get R513. Later in the shift the 600 staff came over to the 200 unit to ask if they had seen R513. The 200 unit staff had not seen R513 and asked if they should call a code for a missing resident. R513 was found with no code needing to be initiated. -A CNA statement indicated the CNA had worked a 16-hour shift and during about 14 of those hours, R513 attempted to bite the CNA as well as other CNAs. The CNA witnessed R513 display high aggression at other CNAs. R513 ran over the CNA with the wheelchair, kicked several times, punched, scratched, had hair pulled, and was grabbed in the groin area. R513 was also destructive to the facility property. R513 was found in other resident rooms often. R513 tried to get outside and would check every door handle to see if they were unlocked as R513 went down the hallway. -A CNA statement indicated a resident on the 400 unit called at 3:00 PM to get R513 out of their room. R513 attempted to bite the CNA's arm and then kicked the CNA. At 4:30 PM, R513 came back to the 400 unit with a CNA walking behind R513 and R513 tried to kick the CNA. After dinner at about 5:30 PM, R513 was back on the 400 unit and the CNA assisted another CNA to take R513 back to the 600 unit. -A CNA statement indicated around 4:30 PM on the 400 unit, R513 was very agitated, kicking, trying to bite, pulling shirts and arms of staff. The CNA walked R513 back to the 600 unit holding R513's hand because R513 would not let go and gave R513 a doll to hold. After 30 minutes, R513 was back on the 400 unit, making statements that R513 had to get out of there because they want me dead. R513 was very agitated as before. R513 became more agitated with redirection. R513 tried to leave the building through the front door and then again on the 600 unit causing the alarm to go off. -An LPN statement indicated R513 was seen wandering the halls in the wheelchair. R513 came onto the 200 unit around 4:00 PM and began attempting to enter other residents' rooms. R513 attempted to open the patio door initiating the alarm. Staff tried to redirect R513 but was unsuccessful and R513 continued to wander. The 600 unit staff came looking for R513 eventually. Around 9:00 PM, the LPN saw R513 with R513's POA. R513 was becoming combative with R513's POA so the LPN offered assistance. The LPN allowed R513's POA to wheel R513 around the 200 unit as long as R513 stayed out of residents' rooms. Surveyor noted with all the interviews, R513 had been agitated all day with physical aggression and going into multiple resident rooms with no initiation of continuous supervision to keep other residents safe. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 6/10/2025 at 4:04 PM, RN-KK stated R513 did not have the behaviors when first admitted but as the dementia progressed, R513 became very difficult to handle. RN-KK stated R513 would try to get out of doors that were locked and had hitting behaviors before R513 was discharged from the facility. RN-KK stated R513 would give a staff member a hug and then would kick the staff member. RN-KK stated R513 kept going to the other side of the building and that is where stuff happened. Surveyor clarified with RN-KK that stuff referred to R513 hitting and kicking R67. RN-KK stated yes. RN-KK stated R513 needed to be one-on-one constantly because R513 was not safe for themselves or other people around them. RN-KK stated RN-KK would wait as long as possible to call R513's POA to come in, but that was the only avenue they had to keep a constant eye on R513. Surveyor asked RN-KK how the one-on-one staff member was assigned. RN-KK stated RN-KK was the one-on-one while still doing all the other nursing duties that were required. RN-KK stated the facility does not have sitters or a single staff member assigned just for the one-on-one. RN-KK stated the facility accepts new admission residents that need one-on-one for safety, and it is upsetting to the staff and the family of the resident when they cannot provide one-on-one. Surveyor noted the facility did not get a statement from RN-KK for the incident on 4/5/2025. In an interview on 6/11/2025 at 3:52 PM, Surveyor asked CNA-LL if CNA-LL recalled R513. CNA-LL stated R513 wandered quite a bit, constantly trying to elope, and came to the other side of the facility all the time. CNA-LL stated R513 was aggressive, kicking and hitting. CNA-LL stated CNA-LL was always trying to remove R513 from other residents' rooms so no one would get hurt. Surveyor asked CNA-LL if CNA-LL was working with R67 on 4/5/2025 when R513 came into R67's room. CNA-LL stated CNA-LL was working on R67's unit that day and did not know R513 was in R67's room until CNA-LL went into R67's room, saw R67 on the floor and R513 was in a wheelchair kicking towards R67. CNA-LL stated CNA-LL could not see if R513 made contact with R67 or not. Surveyor asked CNA-LL if R513 had ever been a one-on-one. CNA-LL stated R513 was never a one-on-one; no one was assigned to specifically watch R513. CNA-LL stated, Should (R513) have been? Yes. Surveyor asked CNA-LL what would happen when R513 was on the opposite side of the facility from R513's room/unit. CNA-LL stated the staff would have to call R513's unit or bring R513 back to the unit themselves. CNA-LL stated R513 was really hard to watch, but the family came in to watch R513 and walk around with R513. CNA-LL stated it would have been nice to have someone assigned to R513. CNA-LL stated there are a few residents currently that would benefit from having a one-on-one. CNA-LL stated staff are pulled in different directions, so it is hard to watch those residents with behaviors and keep everyone safe. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 6/16/2025 at 10:49 AM, Surveyor asked DON-B about the resident to resident altercation on 4/5/2025 between R513 and R67. DON-B stated DON-B was with R513 from 6:00 PM until 8:00 PM on 4/5/2025. DON-B stated DON-B had taken R513 back to R513's unit where R513 had calmed down. DON-B stated DON-B was getting ready to leave the facility and found out R513 had gone back into R67's room where the incident occurred. Surveyor asked DON-B if R513 ever had one-on-one supervision to keep R513 safe as well as other residents. DON-B stated R513 never had a specific CNA assigned to do one-on-one with R513. DON-B stated there is a float CNA that would take that role, but otherwise nursing staff would take turns watching R513 and activities would help as well. DON-B stated it became line of sight monitoring because R513 would get more agitated if someone was right next to R513. DON-B stated on 4/5/2025, R513's behaviors would go away once R513 was resting; they did not anticipate R513 getting back up and being agitated again. DON-B stated R513 did not always have behaviors, R513 would just wander around the building. Surveyor shared with DON-B the concern R513 had been having behaviors all that day and there was no increased supervision to protect R67 from physical abuse. Surveyor shared R513's care plan indicated R513 was to have one-on-one with wandering and behaviors that was not implemented at any time. Surveyor shared interviews with staff said R513 never had one-on-one supervision and that would have been very effective. Surveyor shared with DON-B the concern that staff removed R513 from R67's room without any incident on 4/5/2025, but with the behaviors R513 was exhibiting and not increasing supervision, R513 was able to return to R67's room where R67 fell and was potentially physically assaulted by R513.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure 2 (R97, R39) of 5 residents reviewed were free from chemical restraints. *The facility has no evidence of Abnormal Involuntary Monitory Scale (AIMS) monitoring prior to administrating R97's psychotropic medications. * The facility has no evidence of Abnormal Involuntary Monitory Scale (AIMS) monitoring prior to administrating R39's psychotropic medications. Findings Include: The facility's policy titled Psychotropic Medications - Use of, dated 09/2020, documents the following: .A baseline AIMS assessment will be initiated when receiving antipsychotic medications. (A re-assessment will be completed every six months.) . 1.) R97 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease (a progressive brain disorder that slowly destroys memory, thinking skills, and eventually, the ability to carry out the simplest tasks) and dementia (memory loss). Surveyor reviewed R97's Electronic Medical Record (EMR) including current physician orders, Medication Administration Record (MAR), and Treatment Administration Record (TAR). R97 is prescribed Quetiapine Fumarate (Seroquel) Tablet 25 mg, an antipsychotic medication for Alzheimer's disease, Rivastigmine Tartrate (Exelon) Capsule 1.5 mg, a cholinesterase inhibitor (medication to improve memory function) for Dementia and Memantine HCl (Namenda) Oral Tablet 10 mg, a medication used to treat Dementia. On 6/11/25, Surveyor notes R97's EMR did not include an Abnormal Involuntary Movement Assessment (AIMS) score. On 6/11/25 at 3:15 PM, Surveyor requested an AIMS assessment for R97 from the facility. On 6/12/25 at 9:10 AM, Surveyor followed up with the facility regarding R97's AIMS assessment. The facility was unable to provide Surveyor with R97's AIMS assessment. On 6/12/25 at 12:55 PM, Surveyor shared concern with Nursing Home Administrator (NHA)-A that R97 is receiving psychoactive medications, including Quetiapine Fumarate, an antipsychotic medication. No additional information was provided by the facility at this time. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.) R39 is a [AGE] year-old resident who was admitted to the facility on [DATE]. R39's diagnoses include pulmonary embolism (blood clot in the lungs), paraplegia (a type of paralysis that affects the lower half of the body), Parkinson's Disease (a progressive nervous system disorder that affects movement), Alzheimer's disease (a progressive brain disorder that slowly destroys memory, thinking skills, and eventually, the ability to carry out the simplest tasks), dementia (memory loss), mood disturbance and anxiety, depression, and anxiety disorder. R39's Quarterly Minimum Data Set (MDS) completed on 5/27/25, documents R39 as having a Brief Interview for Mental Status (BIMS) score of 14, indicating R39 is cognitively intact. Surveyor reviewed R39's Electronic Medical Record (EMR) which documents R39's current physician orders, Medication Administration Record (MAR), and Treatment Administration Record (TAR). R39 is prescribed Memantine HCL ER (Namenda) 28 mg by mouth in the morning related to Alzheimer's Disease ordered on 4/4/25, at 7:14 AM. R39 is prescribed Mirtazapine (Remeron) 15 mg by mouth at bedtime for sleep disturbance ordered on 4/3/25, at 6:55 PM. Surveyor notes R39's EMR did not include an AIMS assessment. On 6/12/25, at 9:38 AM, Surveyor requested an AIMS assessment for R39 from the facility. Surveyor was provided a copy of R39's AIMS report dated 5/25/25. On 6/12/25, at 3:18 PM, Surveyor notified Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B of concerns with R39 taking psychotropic medications without having an AIMS assessment performed. Surveyor acknowledged the AIMS assessment dated [DATE] however, notified the facility of concerns with no AIMS assessment being performed prior to R39 taking psychotropic medications (Mirtazapine and Memantine). NHA-A and DON-B acknowledged the concern. Surveyor requested additional information if available.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 4.) R91 was admitted to the facility on [DATE] with diagnoses that included gout, congestive heart failure, obesity, type 2 diabetes mellitus, chronic kidney disease and inflammation of right lower extremity. The most recent Annual MDS (minimum data set), dated [DATE], documents that R91 has a BIMS (brief interview for mental status) of 13 indicating R91 is cognitively intact. R91 is at risk for developing a pressure injury and at the time did not have any unhealed areas of skin impairment. Surveyor conducted a review of R91's individual plan of care and noted the following: R91 is with actual alteration in skin integrity r/t (related to) red groin, and MASD (moisture associated skin damage), immobility and incontinence. Res (resident) refusing air mattress and prefers to have a foam pressure reducing mattress. Hx (history): edema and diabetic and stasis ulcers to bil (bilateral) lower extremities. Skin tears to RLE (right lower extremity) noted. Resident takes off own dressings at times if dressings on and prefers not re-dressed at times. Date Initiated: [DATE] o Skin will remain grossly intact thru next review. Date Initiated: [DATE] o Absorbent to wick up moisture. Date Initiated: [DATE] o Barrier cream to areas exposed to moisture/incontinence. Date Initiated: [DATE] o Bathe with mild soap. Date Initiated: [DATE] o Elevate heels off bed (non-arterial). Date Initiated: [DATE] o Engage resident and/or family in risk reduction interventions. Date Initiated: [DATE] o Inspect skin daily with care. Date Initiated: [DATE] o Monitor labs, weight and/or intake. Date Initiated: [DATE] o Monitor nutritional status. Date Initiated: [DATE] o monitor RLE skin tears for s/s (signs/symptoms) of infection, until healed. Date Initiated: [DATE] o Pericare after incontinent episodes. Date Initiated: [DATE] o Position body with pillows/support devices. Date Initiated: [DATE] o Pressure reduction support on wheelchair. Date Initiated: [DATE] o Teach resident to shift weight in the wheelchair. Date Initiated: [DATE] (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o Treatment as ordered Date Initiated: [DATE] o Use assistive devices to decrease friction (Hoyer lift, draw sheet). Date Initiated: [DATE] o Weekly wound progress assessment by nurse. Date Initiated: [DATE] Nursing note dated [DATE] at 1:27 PM; Pressure injury to left buttocks and blood blister to right great toe reported by CNA's this AM. NP (nurse practitioner), VA (Veteran's Administration), family notified. Treatments in place. Nursing note dated [DATE] at 1:31 PM; Pressure injury to left buttock measuring 4 x 4 cm. Further review of R91's medical record did not provide evidence that a comprehensive assessment had been completed for the pressure injury to the left buttocks or blood blister to the right great toe. On [DATE] at 4:00 PM a physician order was obtained as the following: Betadine to right great toe 2 x (2 times) daily until healed, two times a day. An additional review of the individual plan of care was completed and it was noted it was not updated to reflect the pressure injury to the left buttocks or the blood blister to the right great toe. No additional interventions were put into place to aide in healing these areas. On [DATE] at 8:00 AM; a physician order was obtained for zinc oxide to left buttock, cover with mepilex until healed. one time a day for Skin Condition Nursing note dated [DATE] at 1:26 PM; Notified NP, that wound on buttocks is not improving and needs to be evaluated, notified management at morning nurse's meeting of the same. Surveyor continued the review of the medical record for R91 and did not see any further documentation regarding the NP's response, if a further comprehensive assessment had been completed to the wound on the buttocks or that the plan of care was updated with interventions to prevent the worsening of the area or aide in healing. On [DATE], a NP progress note was written (no time of visit/assessment documented) indicating R91 is receiving ongoing care for bilateral lower extremity wounds at the VA wound clinic. R91 wears compression stockings on both legs to manage swelling, which is noted in his bilateral lower extremities. Additionally, R91 has wounds on his right great toe and left buttock, which is being managed by the facility wound team. Physical Examination: Skin- wound to great toe and left buttock. On [DATE], the facility completed a Braden Scale for Pressure Injury Risk indicating that R91 is at mild risk for pressure injuries. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:45 AM, Surveyor interviewed DON (Director of Nursing)-B regarding R91's areas of skin impairment. Surveyor requested to review any comprehensive assessment of R91's pressure injury to the left buttocks or blister to the right great toe. DON-B stated that she had conducted a skin sweep starting 6/16-[DATE] to identify any new areas of skin impairments. DON-B stated that this information had not been uploaded into the medical record yet. Surveyor asked DON- B if there was any follow-up to the nursing note dated [DATE] that documents the wound to the left buttocks was worsening and needed further evaluation. DON- B stated that R91 does not have a pressure injury, it's a moisture area. On [DATE], DON- B did provide a copy of the skin sweep documentation, dated [DATE] for R91. The skin notes state that 4 x 2 (does not indicate whether centimeter of milimeter) thickness area of MASD (moisture associated skin damage) to the left buttocks area has no signs/ symptoms of infection noted. R91 was previously using urinal and now calls for assistance and more episodes of incontinence. Right great toe stable eschar measuring 1 x .5 centimeters. Betadine continues. NP updated. This documentation was written by DON- B. Surveyor noted the skin sweep documentation does not include additional details to help distinguish if the area on R91's buttock is MASD vs (versus) a pressure injury such as whether the shape is irregular, inflamed, etc. On [DATE] at 12:15 PM, Surveyor interviewed Agency Licensed Practical Nure (LPN)- RR regarding the completion of the treatments for R91 to the buttocks and right great toe. Agency LPN- RR stated she didn't see the area to the buttocks because the CNA's (Certified Nursing Assistants) do the Zinc applications. Agency LPN- RR stated that she only did a treatment to R91's toe. Surveyor asked why she had signed out on the Treatment Medication Administration Record for [DATE] that she did the treatment for zinc oxide to left buttock, cover with mepilex. Agency LPN- RR stated she signed it as completed because she will make sure the CNA applied it. On [DATE] at 12:22 PM, Surveyor interviewed DON- B regarding R91's treatment to the left buttocks being completed by a CNA. DON- B stated that the CNA's definitely are not supposed to being doing any treatments and that she will immediately talk with Agency LPN- RR about this. Surveyor asked DON- B if she was able to find any follow-up to the [DATE] nursing note about the worsening area to R91's buttocks. DON-B stated she was not able to find any follow-up, but the area did not worsen. It once measured 4 x 4 and now it is 4 x 2, clean and healthy. Surveyor asked if there had been any comprehensive assessment of this area and the right great toe. DON- B stated that she had only done a skin sweep of all of the residents and was only looking for new areas. DON-B stated that she has another week (to meet requirement of weekly comprehensive skin assessments) to address these areas. DON- B confirmed that she is the facility's Wound Nurse. On [DATE] at 2:15 PM, Surveyor requested to review the weekly skin check that was signed out as completed on [DATE]. DON- B stated that the nurse's don't document anything when they complete the weekly skin assessment unless there is a new area. Surveyor asked DON-B how the staff would know if there was a new area or not. DON-B stated that they would know because there would be a treatment in place. Surveyor then asked why there had not been a comprehensive assessment of R91's buttocks a right great toe wounds and why the plan of care had not been updated. DON- B was unable to provide any additional information at this time. 2.) R51 was admitted to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis following a cerebral infarction, diabetes, heart failure, legal blindness, bilateral hearing loss, adjustment disorder with mixed anxiety and depressed mood, and mild cognitive impairment. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Estates of Countryside, Inc	1130 Collins Road Jefferson, WI 53549

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R51's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented R51 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 and had impairment to the left arm and left leg. R51's Activities of Daily Living Care Plan, initiated on [DATE], documented R51 used a full body mechanical lift for transfers. R51's At Risk for Skin Breakdown Care Plan was initiated on [DATE] with the following interventions in place on [DATE]: -Absorbent to wick up moisture. -Barrier cream to areas exposed to moisture/incontinence. -Bathe with mild soap. -Inspect skin daily with care. -Monitor for signs/symptoms of infection. -Monitor labs, weight, and/or intake. -Monitor nutritional status. -Monitor wound related pain and administer pain medication as appropriate. -Peri care after incontinent episodes. -Position body with pillows/support devices. -Pressure reduction support on wheelchair. -Turn and reposition every two hours and as needed. -Use assistive devices to decrease friction. -Weekly wound progress assessment by nurse. -Wound care consultation as ordered. On [DATE] at 4:50 AM in the progress notes, nursing documented the nurse requested an air mattress due to R51's decline in condition to avoid pressure wounds. Surveyor noted R51's Care Plan was not revised to include an air mattress at that time. R51 was seen weekly by the wound physician for diabetic ulcers to the left ankle and the right big toe prior to [DATE] when R51 was admitted to the hospital due to altered mental status. R51 was readmitted to the facility on [DATE]. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] on the Initial Nursing Assessment form, nursing documented R51 had a new pressure injury to the coccyx and the outer left great toe; the ulcer to the left heel remains. A Wound and Skin Assessment (WASA) form was completed at the same time documenting the right buttock pressure injury measured 0.2 cm x 0.1 cm with 50% epithelial tissue and 50% granulation tissue. Surveyor noted the pressure injury was not staged and had no depth measurement. Surveyor noted no treatments for the wounds were obtained. On [DATE], R51 was seen by the wound physician who documented R51 had a Deep Tissue Injury (DTI) of the left medial foot that was present on readmission. The DTI measured 1 cm x 1 cm with intact purple/maroon discolored skin. A treatment of skin prep to the left medial foot was ordered at that time. No documentation was found by the wound physician of the coccyx pressure injury that was documented on [DATE]. In an interview on [DATE] at 11:02 AM, Director of Nursing (DON)-B stated DON-B thought the coccyx/right buttock wounds that were noted on readmission on [DATE] were moisture associated dermatitis and not pressure so were not assessed by the wound physician. R51 was seen by the wound physician weekly and the left medial foot was comprehensively assessed with treatment changes as indicated. On [DATE], R51 started hospice services with an admitting diagnosis of cerebral infarction. On [DATE], R51 was seen by the wound physician who documented the left medial foot pressure injury was Unstageable measuring 1.5 cm x 1.4 cm x not measurable with 100% thick adherent devitalized necrotic tissue. R51's At Risk for Skin Breakdown Care Plan was revised on [DATE] with the intervention of a pressure reduction foam mattress or pressure redistribution support (low air or alternation air) in bed. On [DATE] at 9:34 AM, Surveyor observed R51 sitting in a Broda chair in R51's room with a cloth heel boot on the left foot and a sock on the right foot. An air mattress was in place on R51's bed. R51 stated R51 had a bad sore on the left foot. Surveyor noted R51 had documentation of a diabetic ulcer to the left outer ankle and a pressure injury to the left medial foot. No dressings could be observed due to the cloth heel boot on R51's left foot. On [DATE] at 3:52 PM, Surveyor observed R51 in bed lying on an air mattress. A cloth heel boot was in place to the left foot and a gripper sock was on the right foot. R51's left leg was bent at the hip and knee with outward rotation. The outer left foot was resting on the heel boot which ended mid foot and the left fifth toe was resting on the mattress. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 10:41 AM, Surveyor observed R51's wound care performed by Licensed Practical Nurse (LPN)-BB and assisted by Certified Nursing Assistant (CNA)-CC. R51 was lying in bed with egg crate heel boots on that covered the heel only. The left medial foot Unstageable pressure injury was located on the bunion area of the foot. LPN-BB was unsure of how the wound developed. Surveyor noted DTIs to the left lateral foot and the left fifth toe. Surveyor asked LPN-BB if LPN-BB was aware of those areas. LPN-BB stated there was no treatment to those areas that LPN-BB was aware of and had not seen those pressure wounds before. CNA-CC stated CNA-CC worked two days ago, [DATE], and that was when CNA-CC first saw those areas of concern. CNA-CC stated the pressure areas came from R51's shoes because they stopped having R51 wear shoes last week. LPN-BB stated R51's regular boot is in the laundry and LPN-BB pulled the cloth boot out of the laundry basket in R51's closet. LPN-BB stated the pressure wound to the left outer foot came from that boot because the edge of the boot, with the stitched seam, lines up with the edge of the foot where the pressure injury is. LPN-BB stated the egg crate boots must have come from hospice, but LPN-BB would get R51 some new boots. LPN-BB stated LPN-BB would let DON-B know about the new areas as well as notify the Nurse Practitioner and the wound physician. On [DATE] at 5:10 PM in the progress notes, LPN-BB documented R51 had new skin alterations to the left lateral foot and the fifth digit of the left foot that was noted during wound treatment that morning. The DON/wound nurse was notified, and the wound physician was updated. A daily treatment order was obtained and completed that morning. On [DATE], DON-B documented comprehensive assessments of the DTI to the left fifth digit and the left medial foot. On [DATE], the wound physician documented the left foot pressure wounds noted are related to R51's spasticity and inability to adequately offload the wounds despite pressure offloading boots and repositioning by the facility. R51 has attempted to be compliant with this but unfortunately due to underlying medical factors, R51 is unable to maintain offloading position. Surveyor noted R51's care plan did not address the floating of heels or address R51's tendency to position the left leg with outward rotation to prevent the development of pressure injuries. On [DATE] at 9:28 AM, Surveyor observed R51 sitting in a Broda chair. R51 had socks on both feet that were resting directly on the foot board/footrest. Surveyor noted the eggcrate heel boots were on the windowsill in R51's room. R51's left foot was rotated slightly so the side of the foot was touching the foot board where the new DTI areas were discovered on [DATE]. No pillows or heel boots were in place. On [DATE] at 11:02 AM, Surveyor shared with DON-B the concerns that R51's skin was not comprehensively assessed when readmitted to the facility on [DATE], the DTI to the left medial foot was not discovered or assessed until [DATE] when R51 was seen by the wound physician, and R51's care plan did not address R51's positioning with the outward rotation of the left leg to prevent pressure injuries. R51 developed two DTI's that were discovered during wound care on [DATE] when Surveyor was observing, and CNA-CC stated those areas were present two days prior. DON-B stated hospice provided the eggcrate heel boots, and the wound physician said the wounds were unavoidable because of contractures and positioning, the air mattress, and the boots should help and not hinder pressure areas. Surveyor shared with DON-B the concern R51 had known positioning challenges and those were not addressed through assessment or care planning. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3.) R93 was admitted to the facility on [DATE] with diagnoses of dementia, diabetes, congestive heart failure, and anemia. R93's admission Minimum Data Set (MDS) assessment dated [DATE] documented R93 was severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 5 and was dependent for dressing, personal hygiene, transferring, and bed mobility. The Pressure Ulcer Care Area Assessment (CAA) from R93's Significant Change MDS dated [DATE] documented R93 was at risk for the development of a pressure injury. R93's Potential for Alteration in Skin Integrity Care Plan was initiated on [DATE] with the following interventions: -Barrier cream to areas exposed to moisture/incontinence. -Bathe with mild soap. -Daily foot check as (R93) will allow. -Elevate heels off bed as (R93) will allow; (R93) declines frequently. -Inspect skin daily with care. -Moisturize dry skin. -Monitor nutritional status. -Pericare after incontinent episodes. -Position body with pillows/support devices; (R93) will decline use of these. -Pressure reduction support on wheelchair. -Treatment as ordered. -Use of equipment for fragile skin. On [DATE], R93's Potential for Alteration in Skin Integrity Care Plan was revised with the following interventions: -Absorbent to wick up moisture. -Dietary referral as needed; encourage acceptance of supplements. -Educate (R93) and/or family regarding pressure injury management. -Monitor/manage diabetes, assess lower extremities for arterial insufficiency and/or appropriate foot and nail care. -Pressure reduction foam mattress or pressure redistribution support (low air or alternating air) in bed. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor noted no documentation was found for R93's Potential for Alteration in Skin Integrity Care Plan to be revised on [DATE]; no alteration in skin documentation was found or skin assessments documenting any new pressure injury concerns. On [DATE] at 3:37 PM in the progress notes, nursing documented R93 had a large intact blister to the left heel. A new treatment for skin prep to the left heel every shift was initiated. On [DATE] on the Wound and Skin Assessment (WASA) form, Director of Nursing (DON)-B documented the left heel Deep Tissue Injury (DTI) presented as a fluid filled blister that measured 8.5 cm x 11 cm. Surveyor noted this was the first comprehensive assessment after the discovery of the pressure injury three days prior. On [DATE] on the WASA form, DON-B documented the DTI measured 8.5 cm x 9 cm and presented as a deflated blister with exposed dermis. Surveyor noted the exposed dermis was not a characteristic of a DTI but the development into a Stage 3 pressure injury or Unstageable. DON-B assessed R93's left heel pressure injury weekly with the wound evolving into a stable heel cap with 100% eschar on [DATE] and progressing to an Unstageable pressure injury on [DATE] with 100% eschar. Surveyor noted the pressure injury was staged as a DTI while there was 100% eschar from [DATE] until [DATE]. The left heel pressure injury was Unstageable from [DATE] until [DATE] when the wound bed was 100% granulation and staged at a Stage 3. Surveyor noted no wound depth was documented from the development of the wound until [DATE]. On [DATE] at 1:55 PM, Surveyor observed Licensed Practical Nurse (LPN)-BB complete wound care with R93. Surveyor observed LPN-BB apply skin prep to bilateral heels. Surveyor noted R93 did not have any open areas on either heel at that time. In an interview on [DATE] at 10:56 AM, Surveyor asked DON-B what the facility process was for a resident that developed a pressure injury while at the facility. DON-B stated the nurse on the floor would either complete a comprehensive assessment at that time or if it was an LPN that discovered the wound, a Registered Nurse (RN) that was in-house would be notified to come and assess. DON-B stated it would be situational about when the wound would be assessed. DON-B stated the wound physician is in the building weekly and they may wait until the wound round day to have the resident seen by the wound physician. DON-B stated the wound physician would then see the resident weekly for the weekly assessments. Surveyor shared the concern R93 developed a pressure injury to the left heel on [DATE] and was not comprehensively assessed until [DATE]. DON-B stated the facility had an Assistant DON (ADON) that was a wound nurse, but DON-B could not recall if the ADON saw R93 at all during that time. Surveyor shared the concern with DON-B the wound measurements did not include a depth measurement until [DATE]. DON-B stated the wound was superficial, but agreed a depth should have been documented. 5.) R79 was admitted to the facility on [DATE] with pertinent diagnoses that include type 2 diabetes mellitus (happens when the body cannot use insulin correctly and sugar builds up in the blood) and chronic diastolic (congestive) heart failure (occurs when the heart's left ventricle becomes stiff and doesn't relax properly, hindering its ability to fill with blood). Surveyor noted R79 has a physician order dated [DATE] documenting cleanse right fourth toe with soap and water and change band aid daily every day shift for Wound cleansing. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R79's Quarterly Minimum Data Set (MDS) with an assessment reference date of [DATE], documents a Brief Interview for Mental Status (BIMS) assessment score of 12, meaning moderate cognitive impairment. The MDS documents that R79 was not assessed to have any behaviors during the look back period. The MDS documents that R79 is at risk of pressure injuries, however no skin concerns were documented. R79's most recent Braden Scale for Predicting Pressure Score Risk evaluation dated [DATE] documented that R79 was assessed to have a score of 15, indicating R79 is at mild risk of developing a pressure injury. R79's care plan documents R79 is with actual alteration in skin integrity r/t (related to) DM (diabetes mellitus), incontinent, moisture, decreased activity, assistance needed with ADL's(activities of daily living). Swelling. Resident is with rashes to skin at times. Right lower extremity Date Initiated: [DATE] The care plan documents the following interventions: o Educate resident and/or family about risk for pressure ulcer/injury Date Initiated: [DATE] o Inspect skin daily with care Date Initiated: [DATE] o Moisturize dry skin Date Initiated: [DATE] o Pressure reduction foam mattress or pressure redistribution support (low air or alternating air) in bed Date Initiated: [DATE] o Treatment as ordered Date Initiated: [DATE] R79's Nursing Weekly Summary dated [DATE] documents No New Skin Conditions. R79's Nursing Weekly Summary dated [DATE] (no time indicated) documents No New Skin Conditions. R79's progress note written on [DATE], at 9:18 pm, documents Resident has a small open area on his RLE (right lower extremity). Area was washed with warm water and patted dry. Writer applied an oil emulsion dressing, ABD (abdominal) and secured with rolled gauze. Resident tolerated well. NP (Nurse Practitioner) notified. Surveyor noted there is not a comprehensive assessment of this small open area on R79's RLE. The progress note does not specify where the area is located on R79's RLE. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R79's Nursing Weekly Summary dated [DATE] documents both Skin intact and No New Skin Conditions. The sections If Skin Condition present - Document Site, type of condition, TX (treatment), and progress and Additional comments are left blank on the three Nursing Weekly Summary reports reviewed. Surveyor noted [DATE] R79's open area was found, and it was not documented on the [DATE] Nursing Weekly Summary and on the next week's [DATE] Nursing Weekly Summary documents R79's skin was intact. Surveyor noted no update to R79's care plan after the open area was discovered to the right lower extremity on [DATE]. R79's physician order dated [DATE] documents Clean area with warm soapy water, cover with oil emulsion dressing, ABD, and wrap with rolled gauze every day shift for Skin Condition. R79's physician order dated [DATE] documents SKIN CHECK COMPLETED, every day shift every Tue (Tuesday). This was not marked as completed on [DATE]. R79's Skin Sweep form was completed on [DATE], by Director of Nursing (DON)-B that documents 1 x 1 full thickness opened blister, tx (treatment) order in place with the 4th right toe circled on the body chart. Surveyor noted the documentation of a full thickness wound would indicate the pressure injury is either an unstageable, stage 3 or stage 4 pressure injury based upon being a full thickness wound. There is no staging noted by the facility. On [DATE], at 11:40 AM, Surveyor interviewed DON-B regarding the progress note written on [DATE] related to the right lower extremity open area found on R79. Surveyor asked if an assessment was completed. Per DON-B there is probably a paper assessment that was done during the skin sweep. Surveyor noted that R79's 4th right toe was the only skin concern documented on the Skin Sweep form. On [DATE], at 11:56 AM, Surveyor interviewed Registered Nurse (RN)-PP about R79's treatment. RN-PP stated the treatment had already been done for the day. Surveyor stated it was not marked as administered under treatments and RN-PP replied that they write down what need to do then cross off on the paper, R79's treatment is crossed off. RN-PP will document the administration at the end of the shift. Surveyor asked RN-PP to describe the wound to R79's right lower extremity and was told it is a skin tear that the scab came off. When RN-PP did the treatment, the wound was dry with no drainage. The wound bed was pink. On [DATE], at 12:20 PM, Surveyor was provided R79's Skin Sweep form and Surveyor noted only the 4th right toe was documented. There is no reference to the RLE wound receiving a treatment. On [DATE], at 12:27 PM, Surveyor interviewed DON-B regarding the right lower extremity open area not being on R79's Skin Sweep form and was told when DON-B saw R79 on the evening of 17th there was nothing there. Surveyor stated a treatment was in place and should have been seen during sweep. DON-B stated she needs to look into this. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor noted being unable to locate documentation of an assessment of R79's right lower extremity open area. Surveyor noted there was a treatment order that was charted on [DATE] through [DATE]. Surveyor noted the care plan was not updated after discovery of the open area. On [DATE], at 02:52 PM, Surveyor shared with Nursing Home Administrator (NHA)-A, DON-B and Corporate-AA that the extended survey has been completed, the immediate jeopardy has not been removed due to concerns with two additional residents that were reviewed. R79's progress note written [DATE] identified an open area on the right lower extremity. A physician order was obtained and documented. Surveyor was unable to locate assessment information, and the care plan was not updated. This area should have been identified on the skin sweep as there was an active order for a treatment in place. No further information was provided at the time of write up regarding an assessment of R79's open area on the right lower extremity. Based on observation, interview, and record review, the facility did not ensure 5 of 7 residents (R) reviewed (R17, R51, R93, R91 and R79) had a comprehensive assessment and care plan to prevent and heal pressure injuries. * R17 was admitted to the facility on [DATE]. Upon Minimum Data Set (MDS) admission assessment and subsequent MDS assessments, R17 was assessed to be at risk for pressure injuries. R17 had admitting left and right anterior shin open areas. On [DATE], R17 developed a left toe and left ankle venous wounds. On [DATE], R17 was readmitted to the facility following a hospitalization with a venous wound left ankle, diabetic wound left dorsal foot, and diabetic left 4th toe wound. On [DATE], R17 developed a skin tear to the left shin and on [DATE], R17 developed a skin tear to the left leg. On [DATE], Occupational Therapy advised R17 that he should no longer self-propel his wheelchair with his arms and hands due to shoulder, pain and begin to self-propel with his legs and heels. On [DATE], R17 developed a non-pressure wound to the left great toe and on [DATE], the etiology changed from non-pressure wound to arterial wound to the left great toe. On [DATE], R17 developed an arterial wound to the right great toe. On [DATE], R17 had an appointment at the Wound Clinic and the wound Medical Doctor (MD) discovered a new unstageable left heel pressure injury. The wound MD wrote orders that R17 cannot self-propel with his heels and would need staff to push him in wheelchair. The care plan does not indicate use of an air mattress, heel offloading or pressure reducing boots as interventions prior to [DATE] when R17 developed the unstageable left heel pressure injury. There is no care plan for diabetic foot assessment or monitoring. The facility does not have evidence of any discussion with R17 regarding risk and benefits of self-propelling in his wheelchair with his legs and heels. On [DATE], R17 had left great toe amputated. On [DATE], R17's left heel was debrided and now presents as a Stage 4 pressure injury. On [DATE], R17 had a Magnetic Resonance Imaging (MRI) with results R17 has osteomyelitis (inflammation of the bone causing infection) with edema (swelling caused by excess fluid) enhancement of left heel. R17 was scheduled for a partial left heel removal on [DATE], however this did not occur as R17 was hospitalized on [DATE] and expired on [DATE]. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's failure to assess R17's risk for the development of pressure injuries and to establish preventative interventions to address R17's risk led to R17 developing a facility acquired, avoidable stage 4 pressure injury with osteomyelitis. The facility did not establish a care plan to assess R17's diabetic feet daily. The facility encouraged R17 to propel himself using his legs and heels to improve mobility but neglected the likelihood of R17 developing pressure injuries based on his extensive comorbidities and frail skin by using the same repetitive motion causing friction and pressure on the heels. R17 self-propelled with his legs and heels from [DATE] until the pressure wound developed, consequently, discovered by the wound physician on [DATE]. These failures created a reasonable likelihood for serious harm, thus leading to a finding of immediate jeopardy. The facility's failure to prevent the development of a facility acquired stage 4 pressure ulcer with osteomyelitis by ensuring assessment, prevention, and treatment in accordance with current standards of practice created a finding of immediate jeopardy (IJ) that began on [DATE] and has not yet removed by closure of survey on [DATE]. On [DATE] at 03:27 PM, Surveyor notified facility of the IJ. Facility staff present include Nursing Home Administrator (NHA)-A, Assistant Nursing Home Administrator (Assistant Administrator)-F, Senior Leader-H, Assistant Nursi[TRUNCATED]

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	525271	A. Building B. Wing	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Estates of Countryside, Inc	1130 Collins Road Jefferson, WI 53549

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and staff interviews, the facility did not ensure 2 out of 6 residents (R92 & R95) reviewed for being at high risk for falls, received adequate supervision and assistance devices to prevent accidents. R92 is at high risk for falls and had 4 unwitnessed falls at the facility. The facility did not ensure they thoroughly investigated each fall to determine the root cause and to assure that all interventions were in place at the time of the fall and were effective. R95 is at high risk for falls and has experienced several falls while at the facility. The facility did not ensure that they followed R95's toileting plan, which would reduce the chance that R95 would try to toilet herself and potentially fall. In addition, Surveyor observed R95 being transferred with a gait belt and 1 staff member when the plan of care indicates she needs a hoyer lift for transfers. Findings include: Policy Review Fall Management Program, dated 08/2020 The facility is committed to minimizing resident falls and/or injury as to maximize each resident's physical, mental and psychosocial wellbeing. While preventing all resident falls is not possible, it is the facility's policy to act in a proactive manner to identify and assess those residents at risk for falls, plan for preventive strategies and facilitate a safe environment. Procedure: 1.) Complete a fall risk assessment upon admission, re-admission, with significant change, post fall, quarterly and annually. 2.) Educate patient, family or responsible party related to: a. fall prevention b. Call, don't fall for cognitive residents 3.) Educate staff members to check during room rounds the 4 P's a. pain b. positioning c. placement of personal items d. personal needs (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Plan of care reviewed and updated at time of occurrence, quarterly and as needed in order to minimize risk for fall incidents. 5. Use standard fall/ safety precautions for all residents: a. All staff will be trained on the Fall Management Program b. At the time of admission, and in accordance with the plan of care the resident will be orientated to, use the nurse call device. The nurse call device will be placed within the residents reach. c. Call lights to be answered promptly. d. The bed will be maintained in a position appropriate for resident transfers. e. The bed locks will be checked to assure they are in locked position. f. Personal possessions will be within reach when possible. Assistive devices will be within reach if resident is capable of using independently. g. The resident's environment will be kept clear of clutter. Lighting will be appropriate for the time of day. 1.) R92 was originally admitted to the facility on [DATE] with diagnoses including Parkinson's Disease, Lewy body Dementia, congestive heart failure and tremors. The most recent quarterly MDS (Minimum Data Set), dated 5/15/25 documents R92 has a BIMS (brief interview for mental status) score of 15 (intact cognitive function). R92 has experienced falls at the facility since admission, 2 or more without injury. There has been no falls with major injury. The facility conducted falls assessments on 5/6/25, 5/14/25, 6/5/25 and 6/10/25. These assessments all indicated R92 is at high risk for falling. On 10/10/24, the facility initiated a plan of care documenting R92 is at Risk for falls r/t (related to) weakness, Parkinson's disease, and neurocognitive disorder, use of assistive device and need for staff assistance. (R92) is unaccepting of his limitations. Parkinson's, acute encephalopathy (R92) prefers wife not be notified of falls to avoid causing her and himself emotional distress. (R92) continues to transfer self w/o (with out) staff and needs reminders that he is a HOYER (sic). Interventions included: Will accept interventions to help prevent falls through next review. Date Initiated: 01/26/2025. Assist resident to get up and out of bed during the night when resident is not feeling sleepy. Date Initiated: 10/10/2024. Dycem to wheelchair. Date Initiated: 01/26/2025. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encourage and offer rest periods when walking. Date Initiated: 10/10/2024. Encourage resident to Call, don't fall. Date Initiated: 10/10/2024. Encourage resident to keep room free of obstacles. Date Initiated: 05/04/2024. Encourage use of and provide a Reacher as needed to assist resident with getting items from hard-to-reach areas. Date Initiated: 02/24/2025. Ensure adequate lighting for tasks. Date Initiated: 05/04/2024. Keep bed in lowest appropriate position. Date Initiated: 01/26/2025. Keep frequently used items within reach in room. Date Initiated: 10/10/2024. Surveyor conducted a review of R92's medical record and noted the following falls: 4/7/2025 at 02:45 a.m., Post Occurrence Documentation Description of occurrence: Nurse called to (R92's) room to observe resident lying in the supine position on the floor next to his bed. (R92) stated, I tried getting out of bed by myself, slid out of bed on the floor. I was told that I could do this by myself. (R92) denies any pain, resident denies hitting his head. (R92) did not want nurse to call his wife, and stated, Do not wake her up at 0300, I will tell her when she comes to see me today. (R92) was educated on the importance of using his call light for help, and that he still needs the assistance of staff to transfer. Resident verbalized understanding. Charge nurse was called. VS (vital signs) obtained and stable. Neuro checks started. RN completed a head-to-toe assessment. Resident was assisted back to bed via hoyer and 3 staff members. On 4/7/2025 at 11:43 a.m, Interdisciplinary Team (IDT) Note Text: IDT met to review R92's fall incident on 4/7. Root cause is most likely self-transfer. No pain, no injury. Care plan updated. Surveyor conducted a review of the facility's fall investigation dated 4/7/25. Immediate intervention was to re-educate on calling for assistance and placing call don't fall signs in his room. Surveyor verified that the intervention for CALL DON'T FALL sign in room was added to the plan of care back on 10/10/24. In addition, on 4/7/25 the intervention was to continue to remind (R92) to call when needing assistance with transfers. The facility's fall investigation includes a staff statement that documents that R92's call light was turned on. The investigation does not include how long the call light was activated prior to staff finding R92. The investigation does not indicate what other interventions were in place at the time of the fall; for example; was bed in lowest position. Surveyor noted if R92's call light was on R92 did what was expected by R92 to prevent a fall, the investigation does not include a review on if staff implemented the care plan to prevent falls after R92 requested assistance with the call light. On 4/25/2025 at 11:45 p.m., Post Occurrence Documentation: Description of occurrence: (R92) had unwitnessed fall in his room. Found lying on the floor by the door, w/c (wheelchair)and walker by the bathroom door. (R92) was ambulating independently using a walker. Slipped d/t (due to) wet floor and fell. Res. (resident) was in regular socks. No injuries noted. Denied discomfort and hitting his head. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/28/2025 at 11:00 a.m., Interdisciplinary Team Note Text: Clinical IDT met to review (R92's) fall from 4/25. No injury noted. R92 slipped on ice chips he dropped on the floor while attempting to walk to obtain a soda. Administrator to provide education with R92 and family regarding asking for assistance and calling for help. Surveyor conducted a review of the facility's falls investigation for the fall that occurred on 4/25/25. R92 did not have gripper socks on due to resident prefers to go to bed around 9:30 p.m. Fall happened approximately 8:45 p.m. 45 minutes prior to R92's preferred bedtime. The investigation did not indicate if the other falls interventions were in place at the time (i.e. call light in reach). The fall investigation did not include review of whether this was a usual pattern for R92 or steps staff could take to help ensure R92's safety. On 5/3/2025 at 10:17 p.m., Nurses Note Text: (R92) had a fall while self-transferring from recliner to w/c. Educated resident on need to ask for assistance to remain safe. Intervention: ensure w/c is locked so that when resident decides to self-transfer, he is able to do so. On 5/5/2025 at 10:52 a.m., Interdisciplinary Team Note Text: IDC (interdisciplinary clinical) Team reviewed fall on 5/4/25 ([sic] documentation is wrong date, fall was 5/3/25). The goal of the facility is resident safety. R92 continues to be noncompliant with safety education on not (sic) self-transferring. A new intervention was implemented. Family notified. Review of R92's care plan includes the following added interventions: Encourage resident to keep room free of obstacles. Date Initiated: 05/04/2024. Ensure adequate lighting for tasks. Date Initiated: 05/04/2024. Surveyor noted the initial recommendation was to ensure R92's wheelchair was locked for safety, this was not added to the care plan. 5/6/2025 at 03:00 a.m., Post Occurrence Documentation; Description of occurrence: CNA reported (R92) called on call light and as she entered room to answer call light resident was noted to be sitting on floor. Writer entered room and noted resident sitting on floor in front of his recliner. (R92) stated while he was trying to grab his blanket he slipped out of his recliner chair onto floor in sitting position. Resident denies hitting head. Resident denies pain or discomfort. Resident was assessed. VSS (vital signs stable). No injuries noted. MAE's (mobility assessment of extremities) per his norm. Assisted up x2 (with 2 staff) via hoyer lift into recliner. Resident instructed to call for assistance and voiced understanding. Surveyor conducted a review of the facility's fall investigation for the 5/6/25 fall - (R92) and wife were educated regarding fall management program and following interventions. Staff stated (R92) put on call light at approximately 3:00 a.m Staff stated she was doing rounds, finished what she was doing and went to R92. The light was not on long, estimates just a few minutes. A review of the facility's investigation documents (R92) had activated the call light and CNA did enter the room and found R92 to be sitting on the floor. (R92) says he tried to grab his blanket, he slipped out of his recliner chair on to the floor. The investigation did not indicate why R92 was sleeping in recliner and not his bed and how long the call light was activated before staff arrived in R92's room. Surveyor noted R92 again did follow the care plan by activating the call light as instructed by the facility however, a fall still occurred. The facility did not review the effectiveness of this intervention. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/12/2025 at 02:15 a.m., Post Occurrence Documentation: Description of occurrence: Nurse was entering (R92's) room to check his oxygen saturation and observed R92 laying on the floor between his bed and recliner, (bare) feet under the bed and head near recliner. Resident was rolled slightly onto his left side and had a blanket under him; he was not yelling for help. (R92) states he was reaching for a blanket and that he was in his bed (there were multiple blankets in his bed). He denies hitting his head or having any pain. Head to toe assessment complete with full range of motion and no signs of injury, vital signs and neuro check also complete. Resident was transferred into his recliner via hoyer, call light was clipped to his shirt, and he was reeducated about calling for assistance and not attempting to self-transfer for his safety. Surveyor conducted a review of the facility's investigation for the fall that occurred on 5/12/25. (R92) likes to be warm but not hot and will kick off coverings/socks if he is hot. The facility's falls investigation did not include information if the falls interventions were in place at the time of the fall such as the call light being in reach, low bed etc. Surveyor note this the the second fall R92 experienced reaching for a blanket, care plan interventions initiated 10/10/24 included to keep frequently used items within reach in room. On 5/12/2025 at 11:30 a.m., Interdisciplinary Team Note Text: Clinical IDT met to review fall from 5/12. The goal of the facility is resident safety. A new intervention was implemented. All parties notified. Review of R92's fall care plan does not indicate what the new intervention is that has been implemented. 06/12/25 03:16 PM Surveyor interviewed Nursing Home Administrator (NHA)- A and Director of Nursing (DON) -B regarding the fall investigations for R92. Surveyor asked if the facility had investigated the call-light response times on the occasions were R92 activated the call light for assistance and still was found to have an unwitnessed fall. In addition, Surveyor asked if the facility, included in their investigations, whether all falls care planned interventions were in place at the time of the falls for R92. As of the time of the exit, no additional information had been provided. 2.) Facility Policy titled Transfer dated 3/10/2022 documents: Definition: Transfer refers to activities provided to improve or maintain the resident's self-performance in moving between surfaces or planes either with or without assistive devices. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record. General Transfer Guidelines: 1. Resident safety, dignity, comfort and medical condition will be incorporated into goals and decisions regarding the safe transfers of residents. 2. Manual lifting or residents should be eliminated when feasible. 3. Nursing staff, in conjunction with the rehabilitation staff, shall assess individual resident's needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care plan Such assessment shall include: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Resident's mobility (degree of dependency) d. Weight bearing ability e. Cognitive status 4. Staff responsible for direct resident care with be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices . General Transfer Procedure: 9. Use a transfer/gait belt . R95 was initially admitted to the facility on [DATE] with diagnoses that included Unspecified Dementia (a decline in mental ability severe enough to interfere with daily life, affecting memory, thinking, language, and judgment), and history of falling. R95's Quarterly Minimum Daily Set (MDS) with an assessment reference date of 3/13/25 documents Under Section C cognitive patterns a Brief Interview for Mental Status score of 6 indicating R95 having severe cognitive impairment. Under section GG Functional abilities and goals assesses R95's toileting hygiene as: needing supervision or touching assistance. Helper provides verbal cues or touching/steadying assistance as resident completes activity. Under section GG Functional abilities and goals assesses R95's toileting transfer as: set up or clean up: resident completes activity. R95's Care Area Assessment (CAA) with assessment reference date of 12/7/24 identified R95 as a fall risk. CAA section analysis of finding documents: R95 is admitted following a fall at home with pelvis fracture. Pt (patient) with right subdural hematoma (brain bleed) right scalp hematoma, right posterior rib fractures and left symphysis pubis and inferior pubic ramus fracture (pelvic fracture) . Resident since admission fell resulting in injury Resident requires assistance from staff for activities of daily living (ADLS), transfers. R95's Physical Therapy treatment note dated 6/9/25 at 01:55 PM, documents R95 dependent with squat pivot transfer x 2 assist. R95 demonstrated increased agitated behavior. Nursing informed and R95 downgraded to Hoyer (full body mechanical lift) for transfers at this time. R95's Mechanical Lift care plan documents R95 requires the use of a mechanical lift for transfers. Date Initiated: 06/09/2025. The interventions section documents: Resident will tolerate total body (Hoyer) lift transfers from surface to surface with staff assistance. Date Initiated: 06/09/2025 Target Date: 09/10/2025. Instruct resident prior to transferring him/her. Date Initiated: 06/09/2025. Never leave the resident unattended when in the lift. Date Initiated: 06/09/2025. Provide 2 staff assistance for transferring. Date Initiated: 06/09/2025. Use total body (Hoyer lift) when transferring resident. Date Initiated: 06/09/2025. R95's fall care plan documents R95 is at RISK for falls r/t (related to) history of falls, poor safety awareness r/t dementia, impaired balance, (R95) will self-transfer, resident is impulsive with self-transfers. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Family is aware of fall risk Date Initiated: 11/20/2024. R95's interventions section documents: Toilet Use prompt voiding upon waking up, before or after meals and before bed Date Initiated: 02/18/2025. Call don't fall sign initiated for visual reminders Date Initiated: 05/05/2025. Encourage resident to be out of her room when she is awake. Date Initiated: 05/20/2025. enc (encourage) use of grip nonskid socks when in bed for safety Date Initiated: 05/30/2025. Encourage resident to Call, don't fall. Date Initiated: 02/18/2025. Surveyor note call do not fall is a duplicated intervention with two dates of initiation on R95's care plan. R95's Interdisciplinary team (IDT) review on 2/18/25, after R95 had a fall, documents: Root cause of incident was resident attempting to self-transfer to go to the bathroom. Immediate intervention was resident was assisted to the toilet. RN assessed prior to movement. Vitals WNL (within normal limits), neuros (neurological checks) initiated, provider, family notified. Obtained swelling and small bump on head. Physician aware. NNO (no new order). Resident last fall was in December 2024. BIMS (Brief interview for Mental Status) score is 7. Will do prompted voiding with resident. Care plan updated. R95's Nursing Note on 6/9/25 at 9:00 PM, charted by LPN-I documents Note Text: Resident resides at (name of facility) for LTC (long term care) w/dxs (with diagnosis) of dementia, COPD (chronic obstructive pulmonary disease), HTN (hypertension), polyneuropathy, fall hx (history), anxiety, sleep disorder, chronic pain and hearing loss, A&O x 1 (alert & oriented times 1), meds (medications) whole w (with)/water, self-transfers, mobilizes in wheelchair which she self-propels, Gen (general) diet/Reg tex (texture)/Thin liquids, feeds self, APAP (acetaminophen) for pain control, penicillin allergy, bowel/bladder continent usually, calm, polite and cooperative, HOB (head of bed) elevated due to SOB (shortness of breath) while lying flat. Resident's transfer status has been changed to a Hoyer due to decline in condition. Resident is a DNR (do not resuscitate), incapacitated. Review of R95's Certified Nursing Assistant (CNA) care Kardex located during the survey in the resident care binder: Toileting: Toilet Use prompt voiding upon waking up, before or after meals and before bed Date Initiated: 02/18/2025. Transfer: Provide 2 staff assistance for transfer. TRANSFER: HOYER (mechanical lift). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/11/25, at 11:03 AM, Surveyor asked LPN-I if R95 was in R95's room. Surveyor followed LPN-I into R95's room after knocking to check on R95. LPN-I asked Surveyor to step back because LPN-I had to get R95 off toilet. Surveyor stepped back to door then came back in to ask are you transferring R95 off the toilet. LPN-I informed Surveyor yes LPN-I needed to get R95 to the wheelchair. Surveyor observed LPN-I placing R95 back into a wheelchair with no gait belt. LPN-I informed Surveyor R95 had transferred herself to the toilet and LPN-I helped R95 back to the wheelchair. LPN-I informed Surveyor R95 is not safe to transfer on her own but will impulsively self-transfer to the toilet without informing staff. Surveyor observed LPN-I explain to R95 to ask for help and to be safe. LPN-I informed Surveyor we have signs on the wall to remind R95 to not transfer without asking for help. LPN-I informed Surveyor we keep providing education to turn R95's light on. LPN-I informed Surveyor there is nothing we can do about it because R95 just transfers when R95 wants to transfer. Surveyor asked LPN-I if R95's cognition and transfer ability had declined recently. LPN-I informed Surveyor R95 has declined physically and mentally but was not always compliant before the decline. LPN-I again informed Surveyor there not much we can do because R95's impulsiveness. Surveyor asked if R95 was on a prompted toileting program would that help decrease R95's self-transfers. LPN-I informed Surveyor R95 would self-transfer even if R95 was placed on a toileting program. On 06/11/25, at 11:26 AM, Surveyor interviewed CNA-S. Surveyor asked CNA-S if R95 is taken to the bathroom by staff. CNA-S informed Surveyor usually the staff recently but, R95 used to be independent up until about a week ago. CNA-S informed Surveyor R95 is more confused now. Surveyor asked CNA-S when does staff take R95 to the bathroom. CNA-S informed Surveyor that CNA-S didn't usually work the morning shift, and that CNA-S usually worked on the PM shift. Surveyor asked CNA-S what the toileting schedule was for R95 on the PM shift. CNA-S informed Surveyor that when CNA usually works the PM shift, R95 will stay in dining room on the PM shift. Surveyor asked CNA-S if R95 ever needed to go to the bathroom when she was in the dining room on the PM shift. CNA-S informed Surveyor if CNA-S sees R95 in R95's room then CNA-S will ask R95 if R95 needs to go to the bathroom. CNA-S informed Surveyor that is when CNA-S will help R95 to the bathroom. Surveyor asked CNA-S why wouldn't staff follow R95's toileting schedule. CNA-S informed Surveyor the staff will toilet R95 when the staff thinks R95 needs to go to the toilet, that R95 is not on a toileting schedule. Surveyor asked CNA-S if the staff on PM shift use a one assist to transfer R95 to the toilet. CNA-S informed Surveyor that yes, staff did need to use 1 assist for R95 more recently with R95's recent decline in health. Surveyor asked CNA-S if R95 continues to toilet herself, as of the last few days. CNA-S informed Surveyor R95 has continued to toilet herself recently but that R95 was more independent until R95's recent decline in health. Surveyor asked how CNA-S and other staff were transferring R95 now. CNA-S informed surveyor what CNA-S was doing and thought others, probably, were transferring R95 with one assist also. Surveyor asked CNA-S where CNA-S could get information on R95's transfers and toileting schedules. CNA-S informed Surveyor CNA-S wasn't sure where that information was kept. Surveyor asked CNA-S if the facility had more staff could CNA-S toilet R95 more frequently. CNA-S informed Surveyor staff really don't have a chance on PMs to take R95 to the bathroom. Surveyor asked CNA-S how the staff knew what toileting programs residents might be on and how to care for the residents, especially if a staff member was new. CNA-S informed Surveyor staff just know how to care for the residents. Surveyor asked CNA-S if the staff knowledge came just from their experience. CNA-S informed Surveyor yes, staff just know and that R95 has recently just declined and needs 1 assist of staff to transfer now but, R95's decline is still new to us. Surveyor asked CNA-S to explain what R95's decline is new to us meant. CNA-S informed Surveyor that R95 was more independent until very recently and R95 has just become a 1 assist transfer recently. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/11/25, at 11:32 AM, Surveyor interviewed with Licensed Practical Nurse (LPN)-I about R95's interventions to prevent falls including R95's toileting schedule. Surveyor asked LPN-I to explain the CNA charting which shows R95 self-toileting, especially in early June of 2025, while R95 needed staff assistance for transfers, noting as of 2/18/25 R95 was to transfer using a hoyer lift. LPN-I informed Surveyor that R95 was more able to self-toilet back early part of June 2025. LPN-I informed Surveyor R95 just recently declined. LPN-I pointed out in the task charting that staff have been helping R95 more in the later weeks of June of 2025. Surveyor asked LPN-I if R95 required staff assistance and a mechanical lift for transfers why R95 would be self-toileting and be on a toileting program since 2/18/25. LPN-I informed Surveyor that R95 was impulsive and transferred herself no matter how much staff prompted R95 not to self-transfer. Surveyor asked the LPN-I where CNAs get their information for resident care and toileting programs like the one R95 is on related to falls. LPN-I informed Surveyor that LPN-I did not really know where the CNA would find the toileting programs for residents. LPN-I informed Surveyor that LPN-I just knew the nursing end of the charting and LPN-I has little familiarity with that (referring to CNA documentation) charting. RN-G called over to Surveyor from RN-G's office that R95 was recently made a Hoyer (sic)(mechanical lift) and the family doesn't want anything else done for R95 and the doctor thinks R95 had a stroke recently. On 06/11/25, at 12:39 PM, Surveyor interviewed Occupational Therapist (OT)-J. OT-J informed Surveyor that R95 was being discharged from therapies because R95 is not tolerating therapy at this time. OT-J informed Surveyor the facility is a no lift facility, so therapy makes recommendations for safe staff transfers. OT-J informed Surveyor therapy will turn in a care giver training plan to restorative and RN-G implements that transfer status. Physical Therapist (PT)-K came into the office and informed Surveyor that R95 was downgraded to a Hoyer lift from a 1 assist transfer because of R95's recent decline. OT-J informed Surveyor therapy will train the facility staff and on 6/9/25 nursing was informed that R95 was downgraded to using a Hoyer lift for all transfers. On 06/11/25, at 03:20 PM, Surveyor informed Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, Senior Leader-H of concerns with LPN-I transferring R95 alone, without a gait belt despite R95's care plan going back to February indicating a hoyer lift and two staff were to be used. Surveyor informed NHA-A that staff Surveyor interviewed were not aware of R95's prompted toileting fall intervention placed on the care plan on 2/18/25 to prevent falls and that R95 required the use of a Hoyer with 2 staff for transfers.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Estates of Countryside, Inc	1130 Collins Road Jefferson, WI 53549

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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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure residents received the necessary behavioral health care and services to maintain the highest practicable mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care for 1 (R51) of 8 residents reviewed for mood concerns. R51 told a Certified Nursing Assistant (CNA) they did not want to live. No documentation was found that a suicidal evaluation was completed, the physician was notified, or a Care Plan was developed to address R51's depression. Findings include: The facility policy and procedure titled Suicidal Ideation dated 10/2024 documents: POLICY: Facility staff will accurately assess, differentiate, and respond appropriately to individuals expressing suicidal ideation or passive death wishes, ensuring safety, appropriate intervention, and documentation. DEFINITIONS: Suicidal Ideation (SI): Thoughts of ending one's life, which may include a plan, intent, or means to act. Passive Death Wish (PDW): A desire to be dead or not wake up, without an active plan, intent, or behavior to end one's life. PROCEDURE: 1. Residents will be screened for mood disturbances using the PHQ-9 upon admission and, at minimum, quarterly thereafter. 2. If resident expresses passive death wishes, resident will be offered psychosocial support, which may include a referral to the psychologist. 4. If resident does not express a feasible plan with intention, suicidal ideation should be considered passive and care plan should be developed. R51 was admitted to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis following a cerebral infarction, diabetes, heart failure, legal blindness, bilateral hearing loss, adjustment disorder with mixed anxiety and depressed mood, and mild cognitive impairment. R51's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented R51 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 and did not have any symptoms of depression with a PHQ-9 (patient health questionnaire) score of 0. R51 had received psychological services from an outside provider that came to the facility for visits. R51 had discontinued services in February 2024 due to stabilization of depressed mood. Surveyor noted no Care Plan was initiated to address R51's depression to include how depression was manifested for R51 or interventions to address those manifestations. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/7/2025, R51 was seen by a psychologist to evaluate R51 for depression. The psychologist conducted a PHQ-9 and R51 scored 8 indicating mild depression. R51 displayed depressed mood, loss of interest, fatigue, poor concentration, difficulty relaxing and fears. The psychologist documented R51 denied having a poor appetite however was having a difficult time staying awake during meals due to hypersomnia. R51 denied any suicidal ideation. The treatment plan was to have individual psychotherapy 2-4 times per month to remediate symptoms of mental health such as depressed mood, anxious mood, and pain management through use of evidence-based adaptive coping strategies and skill. R51 agreed to the psychological consult and treatment. On 4/14/2025 at 11:21 PM in the progress notes, Registered Nurse (RN)-Y documented a CNA reported to RN-Y that R51 was refusing cares and meals. R51 does not want to live. RN-Y advised the CNA to report this to Social Services. At 11:38 PM in the progress notes, RN-Y documented Nursing Home Administrator (NHA)-A was updated on R51's status. No documentation was found indicating an assessment was completed after R51 verbalized the desire not to live. No Care Plan was initiated to address R51's statement of not wanting to live. No documentation was found indicating R51's psychologist was informed of R51's statement of not wanting to live. On 5/2/2025, R51 was admitted to the hospital with altered mental status and was readmitted to the facility on [DATE]. On 5/14/2025, R51 was admitted to hospice services with an admitting diagnosis of cerebral infarction. A Hospice Care Plan was initiated at that time and addressed discussion and acceptance of impending end of life. R51's Significant Change MDS assessment dated [DATE] documented R51 was cognitively intact with a BIMS score of 13 and was moderately depressed with a PHQ-9 score of 10. The Care Area Assessment (CAA) for Mood documented R51 had moderate depressive symptoms, and a care plan should be developed to address R51's mood. Surveyor noted no mood care plan was initiated. On 5/27/2025, R51 was seen by the psychologist and the psychologist documented R51 was receiving hospice services and may benefit from psychiatric treatment as opposed to psychotherapy at this point. No documentation of follow up to a psychiatrist was found. In an interview on 6/11/2025 at 11:16 AM, Surveyor asked RN-Y if RN-Y could recall the event on 4/14/2025 and the conversation with a CNA stating R51 did not want to live. RN-Y reviewed the progress notes from 4/14/2025 and recalled being told R51 was refusing cares and meals and made the statement R51 did not want to live, but could not recall which CNA had approached RN-Y. RN-Y stated RN-Y told the CNA to let the social worker know but was not sure who the social worker was at that time. RN-Y was not sure what happened with R51 after the statement was made. RN-Y stated RN-Y informed NHA-A because that is what RN-Y documented but did not have any further information. RN-Y stated RN-Y did not follow up with R51 as to R51's state of mind at that time. RN-Y stated something should have been implemented but did not know what that would be. RN-Y stated R51 had recently been put on hospice. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 6/11/2025 at 11:37 AM, Surveyor asked Director of Social Services (DSS)-Z when DSS-Z started working at the facility. DSS-Z stated DSS-Z started working at the facility in March 2025. Surveyor asked DSS-Z if DSS-Z was aware of R51's statement on 4/14/2025 of not wanting to live. DSS-Z read R51's progress notes from 4/14/2025 out loud so NHA-A, who was in the room, could hear what the progress note said. DSS-Z stated R51 is not suicidal. DSS-Z stated R51 was failure to thrive and declining in condition, so they had a conversation about hospice and R51 was admitted to hospice services. DSS-Z stated the verbiage of not wanting to live is not suicidal. DSS-Z stated they have parameters that they would put in place at that time if someone was suicidal. Surveyor asked how the facility would determine if a resident was suicidal or not. DSS-Z stated they would do a depression assessment, the PHQ-9, to show that. Surveyor asked DSS-Z if the facility did a PHQ-9 at that time. DSS-Z stated R51 was not suicidal. Surveyor noted no assessment was completed to determine if R51 was or was not suicidal or what was meant by R51's statement of not wanting to live. No documentation was found indicating anyone approached R51 at that time to determine R51's state of mind. Surveyor stated to NHA-A that RN-Y documented NHA-A was told of R51's statement of not wanting to live. NHA-A had no recollection of being informed of R51's statement. In an interview on 6/12/2025 at 1:16 PM, Surveyor shared with DSS-Z the concern R51 did not have a care plan to address depression. DSS-Z stated behaviors and depression are addressed in different sections of the care plan. Surveyor shared with DSS-Z the concern R51's manifestations of depression are not documented and there are no interventions to address the depression. Surveyor noted the care plan with behavioral symptoms are for agitation but not for depression. On 6/12/2025 at 3:01 PM, Surveyor shared with NHA-A and Director of Nursing (DON)-B the concern R51 refused cares and meals on 4/14/2025 and stated R51 did not want to live. The statement was never followed up on with an assessment to determine the degree of depression, no call was made to psych services that R51 already had in place, and no mood or depression care plan was created even after the Significant Change MDS assessment triggered the Mood CAA where it was documented a care plan would be initiated to address mood.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure the drug regimen of each resident was reviewed at least once a month by a licensed pharmacist, and that irregularities identified by the pharmacist were reviewed, and action was taken to address them, for 1 (R39) of 5 residents reviewed. R39 did not have regular monthly reviews performed by the pharmacist. Findings include: The facility's policy titled, Medication Regimen Reviews (MMR) Scheduled and Interim and dated 01/2022, documents the following: The consultant pharmacist will review the medication regimen, as required by State and Federal regulations. This review should include a review of the resident's medical record. The consultant pharmacist's MMR report or the interim MMR report will be given to the director of nursing (or designee), upon completion of all medication regimen reviews. The facility nursing staff will follow up with the prescribing physician and record the response on the report and/or the interim review and make changes as ordered by this physician, within a reasonable time frame. The completed original reports and/or interim reviews will be kept at the facility. R39 is a [AGE] year-old resident who was admitted to the facility on [DATE]. R39's diagnoses include pulmonary embolism (blood clot in the lungs), paraplegia (a type of paralysis that affects the lower half of the body), Parkinson's Disease (a progressive nervous system disorder that affects movement), Alzheimer's disease (a progressive brain disorder that slowly destroys memory, thinking skills, and eventually, the ability to carry out the simplest tasks), dementia (memory loss), mood disturbance and anxiety, depression, and anxiety disorder. R39's Quarterly Minimum Data Set (MDS) completed on 5/27/25, documents R39 as having a Brief Interview for Mental Status (BIMS) score of 14, indicating R39 is cognitively intact. Surveyor reviewed R39's Electronic Medical Record (EMR) which documents the Registered Pharmacist (RPh) performed the following monthly medication reviews: 5/12/25 - no recommendations after review from RPh 3/11/25 - no recommendations after review from RPh 2/3/25 - no recommendations after review from RPh 12/20/24 - no recommendations after review from RPh (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor notes R39's EMR did not include monthly medication reviews in January 2025 and April 2025. On 6/12/25, at 12:55 PM, Surveyor notified Nursing Home Administrator (NHA)-A that R39's EMR did not include monthly medication reviews in January 2025 and April 2025 and requested documentation if available. On 6/12/25, at 3:18 PM, Surveyor notified NHA-A and Director of Nursing (DON)-B of concerns with R39 not having a monthly pharmacy review performed in January 2025 and April 2025. NHA-A and DON-B acknowledged the concern. DON-B stated R39 was hospitalized in April and did not trigger again for the pharmacist to review after R39 had returned from the hospitalization. Surveyor requested additional information if available.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2.) R94 was admitted to the facility on [DATE]. R94's diagnoses include Atrial Fibrillation (a heart condition that causes an irregular pulse rate) and Hypertension (High blood pressure). R94's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/25/25 documents R94 as being rarely to never understood. R94's Quarterly MDS with an ARD of 4/25/25 documents that R94 received an anticoagulant (a medication that thins ones blood to prevent clotting) medication during the 7 day assessment period. Surveyor reviewed R94's Electronic Medical Record (EMR) which documents R94's current physician orders, Medication Administration Record (MAR), and Treatment Administration Record (TAR). R39 is prescribed Eliquis 5 mg two times a day for Atrial Fibrillation, last ordered on 10/25/24. Surveyor reviewed R94's MAR and TAR. Surveyor noted there is no documented monitoring of R94's Eliquis, an anticoagulant medication, for potential signs and symptoms of an adverse effect from this medication, such as bleeding, bruising, or fatigue. On 6/12/25 at 12:45 PM, Surveyor notified Nursing Home Administrator (NHA)-A of R94 receiving Eliquis, an anticoagulant medication, with no documented monitoring for signs and symptoms of potential side effects. No further information was provided by the facility at this time. Based on record review and interview the facility did not ensure 2 (R39 and R94) of 5 residents drug regime reviewed was free from unnecessary medications. *R39 receives an anticoagulant (Eliquis) in which the facility did not adequately monitor. *R94 receives an anticoagulant in which the facility did not adequately monitor. Findings include: 1.) R39 is a [AGE] year-old resident who was admitted to the facility on [DATE]. R39's diagnoses include pulmonary embolism (blood clot in the lungs), paraplegia (a type of paralysis that affects the lower half of the body), Parkinson's Disease (a progressive nervous system disorder that affects movement), Alzheimer's disease (a progressive brain disorder that slowly destroys memory, thinking skills, and eventually, the ability to carry out the simplest tasks), dementia (memory loss), mood disturbance and anxiety, depression, and anxiety disorder. R39's Quarterly Minimum Data Set (MDS) completed on 5/27/25, documents R39 as having a Brief Interview for Mental Status (BIMS) score of 14, indicating R39 is cognitively intact. Surveyor reviewed R39's Electronic Medical Record (EMR) which documents R39's current physician orders, Medication Administration Record (MAR), and Treatment Administration Record (TAR). R39 is prescribed Eliquis 5 mg two times a day for history of pulmonary embolism, last ordered on 4/3/25. Surveyor reviewed R39's MAR and TAR, and notes there is no monitoring of R39's Eliquis for potential signs and symptoms of an adverse effect from this medication, such as bleeding, bruising, fatigue, dizziness, etc. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/25, at 12:54 PM, Surveyor interviewed Registered Nurse (RN)-U who indicates staff monitor residents who are taking an Anticoagulant such as Eliquis for potential side effects. RN-U states staff look for bleeding or bruising and document in the MAR or TAR. RN-U states if a resident has a fall and is taking an Anticoagulant, the resident will be sent out to the emergency room (ER) for evaluation. On 6/12/25, at 3:18 PM, Surveyor notified Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B of concerns with R39 taking Eliquis with no monitoring for signs and symptoms for potential side effects. NHA-A and DON-B acknowledged the concern. Surveyor requested a policy for Anticoagulant monitoring if available. DON-B notified Surveyor the facility does not have a policy for Anticoagulants such as Eliquis or Xarelto however, the facility has a policy for Warfarin monitoring. No further information was provided by the facility at this time.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview and record review, the facility did not ensure food was prepared and served in a form designed to meet individual needs for 1 (R25) of 1 residents reviewed for a mechanically-altered diet. R25 has a mechanical soft diet order, R25 was served a regular diet meal. Findings include: The Facility Policy titled Regular Ground/Mechanical Soft dated 7/2023, documents (in part): Purpose The regular mechanical soft diet is for adults who have difficulty chewing. This diet is similar to the regular diet with some modifications to hard to chew foods. This diet is not intended to be used for modifications required by the National Dysphagia Diets. Rationale Foods that are difficult to chew are replaced with foods that have been altered into a form that can be easily swallowed. Food that may be modified because they are tough and difficult to chew include meats, poultry, fish, raw vegetables, and other fibrous foods . According to Healthline.com A mechanical soft diet is a texture-modified diet that restricts foods that are difficult to chew or swallow. It's considered Level 2 of the National Dysphagia Diet in the United States. Foods can be pureed, finely chopped, blended, or ground to make them smaller, softer, and easier to chew. It differs from a pureed diet, which includes foods that require no chewing. Surveyor observed lunch being served in the 600 unit. Aide-V prepared one plate with food that was to be a mechanical soft consistency and serve the plate to a resident. Aide-V later plated a second mechanical soft meal, which the Dietary Director-C declined taking. The plate was set to the side. The mechanical soft meal included minced ham, soft cooked broccoli, macaroni and cheese, and a dinner roll. On 06/09/25, at 12:01 PM, Surveyor interviewed Aide-V and asked how many residents on the unit were prescribed a mechanical soft diet and was told two. Surveyor stated that only one was served, the other plate was set to the side. Aide-V walked over to the table where the two residents prescribed mechanical soft diets sat and removed the regular diet plate that was served incorrectly to R25. R25's physician order with a start date of 1/14/25 documents Mechanical Soft texture, Thin Liquids consistency. On 06/10/25, at 10:51 AM, Surveyor discussed the concern of the mechanical soft meal not being served to R25 with Dietary Director-C. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/10/25, at 03:13 PM, during the end of day meeting, Surveyor informed Nursing Home Administrator-A and Director of Nursing-B of the concern that R25 had a regular diet meal served instead of a mechanical soft meal. No further information was provided as to why the wrong diet was served to R25.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility did not provide adaptive eating equipment to 1 (R95) of 1 sampled resident reviewed for assistive eating devices. Surveyor observed R95 did not receive therapy recommended assistive eating devices needed to maintain or improve R95's ability to eat or drink independently during 2 out of 3 Surveyor observed meals. Finding include: Facility Clinical Practice Guidelines titled; Feeding a Resident dated 09/20. Policy: Residents who need assistance will be fed a well-balanced meal, by a nurse, C.N.A. (certified nursing assistant), or an individual who has completed a state approved feeding course Procedure: 3. Check the tray before serving the meal to make sure everything is on the tray and it is accordance with the resident's diet. Correct anything wrong 9. Use appropriate utensil and adaptive equipment to feed the resident R95 was initially admitted to the facility on [DATE] with diagnoses that included Unspecified Dementia (a decline in mental ability severe enough to interfere with daily life, affecting memory, thinking, language, and judgment), Vitamin D deficiency (nutritional deficiency of vitamin D), and Deficiency of other specified group B vitamins (nutritional deficiency of B vitamins). R95's Quarterly Minimum Daily Set (MDS) with an assessment reference date of 3/13/25 documents Under Section C cognitive patterns a Brief Interview for Mental Status score of 6 indicating R95 having severe cognitive impairment. Under section GG Functional abilities and goals documents R95 as being independent with eating. R95's GG (functional abilities and goals) screener dated 6/10/25 documents for eating, R95 completes activity. Assistance may be provided throughout the activity or intermittently. R95's Occupational Therapy note dated 5/29/25. At 04:20 PM documents, This OTA (occupational therapy assistant) spoke with OTR (occupational therapist registered) on 5/28/25 about patient's recent right-hand wrist drop issue. Right hand appears to have a small bruise on right wrist area. Patient stated I don't even know how I hurt my hand. Right versus left measurements are as follows hand grip is 2#/30#, and 3-point pinch is 1#/2#. This OTA provided patient instruction on how to use built up handled spoon with left hand to inc (increase) her I (independence) while feeding herself. OTR plans on S/U (setting up) goals for self-feeding d/t (due to) recent issue. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R95's Occupational Therapy note dated 5/30/25, at 11:31 AM documents, Staff were instructed in wear and care of right hand WHO (wrist hand orthotic) and use of tubigrip under for skin integrity management. Patient reported comfort with use. Discussed lack of active wrist extension and digit extension with floor nurse, as well as lean to right side this morning. Nursing agreed with change of condition and was communicating with appropriate medical team. OT (occupational therapist) spoke with kitchen and requested 2 handle cups with lids and built-up utensils on trays. Therapeutic activities: dynamic balance activities during sitting and fine motor coordination training. Review of R95's CNA Task: GG-Eating indicates: built up handles on silverware, 2 handled cups with lid and cut food into small pieces during meals had daily documentation by certified nursing assistants on R95's functional ability every meal since 5/30/25, when these adapted utensils were implemented by therapy. On 06/10/25, at 08:28 AM, Surveyor observed R95 sitting bent over, with R95's head in their lap, sleeping at a table during the breakfast meal. Surveyor observed R95's cereal all over table surrounding R95's cereal bowel. Surveyor observed there were no staff by R95's table helping R95. Surveyor observed R95 had no adaptive spoons or 2 handled cups to assist in R95's meal as recommended by occupational therapy on 5/30/25. On 06/10/25, at 0829 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-I about R95's current condition. Surveyor asked LPN-I if R95 needed help in the dining room. LPN-I informed Surveyor that they are speaking today and that the family is looking at hospice for R95. LPN-I informed Surveyor that R95 has declined in abilities recently. Surveyor asked LPN-I if R95 needed help eating. LPN-I informed Surveyor it depends on R95's cognitive abilities for the day, but often R95 will still feed still herself with set up. LPN-I informed Surveyor that R95 is weaker today. On 06/10/25, at 12:20 PM, Surveyor observed lunch on the unit where R95 resides. Surveyor observed Certified Nursing Assistant (CNA)-N initially helping R95 eat and drink. Surveyor observed CNA-N was standing over R95 while helping R95 eat the meal. (Cross-reference F550). Surveyor observed that CNA-N was the only staff helping in the dining area. On 06/10/25, at 12:24 PM Surveyor observed R95 feeding self with the built-up adaptive spoon but no 2 handled cups. On 06/10/25, at 12:25 PM, Surveyor observed CNA-N came over to sit by R95 because R95 started to fall asleep. Surveyor observed CNA-N give R95 verbal cues to eat. On 06/11/25, at 08:36 AM Surveyor observed breakfast on the unit where R95 resides. Surveyor observed R95 eating cereal with a regular spoon and a regular single handle cup was in front of R95. Surveyor observed R95 feeding self very slowly with regular spoon. Surveyor observed R95 had no adaptive spoon or 2 handled cups. (continued on next page)

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	525271	A. Building B. Wing	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Estates of Countryside, Inc	1130 Collins Road Jefferson, WI 53549

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/11/25, at 11:32 AM, Surveyor interviewed LPN-I about R95's adaptive eating equipment and R95's ability to feed herself. LPN-I informed Surveyor R95 was more independent the early part of June 2025 but now R95 often needs more encouragement and set up from staff. Surveyor asked LPN-I if staffing for meals was adequate because Surveyor noted one staff available to help during one of the meals. LPN-I informed Surveyor staffing is good, we get our stuff done. Surveyor asked LPN-I why the adaptive spoon and cups were not always being used for R95. LPN-I informed Surveyor that it must been accidentally overlooked by staff because R95 needs to use the built-up spoon. Surveyor asked where staff would find the information about the adaptive eating equipment. LPN-I informed Surveyor that LPN-I doesn't really know where the CNA's would find that information because the CNA's charting is different than nursing's charting. On 06/12/25, at 09:12 AM Surveyor interviewed Occupational Therapist (OT)-J about R95's therapy and use of special equipment for meals. Surveyor asked OT-J when R95 started using the adaptive utensils at meals to facilitate independence with R95 feeding herself. OT-J informed Surveyor that OT-J believed it was sometime after 5/30/25, maybe 6/2/2025. OT-J informed Surveyor that OT-J spoke with kitchen to have built up handles on the spoons and 2 handle cups with a lid. OT-J informed Surveyor the OT-J would have to look at OT-J's notes to confirm and get back to the Surveyor. On 06/12/25, at 02:06 PM, OT-J gave Surveyor therapy notes indicating that OT-J had seen R95 on 5/30/25 and implemented the adaptive eating utensils for R95 because of R95's contractures and that OT-J informed the unit staff and the kitchen staff of R95's need for adaptive utensils at meals. OT-J informed Surveyor that it was OT-J that implemented these adaptive eating utensils for R95 on 5/30/25. Surveyor asked OT-J why these items had not made it to R95's care plan yet. OT-J informed Surveyor that OT-J gives the facility education sheet to the restorative nurse and doesn't keep a copy. OT-J informed Surveyor the restorative nurse puts these types of interventions in the resident's care plan. OT-J informed Surveyor that OT-J had spoken to staff and the kitchen and that they were made aware of the adaptive eating equipment for R95. On 06/12/25, at 09:31 AM, Surveyor interviewed Registered Nurse (RN)-G and CNA-T about R95's care plan not showing the adaptive eating equipment. RN-G informed the Surveyor that restorative will place it in the task section of the certified nursing assistants charting but that restorative is not allowed to place dietary interventions into the resident's care plan. RN-G informed Surveyor that interventions for the dietary care plan will come from an order. RN-G informed Surveyor that restorative doesn't get dietary orders because it is the dietary managers responsibility to get dietary orders. On 06/12/25, at 09:42 AM, Surveyor interviewed Dietary Supervisor-C about R95's recommendation for adaptive eating utensils. Dietary Supervisor-C informed Surveyor that nursing needs to put in the order and then it comes into the nutrition management program and then Dietary Supervisor-C will update the resident care plan. Dietary Supervisor-C informed Surveyor R95's order for adaptive equipment has not come through the nutrition management system yet so the care plan has not been updated. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/12/25, at 11:03 AM, Surveyor interviewed Corporate-AA, Assistant Administrator-F, Director of Nursing (DON)-B and Nursing Home Administrator (NHA)-A about R95's adaptive eating equipment not being used in 2 out 3 meals Surveyor observed. Surveyor asked who should have placed the order for R95's therapy's recommendation for R95 having adaptive eating equipment to maintain independence for self-feeding. NHA-A informed Surveyor that would be restorative nurse responsibility. NHA-A informed Surveyor Restorative is responsible to place that order. Surveyor expressed concern about the resident not having adaptive utensils on 2 or 3 meals and that the 5/30/25 recommendation had not been ordered or put in the care plan as of today (6/12/25). Surveyor informed NHA-A the CNA's task section had the adaptive eating equipment listed and documented by the CNA's. NHA-A informed Surveyor that the restorative nurse was new and may not have realized that these orders were the responsibility of the restorative department. NHA-A informed Surveyor the facility would make sure R95's order for adaptive eating equipment would be addressed. On 06/16/25, at 08:12 AM, NHA-A gave Surveyor a training done for R95's built up silverware done on 6/13/25 with only 4 staff signatures on the sheet. The sheet was done by a speech language pathologist. Surveyor noted on the training sheet, R95's adaptive eating equipment was documented as now being used as needed. On 06/16/25, at 08:52 AM, Surveyor interviewed OT-J on why R95's adaptive equipment was changed to being used as needed. OT-J informed Surveyor this training sheet is not from OT-J. Surveyor asked when this became an as needed intervention because in previous interviews OT-J and LPN-I informed Surveyor R95 needed the adaptive eating equipment. OT-J informed Surveyor OT-J doesn't know why the speech language pathologist wrote this as needed because OT-J was the one addressing that area. Physical Therapist (PT)-K informed Surveyor that the speech language pathologist informed PT-K that hospice asked Speech Language Pathology to reevaluate R95's need for the adaptive eating equipment on 6/13/25 because R95 was admitted to hospice on 6/13/25.

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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 ensure food was prepared and served in a sanitary manner. This practice had the potential to affect 111 of 111 residents dining in the facility. Staff did not wear beard restraints consistently in the kitchen. Findings include: The facility policy and procedure titled, Hair Covering dated 5/24, states in part: Policy Hair will be covered when in the kitchen operations areas. Purpose To prevent physical contamination of food Procedure 1. While in the kitchen operations area staff will cover hair to prevent physical contamination of food . 3. Staff with facial hair, with the exception of eyebrow and eyelashes, will wear a beard cover. Mustache or beard restraints shall be used for any facial hair exceeding half (1/2) inch in length. On 06/09/25, at 10:30 AM, Surveyor observed Dietary Director-C preparing rue with beard net not pulled up over mustache. On 06/09/25, at 10:36 AM, Surveyor observed Dietary Director-C stirring pots on stove with beard net not pulled up over mustache. On 06/09/25, at 10:48 AM, Surveyor observed Cook-W enter kitchen and start prepping food without donning a beard net. On 06/10/25, at 10:46 AM, Surveyor observed Cook-W prepping food with no beard net. On 06/10/25, at 10:51 AM, Surveyor interviewed Dietary Director-C regarding expectations for facial hair coverings. Surveyor relayed concern to Dietary Director-C of two observations of no beard net on Cook-W. Also, observations of Dietary Director-C with mustache exposed. On 06/10/25, at 03:13 PM, during the end of day meeting, Surveyor informed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B of the concern that observations were made during food preparations of beards and mustaches not covered. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 06/11/25, at 11:47 AM, NHA-A asked Surveyor to swap out the policy for hair covering that had been given previously, stating that a newer version was found. The new policy states mustache or beard restraints shall be used for any facial hair exceeding half (1/2) inch in length. Surveyor noted that the first policy given stated mustache or beard restraints shall be worn, without a length specified. On 06/11/25, at 03:33 PM, during the end of day meeting, Surveyor discussed with NHA-A and DON-B that the State of Wisconsin regulation is 1/2 inch, but the federal regulation is that no facial hair can be exposed.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure it completed accurate mandatory submission of staffing information based on payroll data in a uniform electronic format to the Centers for Medicare & Medicaid Services (CMS). This had the potential to affect all 111 residents residing in the facility. Staffing information for Quarter 2 ([DATE] - [DATE]) of the Payroll Based Journal (PBJ) was not accurately submitted to CMS. Findings include: The CMS Electronic Staffing Data Submission Payroll-Based Journal, Long-term Care Facility Policy Manual, dated [DATE], indicates: Chapter 1: Overview, 1.1 introduction .(U) mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS .1.2 Submission Timelines and Accuracy. Direct care staffing and census data will be collected quarterly and is required to be timely and accurate .Report Quarter: staffing and census data will be collected for each fiscal quarter. Staffing data includes the number of hours paid to work by each staff member each day within a quarter. Census data includes the facility's census on the last day of each of the three months in a quarter. The fiscal quarters are as follows: Fiscal Quarter, Date range: (quarter) 1 [DATE]-[DATE], (quarter) 2 [DATE]-[DATE], (quarter) 3 [DATE]-[DATE], (quarter) 4 [DATE]-[DATE] . Surveyor reviewed the PBJ Staffing Data Report, CASPER Report 1705D, for Fiscal year 2025 (run on [DATE]) which indicated the Facility had excessively low weekend staffing and a one star staffing rating for the 2nd Quarter ([DATE]-[DATE]). Surveyor reviewed the Facility's weekend schedules from [DATE] to [DATE]. Surveyor noted licensed nurses and certified nursing assistants present on each shift, for each unit. Surveyor noted these schedules included call ins, agency staff and staff who picked up shifts. Surveyor noted there did not appear to be excessive call-ins. On [DATE], at 10:47 AM, Surveyor interviewed Scheduler-X regarding staffing. Per Scheduler-X the lowest number staffed, per 24-hour period, is 20 aides and 12 nurses scheduled. The goal for a 24-hour period is 27 aides and 14 nurses/medication technicians. Surveyor reviewed the Facility Assessment and noted for Licensed Nurses/Medication Aides the minimum is 11 and Certified Nursing Assistants the minimum is 20 per 24-hour period, this was compared to the provided schedules. No discrepancies were found. (continued on next page)

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE], at 12:16 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A regarding how the facility functions when at the minimums for nursing staff per the Facility Assessment. Per NHA-A ideally, they would like more staff than those minimums, but you cannot account for call ins. The numbers in the Facility Assessment are the absolute minimum to run the facility. Surveyor stated that the facility triggered for one star staffing and low weekend staffing, was there an issue with how the data was reported to CMS. NHA-A stated they were confused because don't get much info from CMS, NHA-A got a report from CMS and quickly went through it. NHA-A thought there was a reporting error, then went back through and then figured out it was ancillary staff. Surveyor asked if it was the ancillary staff then why not trigger every quarter and NHA-A didn't know. Corporate sends information from payroll department and agency hours pull in as well, all hours get sent. NHA-A then stated that there was one error with reporting. A Licensed Practical Nurse graduated in December and got licensed in December or early January. The nurse was still being reported as an aide. This was just changed a couple weeks ago so will be fixed for second quarter. On [DATE], at 01:47 PM, Surveyor interviewed Scheduler-X regarding each unit having multiple residents that use the mechanical lift. If a NOC shift person calls in, then the remaining aides split a unit. Surveyor asked how the unit is covered. Per Scheduler-X the nurse oversees the unit, and the remaining two aides watch the call lights and switch off on answering. All residents still get the regular two-hour rounds. Surveyor asked if residents were safe with staffing at the minimum numbers. Scheduler-X replied that residents aren't not (sic) being attended to, they aren't not (sic) getting care. Per Scheduler-X some staff will come in early to help when there are call ins. Surveyor asked if Scheduler-X had access to call light logs and was told no. Surveyor stated there are 35 residents who have elected full code, how can two nurses on NOC handle that. Scheduler-X stated that there are two full time night shift aides that took the cardiopulmonary resuscitation (CPR) class. The Medication Technicians have taken CPR class as well. On [DATE], at 02:14 PM, Surveyor spoke with NHA-A regarding the data regarding staffing not being accurately submitted. No additional information was provided. On [DATE], at 07:25 AM, Per NHA-A they spoke with corporate, and the payroll system being used was changed to a new vendor. The reporting was supposed to be fixed for 1st quarter, but it was not. NHA-A stated this has been taken care of.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, 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 for 2 (R32, R74) of 6 residents observed. *R32 was readmitted to facility on 5/13/25 with a hospital acquired stage 3 pressure injury. R32 was placed on Enhanced barrier precautions (EBP) on 5/13/25. Surveyor observed on 6/9/25 R32 had no indication that R32 was on EBP. Care Plan documents R32 continued EBP until 6/12/25 when the facility discontinued EBP for a stage 3 pressure ulcer not yet healed. Surveyor observed R32's wound care on the stage 3 coccyx pressure ulcer on 6/11/25 with nurse not following EBP during R32's treatment. *R74 was observed by Surveyor on 6/9/25 [NAME] with drainage on R74's bandaged leg wounds and not in Enhanced Barrier Precautions (EBP) until 6/10/25. R74's care plan has no documentation of R74 being on EBP for R74's 4/25/25 hospital readmission to the facility with a hospital acquired stage 3 coccyx pressure injury. Findings include: Facility policy titled ENHANCED BARRIER PRECAUTIONS dated 12/24 POLICY: Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) in nursing homes. As well as to prevent multi-drug resistant organism acquisition of those with an increased risk of acquiring MDROs including residents with a chronic wound or an indwelling medical device. GUIDELINES: 1. EBP involves gown and gloves use during high-contact resident care activities for residents known to be infected or colonized with MDROs when contact precautions do not otherwise apply. As well as residents with a chronic wound and/or indwelling medical device. 2. The facility will use a risk-based approach (critical thinking} to determine which type of precautions, if any, are warranted. After completing the risk based assessment (critical thinking) the facility will determine if residents with more common MDROs (MRSA, VRE, and ESBL-producing Enterobacterales) need EBP. 3. A subset of targeted MDROs is considered an extensively drug resistant organism (XDRO). ALL those infected or colonized with an XDRO will require EBP for the duration of their stay at the facility, unless contact precautions are warranted. a. Candida auris (CA). b. Carbapenemase-producing Enterobacteriaceae (CRE). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Carbapenemase-producing Acinetobacter baumannii (CRAB). d. Carbapenemase-producing Pseudomonas aeruginosa (CRPA). PROCEDURE: 1. High-Contact Resident Care Activities include the following: a. Dressing. b. Bathing/Showering. c. Transferring. d. Changing linens. e. Providing hygiene. f. Changing briefs or assisting with toileting. g. Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator. h. Wound care. 2. Residents that have indwelling medical devices, regardless of MDRO status, will be on EBP. a. Some examples may include central vascular line (including hemodialysis catheter), urinary catheter, feeding tube, tracheostomy, and ventilator (excludes peripheral IVs). b. Devices that are fully embedded within the body (e.g., pacemakers) would not be an indication for ESP. c. Other devices such as a colostomy, ileostomy, or a Jackson Pratt (JP) drain would not require EBP. 3. Residents that have a wound requiring a dressing, regardless of [NAME] status, will require ESP. a. Types of wounds where ESP would be indicated include, but are not limited to: pressure ulcers, diabetic foot ulcers, arterial, chronic wounds (e.g., wound vacs) a wound that is not well-approximated (not healing as intended) and chronic venous stasis ulcers. b. Fresh/healing surgical wounds is not an indication for EBP. c. Residents with draining wounds that cannot be contained (e.g., residents who cannot maintain adequate hygiene), or the resident has an infection or condition listed in CDC's (Centers for Disease Control) Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. Post the CDC EBP sign outside of the resident's room. e. Gown and gloves use prior to the high-contact care activity (change PPE before caring for another resident). f. Eye protection may be needed if performing activity with risk of splash or spray (e.g., wound irrigation). 4. Make PPE available and accessible outside of the resident's room (each room does not need their own set-up). 5. Ensure that alcohol-based hand rub is accessible for hand hygiene as needed. 6. Provide a trash receptacle at the exit of the resident's room for discarding PPE after removal and before exiting the room, or before providing care to another resident in the same room. 7. When entering the resident's room for reasons other than to provide high contact resident care activities, use of gown and gloves are not required. Instead, perform hand hygiene prior to entering and exiting the room. 8. Residents are not restricted to their rooms or from group activities when EBP is in place. 9. EBP does not replace existing guidance for the use of contact precautions for other pathogens. Contact precautions still need to be used for infected or colonized residents in certain situations, including but not limited to, C. difficile, norovirus, scabies, shingles (until the lesions are dry), etc. 10. EBP can be discontinued when chronic wounds heal or indwelling medical devices are removed. Memorandum QSO-24-08-NH on 3/20/24 from the Center for Clinical Standards and Quality/Quality, Safety & Oversight Group documents: Subject: Enhanced Barrier Precautions in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs). EBP are indicated for residents with any of the following: o Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply; or o Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. Wounds generally include chronic wounds, not shorter-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage (e.g., Band-Aid®) or similar dressing. Examples of Page 3 of 5 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. Document/Room Signage titled, (STOP) Enhanced Barrier Precautions documents: Everyone Must: Clean their hands, including before entering and when leaving the room. Providers and Staff Must Also: Wear gloves and a gown for the following activities. Dressing, Bathing/Showering, Transferring, Changing Linens, providing hygiene, changing briefs or assisting with toileting. Device care or use: central line, urinary catheter. Feeding tube, tracheostomy. Wound Care: any skin opening requiring a dressing. Do not wear the same gown and gloves for the care of more than one person. 1.) R32 was initially admitted to the facility on [DATE] with diagnoses that included Chronic Obstructive pulmonary Disease (lung disease that stops air flow), Congestive Heart Failure (Chronic condition causing heart to not pump blood efficiently), Polyneuropathy (central nervous system disorder causing numbness, weakness, pain primarily in distal parts of the arms and legs). R32's significant change in condition Minimum Daily Set (MDS) with an assessment reference date of 3/24/25 documents Under Section C cognitive patterns a Brief Interview for Mental Status score of 15 indicating R74 has intact cognition. Under section M Skin Conditions documents R74 as having 0 pressure injuries. R32's (name of a wound physician group) wound consultation completed 5/13/25, the day of R32's readmission from hospital, documents R32's stage 3 coccyx wound: Wound Size (L x W x D): 3 x 1 x 0.2 cm Surface Area: 3.00 cm² Exudate: Moderate Sero - sanguineous R32's (name of a wound physician group) wound consultation day of R32's readmission from hospital dated 6/03/25 documents R32's stage 3 coccyx wound: (continued on next page)

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Alden Estates of Countryside, Inc	1130 Collins Road Jefferson, WI 53549

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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 - Few	Wound Size (L x W x D): 2 x 0.7 x 0.1 cm Surface Area: 1.40 cm² Exudate: Light Sero - sanguineous Granulation tissue: 100 % Wound progress: Improved evidenced by decreased surface area R32's Nursing Note dated 5/13/25, at 08:19 AM, documents Late Entry: Day of Antibiotic Therapy: DAY 1. What day if beyond 14: Temperature: T 98.8 - 5/13/2025 04:43 Route: Forehead (non-contact) What antibiotic being used for: Other. Other Type: Sepsis Antibiotic & Delivery Method: Ertapenem Sodium 1 GM IV via midline x 2 days Reaction to Medication: NO Sign and Symptoms of Infection: NO Signs or Symptoms of infection Exhabiting {SIC} the following signs & symptoms: Precautions: Contact Summary (if applicable): Enhanced Barrier Precautions r/t (related to) midline and wound R32's Alteration in Skin integrity care plan documents: Pressure ulcer(s) on coccyx present on admission date initiated 05/13/25. Intervention section documents: Enhanced Barrier Precautions will be implemented during high contact resident care activities for chronic wounds including, but not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis Ulcers Date Initiated: 05/13/2025 Resolved Date: 06/12/2025. R32's physician's order dated 05/13/25 at 09:33 AM and discontinued 6/3/25 at 01:13 PM, documents: Maxorb II 2 X 2, Apply to coccyx topically every day shift, every Tue, Thu, Sat for Skin Condition CLEANSE AREA W/NS, AND APPLY medihoney, f/b alginate and a foam border. R32's physicians order dated 6/3/25, at 01:12 documents: Zinc Oxide Ointment 20 % Apply to coccyx topically every shift for Skin Condition. On 6/9/25, at 0936 AM, Surveyor interviewed R32. Surveyor asked R32 if R32 had any concerns. R32 informed Surveyor that R32 has a big sore on R32's bottom. Surveyor asked R32 how R32 developed that sore on her bottom. R32 informed Surveyor R32 had a stay in the hospital and that R32 went for my heart a couple months ago. Surveyor asked R32 if R32 ever had people care for R32 in the last month wearing gowns, masks and gloves and a little cart outside of the room or heard the word precautions or isolation. R32 informed Surveyor that R32 did not recall that happening. (continued on next page)

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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 - Few	On 06/10/25, at 12:44 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-M R32 was placed into placed into EBP after R32's readmission in mid-May 2025. LPM-M informed Surveyor that LPN-M could not recall if R32 was in EBP since May 2025. Surveyor asked LPN-M if LPN-M could find out if R32 was placed in EBP. LPN-M informed Surveyor that LPN-M would find out for the Surveyor. On 06/10/25, at 12:55 PM, Surveyor was approached by LPN-M. LPN-M informed Surveyor that LPN-M spoke to Director of Nursing DON-B and DON-B informed LPN-M that the infection control-Assistant Director of Nursing (ADON)-D makes the decision which residents go into EBP. On 06/10/25, at 01:17 PM, Surveyor interviewed ADON-D about the facilities enhanced barrier precaution procedures. Surveyor asked ADON-D why if R32 placed into EBP after R32's readmission from the hospital. ADON-D informed Surveyor the ADON-D could not recall off hand if R32 was placed in EBP, but could check with DON-B. ADON-D informed Surveyor we have no wound nurse currently, so DON-B is the acting wound nurse, and she sees residents on wound rounds with the wound doctor weekly. Surveyor asked ADON-D when ADON-D should place a resident in EBP. ADON-B informed Surveyor any chronic wounds, wounds needing dressings to contain drainage, Foley catheters, Multi Drug Resistant Organisms) MDRO's, PICC (long term intravenous) lines, tube feeding, pressure ulcers, and diabetic ulcers. Surveyor asked ADON-D if all stage 3 pressures ulcers would be placed into EBP. ADON-D informed Surveyor that stage 3 pressure ulcers would be placed into EBP. Surveyor asked ADON-D if a resident still some drainage from a wound had (Surveyor noted the wound note for R32's stage 3 coccyx documented on 6/3/25 light serosanguineous drainage), and especially if it was a stage 3 pressure ulcer would the resident typically be in EBP. ADON-D informed Surveyor stage 3 pressure ulcers are typically placed in EBP. On 06/11/25, at 07:19 AM, interviewed Occupational Therapist (OT)-J about R32's therapy. Surveyor noticed therapies went into R32's room. Surveyor asked OT-J if OT-J remembered any EBP that R32 was may have been in recently when therapy worked with R32. OT-J informed Surveyor that OT-J couldn't recall if R32 was in EBP or not. On 06/11/25, at 09:21 AM, Surveyor interviewed R32 about R32's pressure injury of the coccyx. R32 informed Surveyor that R32's bottom getting better and that the cushion in R32's chair helped with R32's comfort. On 06/11/25, at 01:52 PM, Surveyor observed Therapy working with R32 with no personal protection equipment. On 06/11/25, at 01:59 PM, Surveyor observed R32's wound care with DON-B. DON-B informed Surveyor that the wound has epithelial tissue closing around wound and R32's wound was getting close to being closed. Surveyor observed good hand hygiene with gloves with no other enhanced barrier precautions (EBP) being followed. Surveyor noted R32's care plan documents R32 is still in EBP. Surveyor noted small area in middle of R32's stage 3 pressure area is still open and R32 was wearing a disposable brief. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/11/25, at 02:11 PM, Surveyor interviewed DON-B following R32's treatment by DON-B. Surveyor asked DON-B if DON-B found the information Surveyor requested on basing pressure ulcers as chronic wounds must be over 30 days and if pressure ulcers had to have a traditional dressing. DON-B informed Surveyor that DON-B and corporate are still looking for that information. DON-B informed Surveyor that R32's wound was not draining and that it had no dressing so R32 should not be in EBP any longer. Surveyor asked DON-B while R32's wound is almost closed it is not completely closed and DON-B could not provide when R32's EBP ended. Surveyor informed DON-B that as of today R32's care plan indicates that R32 is still in Enhanced barrier precautions. DON-B replied to Surveyor oh. On 06/11/25, at 09:57 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A and DON-B Surveyor asked DON-B you would agree with the ADON-D that stage 3 pressure ulcers should be in EBP. Surveyor asked DON-B why R32 did not have an EBP sign and cart outside R32's room when R32 was in EBP and had a stage 3 pressure ulcer. DON-B informed Surveyor that yes stage 3 pressure wounds should be in EBP, but that any wound that no longer needing a dressing did not require EBP and that DON-B was checking with corporate for the information to verify that. 2.) R74 was initially admitted to the facility on [DATE] with diagnosis that included Chronic Obstructive pulmonary Disease, Type 2 Diabetes Mellitus, and Congestive Heart Failure. R74's Quarterly Minimum Daily Set (MDS) with an assessment reference date of 4/29/25 documents Under Section C cognitive patterns a Brief Interview for Mental Status score of 15 indicating R74 has intact cognition. Under section M Skin Conditions documents R74 as being readmitted on [DATE] with a stage 3 pressure ulcer. R74's (name of a wound physician group) wound consultation dated 4/29/25 documents R74's stage 3 coccyx wound: Wound Size (L x W x D): 1.5 x 1 x 0.2 cm Surface Area: 1.50 cm² Exudate: Moderate Sero - sanguineous Slough: 20% Granulation tissue: 80% R74's (name of a wound physician group) wound consultation dated 6/3/25 documents R74's stage 3 coccyx wound: Wound Size (L x W x D): 0.3 x 0.3 x 0.1 cm Surface Area: 0.09 cm² Exudate: Light Sero - sanguineous (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Granulation tissue: 100% Wound progress: Improved evidenced by decreased depth, decreased necrotic tissue, decreased surface area R74's nursing noted dated 6/4/25, at 06:12 PM, documents, Day of Antibiotic Therapy: DAY 5 What day if beyond 14: Temperature: T 98.2 - 6/4/2025 09:32 Route: Tympanic What antibiotic being used for: Cellulitis Other Type: Antibiotic & Delivery Method: Cephalexin Tablet 500 MG q (every) 12 hrs (hours) x (for) 7 days Reaction to Medication: NO Sign and Symptoms of Infection: Signs and Symptoms of infection are present (Describe below) Exhibiting the following signs & symptoms: skin is red, warm, swollen, and draining Precautions: Not Applicable Summary (if applicable): R74's physician's order dated 04/30/25, at 10:53 PM, discontinued on 06/03/25 at 08:36 PM documents: Maxorb II 2 X 2, Apply to left buttock/coccyx topically every day shift for Skin Condition CLEANSE AREA W/NS (with normal saline) apply Maxorb and foam border, R74's physician's order dated 06/02/25, at 02:25 PM, discontinued on 06/04/25 at 02:23 PM, documents: Clean & dry BLE (bilateral lower extremities). Apply ABD (abdominal) pads to weeping areas & cover with Kerlix & tubigrips. every day shift for SKIN CARE. R74's physician's order dated 06/08/25, at 02:05 PM, discontinued on 06/15/25 at 03:53 PM, documents: Vaseline Petrolatum Gauze External Pad (Wound Dressings) Apply to BLE topically every morning and at bedtime for Wound Therapy On 6/9/25, at 10:45 Surveyor interviewed R74. Surveyor asked R74 how R74 was doing today. R74 informed Surveyor that R74 was doing fair. Surveyor asked R74 if people ever had taken care of R74 with gowns and a cart outside of R74's for R74's wound on their bottom or leg. R74 informed Surveyor that R74 thought that when R74 was sick a while back but doesn't remember. (Surveyor did note in the medical record that R74 was in contact and droplet precautions when R74 returned from hospital on 4/25/25 and removed from precautions on R74's care plan on 4/28/25 for Metapneumovirus). CNA-MM entered R74's room during the interview. Surveyor asked CNA-MM if R74 was ever in EBP or is in EBP. CNA-MM informed Surveyor that CNA-MM did believe that R74 was on precautions recently. On 6/10/25 Surveyor noted R74 was placed in EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/10/25, at 12:44 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-M on why R74 was placed into EBP today, 6/10/25. LPN-M informed Surveyor LPN-M's guess was that Director of Nursing (DON)-B placed R74 in Enhanced Barrier precautions because of R74's bilateral wounds to R74's lower legs but was not sure. LPN-M shared they would find out for the Surveyor. Surveyor asked LPN-M if LPN-M recalls if R74 was in EBP after R74's return from the hospital in late April 25 or Early May 25. LPN-M informed Surveyor that LPN-M did not recall if R74 was in EBP prior to 6/10/25. On 06/10/25, at 12:55 PM, Surveyor was approached by LPN-M. LPN-M informed Surveyor that LPN-M spoke to Director of Nursing DON-B and DON-B informed LPN-M that the infection control-Assistant Director of Nursing (ADON)-D makes the decision which residents go into EBP. On 06/10/25, at 01:45 PM, Surveyor observed CNA-Q discussing with another CNA outside of R74's door that CNA-Q wasn't aware of why EBP was started on 6/10/25 for R74. On 06/10/25, at 01:17 PM, Surveyor interviewed ADON-D about the facility's enhanced barrier precaution procedures. Surveyor asked ADON-D why was R74 placed into EBP. ADON-D informed Surveyor R74 had closed, acute wounds that are now chronic and weeping. ADON-D informed Surveyor that DON-B noted during wound rounds this morning with the wound doctor that R74's legs were weeping and draining. Surveyor asked ADON-D about nursing notes documenting R74 had drainage back on 6/4/25. ADON-D informed Surveyor we have no wound nurse currently, so DON-B is the acting wound nurse, and she sees residents on wound rounds with the wound doctor weekly. Surveyor asked ADON-D when ADON-D should place a resident in EBP. ADON-B informed Surveyor any chronic wounds, wounds needing dressings to contain drainage, Foley catheters, Multi Drug Resistant Organisms) MDRO's, PICC (long term intravenous) lines, tube feeding, pressure ulcers and diabetic ulcers. ADON-D informed Surveyor that residents with stage 3 pressure ulcers would be placed into EBP. Surveyor asked if the wounds on R74's legs were chronic before today. ADON-D informed Surveyor ADON-D did not believe R74's legs were chronic. ADON-D informed Surveyor that with R74's lymphedema that it was unlikely they would heal quickly. Surveyor asked ADON-D if R74 was ever in EBP for R74's hospital acquired pressure injuries and when were those precautions removed. ADON-D informed Surveyor that ADON-D was not sure if R74's pressure injuries were chronic or if R74 was ever on EBP or if R74 was ever removed from EBP. Surveyor asked ADON-D if R74 had a stage 3 pressure injury. ADON-D informed Surveyor that R74 had a stage 3 pressure injury but it was resolved today 6/10/25. Surveyor asked ADON-D if a resident has some drainage from a wound and if it was a stage 3 pressure injury would the resident typically be in EBP. ADON-D informed Surveyor resident with stage 3 pressure injuries are typically placed in EBP. (Surveyor noted the wound note on 6/3/25 documents R74's stage 3 coccyx pressure injury had light drainage). Surveyor asked ADON-D which staff can place a resident on EBP. ADON-D informed Surveyor that ADON-D will place a resident on EBP, but that the floor nurses can place a resident on EBP for the same reasons ADON-D gave Surveyor earlier. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/11/25, at 09:57 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A and DON-B concerning observing wound treatments for R74. Surveyor asked DON-B why R74 was not placed into EBP until 6/10/25. DON-B informed Surveyor that in DON-B's research a chronic wound is anything greater that 30 days. DON-B informed Surveyor R74 had started with leg wounds with fluid filled blisters but the leg wounds did not start draining until over the weekend of 6/7/25; and that is why we started EBP on 6/10/25. DON-B informed Surveyor R74's wounds were dry last week. Surveyor asked DON-B why the delay until 6/10/25 placing R74 on EBP when drainage started over the weekend. DON informed Surveyor DON-B did not see R74's wounds until 6/10/25 during wound rounds with the wound doctor. DON-B informed Surveyor R74 was on EBP for R74's stage 3 pressure injury but does not know when R74's EBP precautions came down because, no one informed DON-B that R74's EBP had been removed. DON-B Informed Surveyor that DON-B put R74 back on EBP on 6/10/25 after DON-B saw R74 on wound rounds and noted R74's leg drainage.

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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 residents Pneumococcal immunizations were offered, or refused, as eligible. This was observed with 3 (R19, R109, and R163) of 5 residents whose immunization records were reviewed. *R19, is [AGE] years old, admitted on [DATE] and did not have documentation of Pneumococcal vaccine being offered until 6/11/25, after Surveyor asked for records, then a verbal consent was obtained from R19's Power of Attorney (POA) * R109, is [AGE] years old, admitted on [DATE] and did not have documentation of Pneumococcal vaccine being offered until 6/11/25, after Surveyor asked for records. * R163, is [AGE] years old, admitted on [DATE] and did not have documentation of Pneumococcal vaccine being offered until 6/11/25, after Surveyor asked for records. Findings include: The facility's policy and procedure titled, Pneumococcal Vaccination, dated 01/2025 was reviewed. The policy documents in part: Policy: It is the policy of this facility that residents will be offered immunizations against pneumococcal disease in accordance with The Advisory Committee on Immunization Practices (ACIP) recommendations. Procedure: 1. The pneumococcal vaccine as recommended by the CDC and ACIP varies by resident's age. 2. Vaccination Age Categories per Center for Disease Control (CDC): a. age [AGE] years or older who have: i. Not previously received a dose of PCV13 (Pneumococcal Conjugate Vaccine), PCV15, or PCV20 or whose previous vaccination history is unknown: 1 dose PCV15 or 1 dose PCV20 . b. age [AGE]-64 years with certain underlying medical conditions or other risk factors who have: i. Not previously received a PCV13, PCV15, or PCV20 or whose previous vaccination history is unknown: 1 dose PCV15 or 1 dose PCV20 . 3. If consented or declined, it will be documented in the residents' medical records. Historical information will be entered if available. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1.) R19 was admitted to the facility on [DATE] with pertinent diagnoses that include pulmonary embolism (occurs when a blood clot gets stuck in an artery in the lung, blocking blood flow to part of the lung), lobar pneumonia (a type of pneumonia characterized by the infection and inflammation of one or more lobes of the lung), acute and chronic respiratory failure with hypoxia (a condition in which your blood doesn't have enough oxygen or has too much carbon dioxide), type 2 diabetes mellitus (happens when the body cannot use insulin correctly and sugar builds up in the blood), and chronic systolic (congestive) heart failure (occurs when the left ventricle can't pump blood efficiently). R19's Medicare 5 day Minimum Data Set (MDS) with an assessment reference date of 5/21/25, documents a Brief Interview for Mental Status (BIMS) assessment score of 14, indicating that R19 is cognitively intact. R19 is over [AGE] year. There isn't documentation of any pneumococcal vaccinations being offered or refused upon admission to facility. The Wisconsin Immunization Registry (WIR) does not have any pneumococcal vaccine administration on record. R19 would be eligible for the PCV15, or PCV20. On 06/11/25, at 01:44 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-D who stated they thought they didn't have to ask about vaccinations for short term residents. ADON-D got consents today. ADON-D wasn't aware about asking at admission. Facility just had a vaccination clinic in April, ADON-D is catching up now. ADON-D will be working with pharmacy for another clinic date. On 06/11/25, at 03:33 PM, during the end of day meeting, Surveyor shared concern with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B that R19 was not offered the pneumococcal vaccination until today, after evidence of the vaccination was requested. Surveyor noted no further evidence of documentation of R19 being offered or refusing the pneumococcal vaccine upon admission to the facility was provided. 2.) R109 was admitted to the facility on [DATE] with pertinent diagnoses that include enterocolitis (an inflammation that occurs throughout your intestines), type 2 diabetes mellitus (happens when the body cannot use insulin correctly and sugar builds up in the blood), chronic obstructive pulmonary disease (lungs become inflamed, damaged and narrowed) and heart failure (occurs when the heart muscle doesn't pump blood as well as it should). R109's Medicare 5 day Minimum Data Set (MDS) with an assessment reference date of 5/26/25, documents a Brief Interview for Mental Status (BIMS) assessment score of 15, indicating that R109 is cognitively intact. R109 is over [AGE] year. There isn't documentation of any pneumococcal vaccinations being offered being offered or refused upon admission to facility. The Wisconsin Immunization Registry (WIR) does not have any pneumococcal vaccine administration on record. R109 would be eligible for the PCV15, or PCV20. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/11/25, at 01:44 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-D who stated they thought they didn't have to ask about vaccinations for short term residents. ADON-D got consents today. ADON-D wasn't aware about asking at admission. Facility just had a vaccination clinic in April, ADON-D is catching up now. ADON-D will be working with pharmacy for another clinic date. On 06/11/25, at 03:33 PM, during the end of day meeting, Surveyor shared concern with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B that R109 was not offered the pneumococcal vaccination until today, after evidence of the vaccination was requested. Surveyor noted no further evidence of documentation of R109 being offered or refusing the pneumococcal vaccine upon admission to the facility was provided. 3.) R163 was admitted to the facility on [DATE] with pertinent diagnoses that include cellulitis of right and left lower limb (a bacterial infection of the skin and underlying tissues, commonly caused by bacteria like streptococcus or staphylococcus), and sepsis (a life-threatening condition that arises when the body's response to an infection spirals out of control, damaging its own tissues and organs). R163's Medicare 5 day Minimum Data Set (MDS) with an assessment reference date of 6/3/25, documents a Brief Interview for Mental Status (BIMS) assessment score of 15, indicating that R163 is cognitively intact. R163 is [AGE] years old. There is no documentation of any pneumococcal vaccinations being offered being offered or refused upon admission to facility. The Wisconsin Immunization Registry (WIR) does not have any pneumococcal vaccine administration on record. R163 would be eligible for the PCV15, or PCV20 per PneumoRecs VaxAdvisor. On 06/11/25, at 01:44 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-D who stated they thought they didn't have to ask about vaccinations for short term residents. ADON-D got consents today. ADON-D wasn't aware about asking at admission. Facility just had a vaccination clinic in April, ADON-D is catching up now. ADON-D will be working with pharmacy for another clinic date. On 06/11/25, at 03:33 PM, during the end of day meeting, Surveyor shared concern with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B that R163 was not offered the pneumococcal vaccination until today, after evidence of the vaccination was requested. Surveyor noted no further evidence of documentation of R163 being offered or refusing the pneumococcal vaccine upon admission to the facility was provided.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure medical records contained documentation related to COVID-19 immunizations for 3 (R19, R109, and R163) of 5 residents reviewed for immunizations. *R19's medical record does not contain any documentation as to whether R19 was offered, received, or declined the COVID-19 immunization. * R109's medical record does not contain any documentation as to whether R109 was offered, received, or declined the COVID-19 immunization. * R163's medical record does not contain any documentation as to whether R163 was offered, received, or declined the COVID-19 immunization. Findings include: The facility's policy and procedure titled, Covid-19 Vaccinations, dated 02/2025 was reviewed. The policy documents in part: Policy: When recommended vaccines are available, the facility will ensure COVID-19 vaccines are readily accessible to both residents and staff. COVID-19 vaccinations can be administered to residents and staff at the facility by a contractor provider, or the facility can assist staff in finding an offsite pharmacy provider. The facility will not cover any expenses related to vaccines. General Guidelines 1. Information will be posted for families, visitors, residents and staff that encourages them to be vaccinated. 2. The facility will actively encourage all residents and healthcare personnel to receive COVID-19 vaccinations, particularly before the peak of fall respiratory season. All recommended doses will be offered in a timely manner to ensure protection during peak infection periods . 4. Before offering the COVID-19 vaccine, all staff members, residents or their representative will be provided with education regarding the benefits and risks and potential side effects associated with the vaccine . 6. The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine and change their decision . Resident Documentation Guidelines 1. The residents medical record includes documentation that indicates, at a minimum the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525271	A. Building B. Wing	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Estates of Countryside, Inc	1130 Collins Road Jefferson, WI 53549

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. That the resident or resident representative was provided education regarding the benefits and potential risks associated with the COVID-19 vaccine; and b. Each dose of COVID-19 vaccine administered to the resident; or c. If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal. 1.) R19 was admitted to the facility on [DATE] with pertinent diagnoses that include pulmonary embolism (occurs when a blood clot gets stuck in an artery in the lung, blocking blood flow to part of the lung), lobar pneumonia (a type of pneumonia characterized by the infection and inflammation of one or more lobes of the lung), acute and chronic respiratory failure with hypoxia (a condition in which your blood doesn't have enough oxygen or has too much carbon dioxide), type 2 diabetes mellitus (happens when the body cannot use insulin correctly and sugar builds up in the blood), and chronic systolic (congestive) heart failure (occurs when the left ventricle can't pump blood efficiently). R19's Medicare 5 day Minimum Data Set (MDS) with an assessment reference date of 5/21/25, documents a Brief Interview for Mental Status (BIMS) assessment score of 14, indicating that R19 is cognitively intact. Surveyor reviewed R19's electronic medical record and was unable to locate whether R19 was offered, received, or declined the COVID-19 immunizations. On 06/11/25, at 01:44 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-D who stated they thought they didn't have to ask about vaccinations for short term residents. ADON-D got consents today. ADON-D wasn't aware about asking at admission. Facility just had a vaccination clinic in April, ADON-D is catching up now. ADON-D will be working with pharmacy for another clinic date. On 06/11/25, at 03:33 PM, during the end of day meeting, Surveyor shared concern with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B that R19 was not offered the COVID-19 vaccination until today after evidence of the vaccination was requested. Surveyor noted no further evidence of documentation of R19 being offered or refusing the COVID-19 vaccination at admission to the facility was provided. 2.) R109 was admitted to the facility on [DATE] with pertinent diagnoses that include enterocolitis (an inflammation that occurs throughout your intestines), type 2 diabetes mellitus (happens when the body cannot use insulin correctly and sugar builds up in the blood), chronic obstructive pulmonary disease (lungs become inflamed, damaged and narrowed) and heart failure (occurs when the heart muscle doesn't pump blood as well as it should). R109's Medicare 5 day Minimum Data Set (MDS) with an assessment reference date of 5/26/25, documents a Brief Interview for Mental Status (BIMS) assessment score of 15, indicating that R109 is cognitively intact. Surveyor reviewed R109's electronic medical record and was unable to locate whether R109 was offered, received, or declined the COVID-19 immunizations. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525271	A. Building B. Wing	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Estates of Countryside, Inc	1130 Collins Road Jefferson, WI 53549

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/11/25, at 01:44 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-D who stated they thought they didn't have to ask about vaccinations for short term residents. ADON-D got consents today. ADON-D wasn't aware about asking at admission. Facility just had a vaccination clinic in April, ADON-D is catching up now. ADON-D will be working with pharmacy for another clinic date. On 06/11/25, at 03:33 PM, during the end of day meeting, Surveyor shared concern with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B that R109 was not offered the COVID-19 vaccination until today after evidence of the vaccination was requested. Surveyor noted no further evidence of documentation of R109 being offered or refusing the COVID-19 vaccination at admission to the facility was provided. 3.) R163 was admitted to the facility on [DATE] with pertinent diagnoses that include cellulitis of right and left lower limb (a bacterial infection of the skin and underlying tissues, commonly caused by bacteria like streptococcus or staphylococcus), and sepsis (a life-threatening condition that arises when the body's response to an infection spirals out of control, damaging its own tissues and organs). R163's Medicare 5 day Minimum Data Set (MDS) with an assessment reference date of 6/3/25, documents a Brief Interview for Mental Status (BIMS) assessment score of 15, indicating that R163 is cognitively intact. Surveyor reviewed R163's electronic medical record and was unable to locate whether R163 was offered, received, or declined the COVID-19 immunizations. On 06/11/25, at 01:44 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-D who stated they thought they didn't have to ask about vaccinations for short term residents. ADON-D got consents today. ADON-D wasn't aware about asking at admission. Facility just had a vaccination clinic in April, ADON-D is catching up now. ADON-D will be working with pharmacy for another clinic date. On 06/11/25, at 03:33 PM, during the end of day meeting, Surveyor shared concern with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B that R163 was not offered the COVID-19 vaccination until today after evidence of the vaccination was requested. Surveyor noted no further evidence of documentation of R163 being offered or refusing the COVID-19 vaccination at admission to the facility was provided.