STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525279	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tudor Oaks Health Center	S77 W12929 McShane Dr Muskego, WI 53150

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure 1 (R12) of 1 resident was clinically appropriate to self administer medications. * R12 was observed with 7 medication pills in a medication cup on the over bed table next to R12. R12's self administration assessment dated [DATE] documents that R12 not approved for the self-administration of medications. Findings include: The facility's undated policy titled, Resident Self-Administration of Medication documents under the Policy section: It is the policy of this facility to support each resident's right to self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely. Under Policy Explanation and Compliance Guidelines: document 3. When determining if self-administration is clinically appropriate for a resident, the interdisciplinary team should at a minimum consider the following: a. The medications appropriate and safe for self-administration; b. The resident's physical capacity to: swallow without difficulty, open medication bottles, administer injections; c. The resident's cognitive status, including their ability to correctly name their medications and know what conditions they are taken for; d. The resident's capability to follow directions and tell time to know when medications need to be taken; e. The resident's comprehension of instructions for the medications they are taking, including the dose, timing, and signs of side effects, and when to report to facility staff; f. The resident's ability to understand what refusal of medication is, and appropriate steps taken by staff to educate when this occurs; g. The resident's ability to ensure that medication is stored safely and securely. 4. The results of the interdisciplinary team assessment are recorded on the Medication Self-Administration Assessment Form, which is placed in the resident's medical record. 1.) R12's diagnosis include dementia (loss of cognitive function that interferes with a person's daily life and activities). R12's power of attorney for healthcare was activated on 1/22/25. R12's self administration of medication assessment dated [DATE] answers no, indicating that R12 is not approved for self-administration of medications. R12's quarterly MDS (minimum data set) with an assessment reference date of 5/8/25 documents a BIMS (brief interview mental status) score of 11, which indicates moderate cognitive impairment for R12. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/16/25, at 8:18 a.m., Surveyor observed R12 sitting in a recliner in R12's room reading the newspaper. Surveyor observed on the over bed table to the right of R12, a medication cup containing 7 pills. R12 stated to Surveyor I (R12) haven't taken my medication yet. Surveyor observed there was not a licensed nurse &/or medication tech in R12's room. On 6/16/25, at 8:23 a.m., Surveyor asked Licensed Practical Nurse (LPN)-U if she gave R12 medication. LPN-U replied yes. Surveyor asked LPN-U why she left R12's medication with R12. LPN-U replied because she told me to and that LPN-U left them (the medication pills) because R12 asked me to. R12's June 2025 MAR (medication administration record) documents that LPN-U checked & initialed (which indicates medication was administered) the following medication: Bumetanide 0.5 mg (milligrams), Carvedilol 12.5 mg, Doxycycline Hyclate 100 mg, Lisinopril 20 mg, Probiotic oral capsule, Senna 8.6 mg, and Spironolactone 12.5 mg. On 6/16/25, at 8:31 a.m., Surveyor asked Registered Nurse/Unit Manager (RN/UM)-D if R12 self administers her own medication. RN/UM-D replied no. Surveyor informed RN/UM-D of the observation of R12's medication in a cup on the over bed table next to R12. On 6/16/25, at 8:41 a.m., Surveyor observed RN/UM-D talking with R12 stating may I take them, referring to R12's medication, and bring them back if you aren't ready to take them. RN/UM-D indicated they have to chart the time when R12 takes the medication. At 8:42 a.m. Surveyor observed R12 start to take her medication with RN/UM-D. On 6/12/25, at 3:15 p.m., during the end of the day meeting Surveyor informed Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B and Corporate Nurse-C R12 of the above findings. No additional information was provided as to why the facility did not ensure that R12 was clinically appropriate to self administer medications.

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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 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 protect 1 (R16) of 1 Resident by not implementing their written policies and procedures to prohibit and prevent the right to be free from verbal abuse from Registered Nurse (RN)-E. * Staff did not report allegations of verbal abuse made by R16 regarding RN-E to the Nursing Home Administrator (NHA)-A immediately. This allowed for additional potential allegations of verbal abuse to occur to other residents whom RN-E provided nursing care to for the remainder of the shift. Findings Include: The facility's undated Abuse, Neglect, and Exploitation documents: Policy Explanation and Compliance Guidelines: 1. The facility will develop and implement written policies and procedures that: a. Prohibit and prevent abuse, neglect, and exploitation of Residents and misappropriation of Resident property b. Establish policies and procedures to investigate any such allegations c. Include training for new and existing staff on activities that constitute abuse, neglect, exploitation, and misappropriate of Resident property, reporting procedures, and dementia management and Resident abuse prevention d. Establish coordination with the QAPI program 3. The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written. Protection of Resident The facility will make efforts to ensure all Residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigations. Examples include but are not limited to: A. Responding immediately to protect the alleged victim and integrity of the investigation F. Providing emotional support and counseling to the Resident during and after the investigation as needed G. Revision of the Resident's care plan if the Resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of the incident of abuse (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reporting/Response A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within specified timeframes a. Immediately, but not later than 2 hours after the allegations is made, if the events that cause the allegation involve abuse or result in serious bodily injury 5. Taking all necessary actions as a result if the investigation, which may include, but are not limited to, the following: a. Analyzing the occurrence(s) to determine why abuse, neglect, misappropriation of Resident property or exploitation occurred, and what changes are needed to prevent further occurrences b. Defining how care provision will be changed and/or improved to protect Resident receiving services B. The Administrator will follow-up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies. 1.) R16 was admitted to the facility on [DATE] with diagnoses of Chronic Kidney Disease(progressive damage and loss of function in the kidneys), Anemia(lack of blood), Chronic Congestive Heart Failure(long term condition where the heart muscle is too weak or still to pump blood efficiently), and Dementia(loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life). R16's Quarterly Minimum Data Set(MDS) completed 3/26/25 documents R16's Brief Interview for Mental Status(BIMS) score to be a 6, indicating R16 demonstrates severely impaired skills for daily decision making. R16's MDS documents at time of assessment that R16 did not have mood or behavior symptoms. R16 is set-up for eating. R16 requires substantial/maximum assistance for showers, mobility, transfers, toileting. R16 requires partial/moderate assistance for upper dressing and is dependent for lower dressing. R16 is frequently incontinent of urinary and occasionally incontinent of bowel. On 4/29/25, at 3:21 PM, the facility submitted a Nursing Home Resident Mistreatment, Neglect, and Abuse Report documenting an allegation of verbal abuse involving RN-E and R16 occurring at 4:30 AM on 4/29/25. It is documented that Certified Nursing Assistant (CNA)-G heard RN-E tell R16 There is no reason you need to be getting up at 4:00 in the morning, there better be something in the toilet once your are done. CNA-G reported immediately to Licensed Practical Nurse (LPN)-F. The report documents that the Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, and Director of Social Services (DSS)-K were immediately notified of the allegation The facility's Misconduct Incident Report submitted 5/6/25 documents that RN-E worked until the end of the shift and only then was she removed from the facility and the work schedule. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor noted the shift ends at 7:00 AM. LPN-F was aware of the allegation of verbal abuse by RN-E at 4:30 AM, but did not report the allegation of verbal abuse immediately to NHA-A, DON-B, and DSS-K. RN-E remained in the facility until 7:00 AM, allowing time for RN-E to have contact with other Residents in the facility. RN-E was not immediately removed from Resident care areas. Surveyor reviewed the working punch detail for RN-E that documents RN-E arrived at the facility at 10:12 PM and left the facility at 6:48 AM. On 4/29/2025, at 5:35 AM, RN-E documented in R16's electronic health record(EMR): R16 called for staff around 430 am and hollering out to get to the toilet, CNA placed R16 on bedpan, but R16 had no results, R16 again hollering out to go to toilet, writer and CNA transferred R16 to toilet with steady lift, R16 was crying its not fair, you people just don't know and think I am crazy R16 was assured by writer that no one believes that, R16 stated I wish I was just dead, GOD please take me, again writer consoled R16. R16 had recent decrease in Lexapro and showing increased behaviors. R16 quiet at this time resting in bed. On 6/11/25, at 12:35 PM, Surveyor interviewed CNA- G via telephone in regards to the allegation of verbal abuse from RN-E directed at R16. CNA-G stated that RN-E and CNA-H were in the process of toileting R16. CNA-G confirmed that CNA-G heard RN-E tell R16 there was no reason for R16 to be up at 4:00 AM and that there better be something in the toilet. CNA-G informed LPN-F immediately of what CNA-G overheard. CNA-G stated that RN-E finished the shift and continued to pass medications. CNA-G stated , that RN-E informed CNA-G at the end of the shift that R16 had expressed R16 wanted to kill herself. CNA-G explained that R16 was screaming at the time CNA-G overheard RN-E tell R16 there was no reason to be up and there better be something in the toilet. CNA-G stated that behavior was very unusual because R16 is normally happy as can be and very thankful for us helping her. On 6/11/25, at 12:58 PM, Surveyor interviewed LPN-F vial telephone in regards to the allegation of verbal abuse from RN-E directed at R16. LPN-F confirmed that CNA-G informed LPN-G of the allegation of verbal abuse involving R16 and RN-E at approximately 4:30 AM. LPN-F stated that CNA-G was very visibly distressed by what CNA-G heard RN-E say to R16 and very upset the rest of the shift and has been still upset about the incident. LPN-F confirmed that LPN-F did not report immediately to NHA-A, DON-B, or DSS-K. LPN-F had other staff write up statements and LPN-F informed DON-B at the end of the shift when DON-B arrived to the facility. LPN-F informed Surveyor that about 5 other CNAs have informed LPN-G that RN-E can be verbally abusive to Residents. On 6/12/25, at 6:46 AM, Surveyor interviewed DON-B. DON-B confirmed that LPN-F approached DON-B in the morning after the shift and provided written statements from staff members. LPN-F explained the circumstances of the allegation of verbal abuse from RN-E towards R16. DON-B then reported the concern to NHA-A. DON-B stated, DON-B has no involvement with allegations of abuse, investigation, or contact with staff members involved in the allegations. DON-B stated that CNA-G is still very distraught about the incident. DON-B was not asked by anyone to place R16 on the 24 hour report board for follow-up. DON-B confirmed that LPN-F did not call DON-B at the actual time the allegation of verbal abuse was reported by CNA-G. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/25, at 10:55 AM, Surveyor interviewed DSS-K in regards to the allegation of verbal abuse involving R16 and RN-E. DSS-K confirmed DSS-K that DSS-K is part of the team that works on the facility facility reported incidents as well as helping to compile and investigate. NHA-A and DSS-K work together to make sure everything is completed. DSS-K stated that DSS-K was informed in the morning when DSS-K arrived to the facility. Surveyor shared with DSS-K there are 3 missing staff statements from the shift of when the allegation of verbal abuse occurred. DSS-K will look for the statements and confirm when abuse/neglect training was last completed. On 6/12/25, at 11:54 AM, DSS-K stated that DSS-K did not submit the missing staff statements to the State Survey Agency because the statements were hearsay. DSS-K stated DSS-K completes training on abuse/neglect and dementia at time of orientation which includes reviewing the facility policy and procedure to immediately report any observations of abuse. DSS-K stated the most recent all staff training on abuse/neglect and dementia was completed in May 2024. On 6/12/25, at 3:24 PM, Surveyor informed NHA-A, DON-B, and Corporate Consultant (CC)-C that LPN-F did not report immediately the allegation of verbal abuse by RN-E directed at R16. Surveyor explained it was reported by CNA-G to LPN-F at approximately 4:30 AM, but RN-E finished the shift which ended at 7:00 AM. Surveyor also shared the concern that the facility did not investigate the statements for 3 employees in order to determine if there was a pattern of RN-E verbally abusing Residents or had additional information to provide. No additional information has been provided by the facility at this time as to why the allegation of verbal abuse involving R16 and RN-E was not immediately reported which resulted in RN-E working the rest of the shift until 7:00 AM potentially placing other Residents in a vulnerable state and exposing to potential verbal abuse.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility did not ensure allegations of verbal abuse were immediately reported to the Administrator and/or Grievance Officer. This was observed with 1 (R16) of 1 Resident reviewed for alleged verbal abuse. * An allegation of verbal abuse by Registered Nurse (RN)-E towards R16 was reported by Certified Nursing Assistant (CNA)-G at approximately 4:30 AM to Licensed Practical Nurse (LPN)-F on 4/29/25. LPN-F informed Director of Nursing (DON)-B at approximately 7:00 AM, after RN-E's shift had ended at the facility. Findings Include: The facility's undated Abuse, Neglect, and Exploitation documents: .Policy Explanation and Compliance Guidelines: 1. The facility will develop and implement written policies and procedures that: a. Prohibit and prevent abuse, neglect, and exploitation of Residents and misappropriation of Resident property b. Establish policies and procedures to investigate any such allegations c. Include training for new and existing staff on activities that constitute abuse, neglect, exploitation, and misappropriate of Resident property, reporting procedures, and dementia management and Resident abuse prevention d. Establish coordination with the QAPI program 3. The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written. Employee Training B. Existing staff will receive annual education through planned in-services and as needed. C. Training topics will include: 1. Prohibiting and preventing all forms of abuse, neglect, misappropriation of Resident property and exploitation 2. Identifying what constitutes abuse, neglect, exploitation, and misappropriation of Resident property (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Recognizing signs of abuse, neglect, exploitation, and misappropriation of Resident property, such as physical or psychosocial indicators 4. Reporting process for abuse, neglect, exploitation, and misappropriation of Resident property, including injuries of unknown sources 5. Understanding behavioral symptoms of Resident that may increase the risk of abuse and neglect such as: d. Outbursts or yelling our Prevention of Abuse, Neglect and Exploitation The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of Resident property, and exploitation that achieves: D. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of Residents with needs and behaviors which might lead to conflict or neglect. H. Assigning responsibility for the supervision of staff on all shifts for identifying inappropriate staff behaviors. Protection of Resident The facility will make efforts to ensure all Residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigations. Examples include but are not limited to: A. Responding immediately to protect the alleged victim and integrity of the investigation F. Providing emotional support and counseling to the Resident during and after the investigation as needed G. Revision of the Resident's care plan if the Resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of the incident of abuse Reporting/Response A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within specified timeframes a. Immediately, but not later than 2 hours after the allegatins is made, if the events that cause the allegation involve abuse or result in serious bodily injury 5. Taking all necessary actions as a result if the investigation, which may include, but are not limited to, the following: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Analyzing the occurrence(s) to determine why abuse, neglect, misappropriation of Resident property or exploitation occurred, and what changes are needed to prevent further occurrences b. Defining how care provision will be changed and/or improved to protect Resident receiving services B. The Administrator will follow-up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies. R16 was admitted to the facility on [DATE] with diagnoses of Chronic Kidney Disease(progressive damage and loss of function in the kidneys), Anemia(lack of blood), Chronic Congestive Heart Failure(long term condition where the heart muscle is too weak or still to pump blood efficiently), and Dementia(loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life). R16 currently has an activated Health Care Power of Attorney(HCPOA) to assist with decision making. R16's Quarterly Minimum Data Set(MDS) completed 3/26/25 documents R16's Brief Interview for Mental Status(BIMS) score to be a 6, indicating R16 demonstrates severely impaired skills for daily decision making. R16's MDS documents at time of assessment that R16 did not have mood or behavior symptoms. R16 is set-up for eating. R16 requires substantial/maximum assistance for showers, mobility, transfers, toileting. R16 requires partial/moderate assistance for upper dressing and is dependent for lower dressing. R16 is frequently incontinent of urinary and occasionally incontinent of bowel. On 4/29/25, at 3:21 PM, the facility submitted A nursing Home Resident Mistreatment, Neglect, and Abuse Report documenting an allegation of verbal abuse involving RN-E and R16 occurring at 4:30 AM on 4/29/25. It is documented that Certified Nursing Assistant (CNA)-G heard RN-E tell R16 There is no reason you need to be getting up at 4:00 in the morning, there better be something in the toilet once your are done. CNA-G reported immediately to Licensed Practical Nurse (LPN)-F. The report documents that the Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, and Director of Social Services (DSS)-K were immediately notified of the allegation The facility's Misconduct Incident Report submitted 5/6/25 documents that RN-E worked until the end of the shift and was then taken off the schedule. Surveyor notes the shift ends at 7:00 AM. LPN-F was aware of the allegation of verbal abuse by RN-E at 4:30 AM, but did not report the allegation of verbal abuse immediately to NHA-A, DON-B, and DSS-K. RN-E remained in the facility until 7:00 AM, allowing time for RN-E to have contact with other Residents in the facility. RN-E was not immediately removed from Resident care areas. Surveyor reviewed the working punch detail for RN-E that documents RN-E arrived at the facility at 10:12 PM and left the facility at 6:48 AM. On 4/29/2025, at 5:35 AM, RN-E documented in R16's electronic health record(EMR): (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R16 called for staff around 430 am and hollering out to get to the toilet, CNA placed R16 on bedpan, but R16 had no results, R16 again hollering out to go to toilet, writer and CNA transferred R16 to toilet with steady lift, R16 was crying its not fair, you people just don't know and think I am crazy R16 was assured by writer that no one believes that, R16 stated I wish I was just dead, GOD please take me, again writer consoled R16. R16 had recent decrease in Lexapro and showing increased behaviors. R16 quiet at this time resting in bed. On 6/11/25, at 12:35 PM, Surveyor interviewed CNA- G via telephone in regards to the allegation of verbal abuse from RN-E directed at R16. CNA-G stated that RN-E and CNA-H were in the process of toileting R16. CNA-G confirmed that CNA-G heard RN-E tell R16 there was no reason for R16 to be up at 4:00 AM and that there better be something in the toilet. CNA-G informed LPN-F immediately of what CNA-G overheard. CNA-G stated that RN-E finished the shift and continued to pass medications. CNA-G stated , that RN-E informed CNA-G at the end of the shift that R16 had expressed R16 wanted to kill herself. CNA-G explained that R16 was screaming at the time CNA-G overheard RN-E stated that to R16. CNA-G stated that behavior was very unusual because R16 is normally happy as can be and very thankful for us helping her. On 6/11/25, at 12:58 PM, Surveyor interviewed LPN-F vial telephone in regards to the allegation of verbal abuse from RN-E directed at R16. LPN-F confirmed that CNA-G informed LPN-G of the allegation of verbal abuse involving R16 and RN-E at approximately 4:30 AM. LPN-F stated that CNA-G was very visibly distressed by what CNA-G heard RN-E say to R16 and very upset the rest of the shift and has been still upset about the incident. LPN-F confirmed that LPN-F did not report immediately to NHA-A, DON-B, or DSS-K. LPN-F had other staff write up statements and LPN-F informed DON-B at the end of the shift when DON-B arrived to the facility. LPN-F informed Surveyor that about 5 other CNAs have informed LPN-G that RN-E can be verbally abusive to Residents. On 6/12/25, at 6:46 AM, Surveyor interviewed DON-B. DON-B confirmed that LPN-F approached DON-B in the morning after the shift had been completed and provided written statements from staff members. LPN-F explained the circumstances of the allegation of verbal abuse from RN-E towards R16. DON-B then reported the concern to NHA-A. DON-B stated, DON-B has no involvement with allegations of abuse, investigation, or contact with staff members involved the allegations. DON-B confirmed that LPN-F did not call DON-B at the actual time the allegation of verbal abuse was reported by CNA-G. On 6/12/25, at 10:55 AM, Surveyor interviewed DSS-K regarding the allegation of verbal abuse involving R16 and RN-E. DSS-K confirmed DSS-K that DSS-K is part of the team that works on the facility facility reported incidents(FRI) as well as helping to compile and investigate. NHA-A and DSS-K work together to make sure everything is completed. DSS-K stated that DSS-K was informed in the morning of 4/29/25 at approximately 8:00 AM, when DSS-K arrived to the facility. On 6/12/25, at 3:24 PM, Surveyor shared the concern with NHA-A, DON-B, and Corporate Consultant (CC)-C that LPN-F did not report immediately the allegation of verbal abuse from RN-E directed at R16. Surveyor explained it was reported by CNA-G to LPN-F at approximately 4:30 AM, but RN-E finished the shift which ended at 7:00 AM. No additional information was provided by the facility as to why the allegation of verbal abuse involving R16 and RN-E was not immediately reported to the Administrator which resulted in RN-E working the rest of the shift until 7:00 AM potentially placing other Residents in a vulnerable state and exposing to potential verbal abuse.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tudor Oaks Health Center	S77 W12929 McShane Dr Muskego, WI 53150

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility did not ensure all allegations involving potential verbal abuse were thoroughly investigated for 1 (R16) of 1 reviewed facility reported incidents (FRI). *An allegation of verbal abuse on 4/29/25 by Registered Nurse (RN)-E towards R16 was not thoroughly investigated. Findings Include: The facility's undated Abuse, Neglect, and Exploitation documents: Policy Explanation and Compliance Guidelines: 1. The facility will develop and implement written policies and procedures that: a. Prohibit and prevent abuse, neglect, and exploitation of Residents and misappropriation of Resident property b. Establish policies and procedures to investigate any such allegations c. Include training for new and existing staff on activities that constitute abuse, neglect, exploitation, and misappropriate of Resident property, reporting procedures, and dementia management and Resident abuse prevention d. Establish coordination with the QAPI program 3. The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written. Protection of Resident The facility will make efforts to ensure all Residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigations. Examples include but are not limited to: A. Responding immediately to protect the alleged victim and integrity of the investigation F. Providing emotional support and counseling to the Resident during and after the investigation as needed G. Revision of the Resident's care plan if the Resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of the incident of abuse Investigation of Alleged Abuse, Neglect and Exploitation (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigations include: 1. Identifying staff responsible for the investigation 3. Investigating different types of alleged violations 4. Identifying and interviewing all involved person, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent and cause 6. Providing complete and thorough documentation of the investigation Reporting/Response A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within specified timeframes a. Immediately, but not later than 2 hours after the allegations is made, if the events that cause the allegation involve abuse or result in serious bodily injury 5. Taking all necessary actions as a result if the investigation, which may include, but are not limited to, the following: a. Analyzing the occurrence(s) to determine why abuse, neglect, misappropriation of Resident property or exploitation occurred, and what changes are needed to prevent further occurrences b. Defining how care provision will be changed and/or improved to protect Resident receiving services B. The Administrator will follow-up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies. 1.) R16 was admitted to the facility on [DATE] with diagnoses of Chronic Kidney Disease(progressive damage and loss of function in the kidneys), Anemia(lack of blood), Chronic Congestive Heart Failure(long term condition where the heart muscle is too weak or still to pump blood efficiently), and Dementia(loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life). (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R16's Quarterly Minimum Data Set(MDS) completed 3/26/25 documents R16's Brief Interview for Mental Status(BIMS) score to be a 6, indicating R16 demonstrates severely impaired skills for daily decision making. R16's MDS documents at time of assessment that R16 did not have mood or behavior symptoms. R16 is set-up for eating. R16 requires substantial/maximum assistance for showers, mobility, transfers, toileting. R16 requires partial/moderate assistance for upper dressing and is dependent for lower dressing. R16 is frequently incontinent of urinary and occasionally incontinent of bowel. On 4/29/25, at 3:21 PM, the facility submitted A Nursing Home Resident Mistreatment, Neglect, and Abuse Report documenting an allegation of verbal abuse involving RN-E and R16 occurring at 4:30 AM on 4/29/25. It is documented that Certified Nursing Assistant (CNA)-G heard RN-E tell R16 There is no reason you need to be getting up at 4:00 in the morning, there better be something in the toilet once your are done. CNA-G reported immediately to Licensed Practical Nurse (LPN)-F. The report documents that the Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, and Director of Social Services (DSS)-K were immediately notified of the allegation. The facility's Misconduct Incident Report submitted 5/6/25 documents that RN-E was at the end of the shift and taken off the schedule. Surveyor reviewed R16's comprehensive care plan. R16's care plan was not updated addressing any psychosocial issues R16 may have. Surveyor noted the shift ends at 7:00 AM. LPN-F was aware of the allegation of verbal abuse by RN-E at 4:30 AM, but did not report the allegation of verbal abuse immediately to NHA-A, DON-B, and DSS-K. RN-E remained in the facility until 7:00 AM, allowing time for RN-E to have contact with other Residents in the facility. RN-E was not immediately removed from Resident care areas. Surveyor reviewed the working punch detail for RN-E that documents RN-E arrived at the facility at 10:12 PM and left the facility at 6:48 AM. Surveyor obtained the schedule from the NOC shift for 4/29/25 and determined that 3(CNA-I, CNA-J, and LPN-F) staff statements were not readily available to Surveyor or submitted with the FRI to the State Survey Agency. On 4/29/2025, at 5:35 AM, RN-E documented in R16's electronic health record(EMR): R16 called for staff around 430 am and hollering out to get to the toilet, CNA placed R16 on bedpan, but R16 had no results, R16 again hollering out to go to toilet, writer and CNA transferred R16 to toilet with steady lift, R16 was crying its not fair, you people just don't know and think I am crazy R16 was assured by writer that no one believes that, R16 stated I wish I was just dead, GOD please take me, again writer consoled R16. R16 had recent decrease in Lexapro and showing increased behaviors. R16 quiet at this time resting in bed. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/11/25, at 12:35 PM, Surveyor interviewed CNA-G via telephone in regards to the allegation of verbal abuse from RN-E directed at R16. CNA-G stated that RN-E and CNA-H were in the process of toileting R16. CNA-G confirmed that CNA-G heard RN-E tell R16 there was no reason for R16 to be up at 4:00 AM and that there better be something in the toilet. CNA-G informed LPN-F immediately of what CNA-G overheard. CNA-G stated that RN-E finished the shift and continued to pass medications. CNA-G stated , that RN-E informed CNA-G at the end of the shift that R16 had expressed R16 wanted to kill herself. CNA-G explained that R16 was screaming at the time CNA-G overheard RN-E telling R16, there was no reason to be up at that time and there better be something in the toilet. CNA-G stated that behavior was very unusual because R16 is normally happy as can be and very thankful for us helping her. On 6/11/25, at 12:58 PM, Surveyor interviewed LPN-F vial telephone in regards to the allegation of verbal abuse from RN-E directed at R16. LPN-F confirmed that CNA-G informed LPN-G of the allegation of verbal abuse involving R16 and RN-E at approximately 4:30 AM. LPN-F stated that CNA-G was very visibly distressed by what CNA-G heard RN-E say to R16 and very upset the rest of the shift and has been still upset about the incident. LPN-F confirmed that LPN-F did not report immediately to NHA-A, DON-B, or DSS-K. LPN-F had other staff write up statements and LPN-F informed DON-B at the end of the shift when DON-B arrived to the facility. LPN-F informed Surveyor that about 5 other CNAs have informed LPN-G that RN-E can be verbally abusive to Residents. LPN-F stated LPN-F has not seen R16 crying any other time or distressed except during this allegation. On 6/12/25, at 6:46 AM, Surveyor interviewed DON-B. DON-B confirmed that LPN-F approached DON-B in the morning after the shift and provided written statements from staff members. LPN-F explained the circumstances of the allegation of verbal abuse from RN-E towards R16. DON-B then reported the concern to NHA-A. DON-B stated, DON-B has no involvement with allegations of abuse, investigation, or contact with staff members involved in the allegations. DON-B stated that CNA-G is still very distraught about the incident. DON-B was not asked by anyone to place R16 on the 24 hour report board for follow-up. DON-B confirmed that LPN-F did not call DON-B at the actual time the allegation of verbal abuse was reported by CNA-G. DON-B stated that RN-E has a history of be very direct with Residents. On 6/12/25, at 9:02 AM, Surveyor interviewed RN-E via telephone. RN-E stated that R16 gets very frustrated with us, says stuff like that, R16 is confused, but has never seen R16 cry. RN-E did not tell DSS-K of R16's psychosocial status. On 6/12/25, at 10:55 AM, Surveyor interviewed DSS-K in regards to the allegation of verbal abuse involving R16 and RN-E. DSS-K confirmed DSS-K that DSS-K is part of the team that works on the facility facility reported incidents as well as helping to compile and investigate. NHA-A and DSS-K work together to make sure everything is completed. DSS-K stated that DSS-K was informed in the morning when DSS-K arrived to the facility. Surveyor shared with DSS-K there are 3 missing staff statements from the shift of when the allegation of verbal abuse occurred. DSS-K will look for the statements and confirm when abuse/neglect training was last completed. DSS-K stated that DSS-K did not feel the need to update the psychologist who is currently treating R16. DSS-K stated that R16 is usually pleasant with an occasion of tearfulness. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/25, at 11:54 AM, DSS-K stated that DSS-K did not submit the missing staff statements to the State Survey Agency because the statements were hearsay. DSS-K confirmed DSS-K did not follow-up on the statements provided by CNA-I, CNA-J, and LPN-F. DSS-K stated DSS-K completes training on abuse/neglect and dementia at time of orientation which includes reviewing the facility policy and procedure to immediately report any observations of abuse. DSS-K confirmed that it is not normal for R16 to state R16 did not want to live. On 5/11/2025, at 4:14 PM, RN-QQ documented: R16 had R16's escitalopram decreased from 10 mg to 5 mg on 4/24/25. Today R16 seems more confused and is having trouble finding her room and seems very anxious. LCTA, respirations are even and unlabored, HR is irregular, BS with in normal limits, no edema noted to BLE. Vs 98.2-89-141/94-22-and 93% on RA. R16 stated that R16 can't remember anything and that R16 might as well be dead. Updated MD and added to report board for monitoring. Surveyor reviewed R16's documented psychology note by Psychology NP (Psych NP)-RR indicates that Psych NP-RR was not notified by the facility that R16 had made expressions of feeling distressed, specifically expressions of not wanting to be alive. On 6/12/25, at 3:24 PM, Surveyor shared the concern with NHA-A, DON-B, and Corporate Consultant (CC)-C that LPN-F did not report immediately the allegation of verbal abuse from RN-E directed at R16. Surveyor explained it was reported by CNA-G to LPN-F at approximately 4:30 AM, but RN-E finished the shift which ended at 7:00 AM. Surveyor also shared the concern that the facility did not investigate the statements for 3 employees in order to determine if there was a pattern of RN-E verbally abusing Residents or had additional information to provide. Further, there was no follow-up on R16's expressions of not wanting to live. No additional information was provided by the facility at this time as to why the allegation of verbal abuse was not thoroughly investigated and R16' expressions of not wanting to live with no follow-up.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 4 (R12, R34, R39, & R41) of 4 residents were notified of the reason for transfer/discharge & bed hold policy in writing to the resident & their representative and the rate to reserve the residents bed was not documented in the Transfer, Bed hold Notice and readmission Rights form. Findings include: The facility's undated policy titled, Bed Hold Notice documents: It is the policy of this facility to provide written information to the resident and/or the resident representative regarding bed hold practices both well in advance, and at the time of, a transfer for hospitalization or therapeutic leave. Under Policy Explanation and Compliance Guidelines documents 1. As part of the admission packet and at the time of a transfer to the hospital or therapeutic leave, the facility will provide the resident and/or the resident representative written information that specifics: a. The duration of the State bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; b. The reserve bed payment policy in the state plan policy, if any. c. The facility policies regarding bed-hold periods to include allowing a resident to return to the next available bed. d. Conditions upon which the resident would return to the facility: The resident requires the services which the facility provides; The resident is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. 2. In the event of an emergency transfer of a resident, the facility will provide written notice of the facility's bed-hold policies to the resident and/or the resident representative within 24 hours. The facility will document multiple attempts to reach the resident's representative in cases where the facility was unable to notify the representative. 3. The facility will keep a signed and dated copy of the bed-hold notice information given to the resident and/or resident representative in the resident's file and/or medical record. 4. The facility will provide this written information to all facility residents, regardless of their payment source. 1.) R12's diagnoses includes dementia (loss of cognitive function that interferes with a person's daily life and activities), atrial fibrillation (irregular and rapid heart beat), depressive disorder, diabetes mellitus (high blood sugar), and malignant neoplasm of colon (cancer). R12's nursing note dated 1/17/25, at 15:41 (3:41 p.m.), by Previous Director of Nursing (DON)-II documents: Residents labs came back H&H (hemoglobin and hematocrit) was down from last labs 7.0 and 21.3 MD (Medical Doctor) aware and if resident is symptomatic may send to ER (Emergency Room) may need possible transfusion. Resident feels dizzy when asked and has complaints of just being off and not feeling like herself. She was agreeable to go to the ER for possible transfusion if it would help her feel better. She was also ok with writer updating her family Son was called and left a message to call writer back. SW had also text son as he is traveling now. Awaiting return call from the family. [Name] ambulance was called, and resident and paperwork were sent to [Name] memorial hospital. Report was called to ER [Name] nurse took report. R12's social service note dated 1/20/25, at 9:23 a.m., documents: Writer obtained verbal consent to hold bed from resident's son. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R12 was readmitted to the facility on [DATE]. Surveyor noted R12's transfer, bed hold notice and readmission rights form dated 1/17/25 under the document section in R12's medical record. This form documents the reason for transfer. Under Bed hold and readmission rights documents 1. If you are paying for your stay from either Private funds or Medicare with Private funds back up: *As outlined in your contact for care, while you are hospitalized or on leave from the facility your bed will bed at the daily current rate 2. If you are paying for your stay from Medicaid (T-19) funds: If you are hospitalized , your bed will be held for 15 days unless you waive this right. * If your hospital duration goes beyond 15 days, you and/or your legal Representative/Responsible Party are able to hold the bed from Private funds at 100% of your current daily rate being charged Surveyor noted for resident/resident representative signature line documents [Name] verbal consent. Date documents 1/20/25. Verbal consent was obtained three days after R12 was discharged to the hospital, written transfer notice & bed hold policy was not provided to R12 and R12's representative and the transfer, bed hold notice & readmission rights form does not have what the daily rate is to hold R12's bed. R12's nurses note dated 1/30/25, at 11:21 a.m., written by LPN-JJ documents Resident refused her AM (morning) medication, insulin, and breakfast. Blood sugar before breakfast was 215. Resident refused to get out of bed. Resident responded to writer stating that she wanted to be left alone and that she wanted to sleep. That she did not want to get up and that it was her right if she wanted to stay in bed. Writer educated resident on the importance of her eating her breakfast because of her diabetes but the resident continued to refuse. [Name] NP (Nurse Practitioner) updated. B/P (blood pressure) 140/68, T (temperature) 98.0, P (pulse) 68, R (respirations) 18 even nonlabored, POX 97% ORA. [Name] NP was in the building and she went to see resident. 1045 [Name] NP came into the nursing office and told writer to call 911, unresponsive episode. Writer called 911. Writer called POA (Power of Attorney) son [Name] updated [Name], received permission to send resident out to hospital. Order received from [Name] NP to send resident out to ER (emergency room) for unresponsive episode. 1100 EMS (emergency medical services) arrived B/P 191/73,T 98.1, P 72, R 18, Pox 95% ORA, Blood Sugar 238 Resident responsive to questioning appropriately. Stated that she wanted to be left alone. Resident went to hospital @ 1130 via ambulance. R12 was readmitted to the facility on [DATE]. Surveyor noted R12's transfer, bed hold notice and readmission rights form dated 1/30/25 under the document section in R12's medical record. This form documents the reason for transfer. Under Bed hold and readmission rights documents 1. If you are paying for your stay from either Private funds or Medicare with Private funds back up: *As outlined in your contact for care, while you are hospitalized or on leave from the facility your bed will bed at the daily current rate 2. If you are paying for your stay from Medicaid (T-19) funds: If you are hospitalized , your bed will be held for 15 days unless you waive this right. * If your hospital duration goes beyond 15 days, you and/or your legal Representative/Responsible Party are able to hold the bed from Private funds at 100% of your current daily rate being charged (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor noted for resident/resident representative signature line documents [Name] verbal yes from son. Date documents 1/30/25. Surveyor noted that written transfer notice & bed hold policy was not provided to R12 and R12's representative and the transfer, bed hold notice & readmission rights form does not have what the daily rate is to hold R12's bed. On 6/12/25, at 12:11 p.m., Surveyor asked Registered Nurse/Unit Manager (RN/UM)-D to explain the process when a resident is transferred/discharged to the hospital. RN/UM-D explained if Health Unit Coordinator (HUC)-T is she will do the paper work and if not the nurse sending the resident out will. RN/UM-D explained they send to the hospital a face sheet, order summary, power of attorney papers, and their medication administration record. The nurse should contact the POA if the resident can't speak and ask if they want a bed hold while they are out. Surveyor asked if written notice of transfer and bed hold policy is sent to the resident and resident representative. RN/UM-D informed Surveyor they get the verbal consent and was not sure if admissions sends this but it is not sent by nursing. On 6/12/25, at 12:25 p.m., Surveyor asked HUC-T if she could explain to Surveyor what she does when a resident is transferred/discharged to the hospital. HUC-T explained to Surveyor she has a blue folder with transfer sheet, face sheet, MAR (medication administration record), TAR (treatment administration record), code status, and any POA paperwork which she sends to the hospital. The nurse contacts the POA or asks the resident about the bed hold. Surveyor asked HUC-T what happens with the bed hold paperwork. HUC-T informed Surveyor the nurse fills out the bed hold paperwork. Surveyor asked HUC-T if any paperwork is sent to the POA. HUC-T replied no the nurse calls. On 6/12/25, at 2:05 p.m., Surveyor asked admission Coordinator (AC)-KK if she is involved with any paper work when a resident is transferred/discharged to the hospital. AC-KK replied no. Surveyor asked AC-KK if she is involved with the bed hold policy or notice of transfer. AC-KK replied no. On 6/12/25, at 2:11 p.m., Surveyor asked Director Social Service (DSS)-K if she is involved with any paper work when a resident is transferred/discharged to the hospital. DSS-K informed Surveyor the nurses review the notice of bed hold and transfer. Surveyor asked what happens with this paperwork. DSS-K informed Surveyor it is usually put into the medical record. 2.) R34's diagnoses include dementia (loss of cognitive function that interferes with a person's daily life and activities), atrial fibrillation (irregular and rapid heart rate) and hypertensive heart disease with heart failure (prolonged high blood pressure that leads to the heart's inability to pump blood effectively). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tudor Oaks Health Center	S77 W12929 McShane Dr Muskego, WI 53150

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R34's nurses note dated 5/16/25, at 5:54 a.m., written by LPN-F documents: CNA found res on the floor at 0250 (2:50 a.m.), sitting/lying in front of her bed with w/c to her left, where it had been all NOC (night). Res (Resident) was witnessed walking in room per CNA who res was assigned and found, coming from BR (bathroom) earlier in NOC and was assisted back to bed w/ (with) safety precautions in place and call light on chest. Rounds completed per CNA at 0100 (1:00 a.m.) and res toileted; per writer at 0200 (2:00 a.m.) and res asleep. Safety precautions/call light in place w/ BR light on. Injuries noted- left brow hematoma, c/o (complained of) left hip pain/disc (discomfort) noted. RN (Registered Nurse) notified and escorted to room per writer and assessed. Writer initiated neuro checks per protocol. [Name] Ambulance called at 0345 (3:45 a.m.). V/S (vital signs) and res stable w/hypotension noted. BP (blood pressure) increased as time went on per EMT (emergency medical technician) taking last BP before leaving unit at 0430 (4:30 a.m.). APAP (acetaminophen) x1 (times one) per pain/disc (discomfort) noted to left hip-7/10 and ineffective prior to leaving- 6/10. RN notified MD/DON (Medical Doctor/Director of Nursing). Writer updated POA (Power of Attorney) son [Name] at 0354 (3:45 a.m.) and directed to have res transferred to [Name] hospital for eval/tx (evaluation/treatment), and POA will meet res there, appreciative for being notified per writer. Res was able to move all extremities w/ (with) noticeable, and c/o left hip pain noted. Writer will report off to AM (morning) RN to call [hospital name] for updated report. R34 was readmitted to the facility on [DATE]. Surveyor noted R34's transfer, bed hold notice and readmission rights form dated 5/16/25 under the document section in R34's medical record. This form documents the reason for transfer. Under Bed hold and readmission rights documents 1. If you are paying for your stay from either Private funds or Medicare with Private funds back up: *As outlined in your contact for care, while you are hospitalized or on leave from the facility your bed will bed at the daily current rate 2. If you are paying for your stay from Medicaid (T-19) funds: If you are hospitalized , your bed will be held for 15 days unless you waive this right. * If your hospital duration goes beyond 15 days, you and/or your legal Representative/Responsible Party are able to hold the bed from Private funds at 100% of your current daily rate being charged Surveyor noted for resident/resident representative signature line documents Res's son [Name] via phone 5/16/25. Surveyor noted that written transfer notice & bed hold policy was not provided to R34 and R34's representative and the transfer, bed hold notice & readmission rights form does not have what the daily rate is to hold R34's bed. On 6/10/25, at 10:48 a.m., Surveyor spoke with R34's POA on the telephone. Surveyor asked when R34 was discharged to the hospital on 5/16/25 did the facility provide to you in writing the reason for the transfer and bed hold policy. R34's POA replied no they told me verbally why being transferred. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/12/25, at 12:11 p.m., Surveyor asked Registered Nurse/Unit Manager (RN/UM)-D to explain the process when a resident is transferred/discharged to the hospital. RN/UM-D explained if Health Unit Coordinator (HUC)-T is she will do the paper work and if not the nurse sending the resident out will. RN/UM-D explained they send to the hospital a face sheet, order summary, power of attorney papers, and their medication administration record. The nurse should contact the POA if the resident can't speak and ask if they want a bed hold while they are out. Surveyor asked if written notice of transfer and bed hold policy is sent to the resident and resident representative. RN/UM-D informed Surveyor they get the verbal consent and was not sure if admissions sends this but it is not sent by nursing. On 6/12/25, at 12:25 p.m., Surveyor asked HUC-T if she could explain to Surveyor what she does when a resident is transferred/discharged to the hospital. HUC-T explained to Surveyor she has a blue folder with transfer sheet, face sheet, MAR (medication administration record), TAR (treatment administration record), code status, and any POA paperwork which she sends to the hospital. The nurse contacts the POA or asks the resident about the bed hold. Surveyor asked HUC-T what happens with the bed hold paperwork. HUC-T informed Surveyor the nurse fills out the bed hold paperwork. Surveyor asked HUC-T if any paperwork is sent to the POA. HUC-T replied no the nurse calls. On 6/12/25, at 2:05 p.m., Surveyor asked admission Coordinator (AC)-KK if she is involved with any paper work when a resident is transferred/discharged to the hospital. AC-KK replied no. Surveyor asked AC-KK if she is involved with the bed hold policy or notice of transfer. AC-KK replied no. On 6/12/25, at 2:11 p.m., Surveyor asked Director Social Service (DSS)-K if she is involved with any paper work when a resident is transferred/discharged to the hospital. DSS-K informed Surveyor the nurses review the notice of bed hold and transfer. Surveyor asked what happens with this paperwork. DSS-K informed Surveyor it is usually put into the medical record. No additional information was provided. 3.) R39 was admitted to the facility on [DATE] and has diagnoses that include myelodysplastic syndrome (group of cancers in which the bone marrow does not produce enough healthy cells), congestive heart failure, hyponatremia (low sodium), anemia, and syndrome of inappropriate secretion of antidiuretic hormone (SIADH, produces to much antidiuretic hormone and body retains to much water). R39 is their own person. On 5/2/2025, R39 was admitted to the hospital for high potassium level and readmitted to the facility on [DATE]. On 6/12/2025, Surveyor reviewed R39's medical record and noted R39's signed transfer, bed hold notice, and readmission rights form from when R39 was transferred and admitted to the hospital on [DATE]. The bed hold and readmission rights documents: . 1. If you are paying for your stay from either private funds or Medicare with private funds back up: as outlined in your contract for care, while you are hospitalized or on leave from the facility your bed will be held at the current daily rate. Surveyor noted that the documents does not indicate what the daily rate it. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/16/2025, at 3:10 PM, Surveyor shared concern with nursing home administrator (NHA)-A that the bed hold document provided on 5/2/2025 to R39 when transferred and admitted to the hospital did not specify the bed hold amount R39 would have to pay. NHA-A stated that when a resident is admitted they are provided a sheet with all the prices on it and should refer to that sheet. Surveyor stated that the amount should be specified on the transfer/ bed hold document at the time of transfer in the event the prices change or the resident is not aware of the pricing at the time of transfer. 4.) R41 was admitted to the facility on [DATE] and has diagnoses that include chronic obstructive pulmonary disease with (acute) exacerbation (lung disease making it difficult to breathe), acute bronchitis (inflammation of the airways), chronic kidney disease stage 3 (impaired kidney function), type 2 diabetes mellitus (difficulty regulating blood sugar), cognitive communication deficit (difficulty remembering), anemia (lower than normal red blood cells) in chronic kidney disease, anxiety disorder, major depressive disorder, localized edema (swelling), hyperlipidemia (excess fats in the blood), unspecified urinary incontinence (impaired bladder control), and spondylosis of the lumbosacral region (arthritis of lower spine). R41 was transferred and admitted to the hospital on [DATE]. R41 was discharged from the hospital to an assisted living facility and did not readmit back to the facility. On 6/16/25 at 09:40 am, Surveyor reviewed R41's medical record and located written bed hold notice signed and dated by R41 and the facility on 3/31/25. Surveyor noted a bed hold notice specifies the reason for transfer to the hospital. Surveyor noted R41 marked an X next to the statement: I have been informed of the bed hold option and decline at this time. Surveyor noted the following verbiage on the bed hold notice: as outlined in your contract for care, while you are hospitalized or on leave from the facility your bed will be held at the current daily rate. Surveyor noted there is not a bed hold rate documented on this form. On 6/16/25 at 3:10 pm, Surveyor informed Nursing Home Administrator (NHA)-A that no bed hold rate was documented on the facility's bed hold notice. NHA-A stated residents get informed of the daily rate on admission in the admission packet, and all residents have the same daily rate amount. NHA-A stated the pay rate is specified in the admission packet, but not given on transfer again. Surveyor informed NHA-A the rate should be specified on the bed hold document at the time of transfer. No additional information was provided.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2.) R12's diagnoses include dementia (loss of cognitive function that interferes with a person's daily life and activities), atrial fibrillation (irregular and rapid heart beat), and syncope (fainting) and collapse. R12's nurses note dated 12/12/24, at 11:45 a.m., documents : Arrived to unit on 12/12/2014 at 1045. Came from [Name] Assisted Living - [Name] house. Resident has fall in her AL (assisted living) apartment and sustained R (right) humerus fx (fracture), no repair. Has RUE (right upper extremity) sling. A&Ox4 (alert and orientated times four). Diabetic on insulin. LCTA (lungs clear to auscultation). No pacemaker. Slight nonpitting edema to BLE (bilateral lower extremity). Continent of bowel and bladder but wears depends or pads in underwear. Has hard time falling asleep. Has reading glasses, not present at time of admission. Natural teeth. Will have occasional pain to RUE with movement. VS (vital signs) at time of admission 167/68 mmHg (millimeters of mercury), 97% room air, 98.2 f (Fahrenheit), 57 bpm (beats per minute), no pain at time of admission. R12's mobility care plan initiated & revised 12/12/24 includes an intervention dated 12/12/24 of *GG Chair/Bed-to-Chair Transfer - 2 assist sit-to-stand. R12's nurses note dated 5/20/25, at 12:26 p.m., by Registered Nurse (RN)-AA documents: Writer was called down to resident's room by HUC (health unit coordinator). CNA (Certified Nursing Assistant) was assisting resident to the bathroom and per CNA resident's legs gave out and CNA was unable to get her back into recliner. CNA had to lower resident to the floor. Resident did not hit head. Resident was incontinent at the time of the fall; CNA was trying to get her to the bathroom to be changed. Resident was assessed and denies pain. No injuries noted at the time of assessment. Writer and two CNAs assisted resident from floor back into wheelchair. Resident was able to stand in the bathroom with CNA assist to get onto toilet. VSS (vital signs stable). Resident stated that her tailbone hurt when sitting on the toilet. Resident has area already noted to left buttocks. Hospice, NP (Nurse Practitioner), POA (Power of Attorney), DON (Director of Nursing), CCM aware of witnessed fall. On 6/16/25, at 2:41 p.m., Surveyor met with Nursing Home Administrator (NHA)-A to discuss R12's falls. Surveyor informed NHA-A R12's fall on 5/20/25 documents the CNA had to lower R12 to the floor. Surveyor informed NHA-A according to R12's mobility care plan R12 was a sit to stand transfer with 2 staff. NHA-A informed Surveyor R12 was a sit to stand when she was first admitted , therapy changed her transfer status and the care plan may not have been revised to indicate this change. NHA-A informed Surveyor she will look for therapy's recommendation and provide the recommendation to Surveyor. On 6/16/25, at approximately 3:00 p.m., NHA-A provided Surveyor with therapy note dated 1/21/25 which documents: For tasks Pt (patient) to transfer with 2ww (wheeled walker) x (times) 1 assist. Surveyor noted that the facility did not revise R12's mobility care plan to reflect the change in transfer status. No additional information was provided. Based on interview and record review the facility did not ensure 2 (R24 and R12) of 12 residents care plans reviewed were revised accordingly. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* R24's care plan was not revised after developing a stage 2 pressure injury to the right heel. * R12's care plan was not revised after therapy gave new recommendations for R12's transfer status. Findings include: The facility policy titled Care Plan Revisions Upon Status Change with no implementation or reviewed/revised date documented, documents: Policy: The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change. Policy Explanation and Compliance Guidelines: 1. The comprehensive care plan with be reviewed and revised as necessary, when a resident experiences a status change. 2. Procedure for reviewing and revising the care plan when a resident experiences a status change: . d. The care plan will be updated with new or modified interventions. e. Staff involved in the care of the resident will report resident response to new or modified interventions. f. Care plans will be modified as needed by the MDS coordinator or other designated staff member. h. The unit manager or other designated staff member will conduct an audit on all residents experiencing a change in status, at the time the change in status identified, to ensure care plans have been updated to reflect current resident needs. 1.) R24 was admitted to the facility on [DATE] and has diagnoses that include Alzheimer's, Dementia, severe protein-calorie malnutrition, muscle weakness, cognitive communicative deficit, and weakness. R24's admission Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 5, indicating that R24 had severely impaired cognition. The MDS documents that the facility assessed R24 being modified independent with 1 staff member for repositioning, and maximal assistance with 1 staff member for putting on and taking off footwear and lower body dressing. R24's Pressure injury Care Area Assessment (CAA) dated 5/3/25 documents: R24's recent hospitalization after a fall at home without major injury, pneumonia with sepsis, and dementia. R24 was admitted for rehab with a goal to discharge home. R24 requires maximal to moderate assistance with most activities of daily living (ADLs) and has a BIMS score of 5. R24 receives scheduled antiplatelet, antidepressant, antihypertension, and anticonvulsant medications and is occasionally incontinent of bowel and bladder. R24 has a history of falling at home and no pressure injuries are noted on the admission skin assessment. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R24's Braden Scale for Pressure Injury Development dated 4/30/24 documents a score of 16, indicating that R24 is at moderate risk for pressure injury development. R24's potential for impaired skin integrity related to immobility care plan was initiated on 5/7/2025 with the following interventions: - Apply moisture barrier as needed. - Braden skin risk evaluation completed on admission, every week for 4 weeks, quarterly, and with any significant change. - Certified nursing assistants (CNAs) to observe skin with morning (am) and bedtime (HS) cares and report any abnormalities to the nurse. - Consult dietician for nutritional assessment as needed (PRN). - Maintain good skin hygiene. Moisturize dry skin PRN. - Monitor labs and weights as ordered. - Observe for alteration in skin integrity and report to nurse practitioner (NP)/physician assistant (PA)/ medical doctor (MD). Skin inspected by licensed staff weekly per schedule. - Pressure relieving device in wheelchair- gel cushion. - Provide adequate nutrition and hydration. Nutritional supplements and vitamins as ordered. On 5/20/2025, at 11:45 AM, in the progress notes nursing documented (nursing) notified that (R24) right heel was bleeding. (R24) has a 1cm X 1cm blister that opened up at the bottom and was bleeding. New orders received from NP . (R24) to wear Prevalon boots when in bed and use gripper socks, to avoid wearing shoes for next couple of weeks. Discontinue skin prep to bilateral heels each shift. R24's potential for impaired skin integrity was revised on 6/10/2025 documenting R24 had a stage 2 pressure injury to the right heel with the following revisions: - Provide dressing changes per MD order - Heel boots while in bed. Surveyor noted that R24's care plan was not revised until 6/10/2025. R24 developed a pressure injury to the right heel on 5/20/2025. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/16/2025, at 11:45 AM, Surveyor interviewed Registered Nurse Unit Manager (RNUM)-D who stated that when an area of concern in noted a care plan revision is completed. Surveyor shared that R24's care plan was not revised until 6/10/2025 for R24's pressure injury that was noted on 5/20/2025. RNUM-D stated that the tasks get updated and then do the care plan later. RNUM-D stated that now staff are revising the care plan right away because staff did not realize when the tasks is updated it does not feed into the care plan. Surveyor and RNUM-D reviewed R24 tasks and could not determine when the tasks were added to R24's medical record. RNUM-D and Surveyor reviewed R24's CNA Kardex and did not locate interventions for R24's right heel pressure injury. On 6/16/2025, at 3:10 PM, Surveyor shared concerns with Nursing Home Administrator (NHA)-A that R24 care plan was not revised on 5/20/2025 when R24 was noted to have a stage 2 pressure injury to the right heel until 6/10/2025. NHA-A stated that the pillow boots were added to the tasks sheet. Surveyor shared that the initiation date of the pillow boots was not able to be located until 6/10/2025 on the care plan. NHA-A understood the concern and shared that R24 was getting the proper interventions right away on 5/20/2025. Surveyor shared that R24's care plan should reflect the revisions on 5/20/2025 when the concern to R24's right heel was first observed, but not documented until 6/10/2025.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2.) R12 was admitted to the facility on [DATE] with diagnoses that include dementia, depressive disorder, chronic kidney disease (progressive damage and loss of kidney function), atrial fibrillation(irregular and rapid heartbeat), malignant neoplasm of colon (cancer), and diabetes mellitus. R12's skin pressure injury care plan initiated 12/12/24 & revised 5/29/25 documents the following interventions: *Apply moisture barrier as needed. Initiated 12/12/24 & revised 12/16/24. *Braden skin risk evaluation completed on admission, Q (every) week for 4 weeks, quarterly, and with any significant change. Initiated 12/12/24. *CNA's (Certified Nursing Assistant) to observe skin with am (morning) and hs (hour sleep) cares and report any abnormalities to the nurse. Initiated 12/12/24 & revised 12/16/24. *Dressing changes per MD (Medical Doctor) order. Initiated 6/10/25. *Mild skin risk per Braden. Initiated 2/17/25. *Observe for alteration in skin integrity and report to NP/PA/MD (Nurse Practitioner/Physician Assistant/Medical Doctor). Skin inspected by licensed staff weekly per schedule. Initiated 12/12/24. *Pressure relieving device in W/C (wheelchair) and on bed. Initiated 12/12/24 & revised 2/17/25. *Encourage [R12's first name] to reposition herself often in bed. Initiated and revised 6/10/25. R12's Braden Scale assessments dated 12/12/24, 12/19/24, & 12/26/24 have a score of 18 which indicates mild risk for pressure injury development. R12's Braden Scale assessments dated 1/2/25 & 1/9/25 have a score of 14 which indicates moderate risk for pressure injury development. R12's Braden Scale assessment dated [DATE] & 2/5/25 have a score of 18 which indicates mild risk for pressure injury development. R12's significant change MDS (minimum data set) with an assessment reference date of 2/6/25 has a BIMS (brief interview mental status) score of 12 which indicates moderate cognitive impairment. R12 is assessed as not having any behavior including refusal of care. R12 is assessed as requiring supervision or touching assistance for toileting hygiene, roll left and right, chair/bed to chair transfer and toilet transfers. R12 is assessed as being occasionally incontinent of urine and always incontinent of bowel. R12 is at risk for pressure injury development and is assessed as not having any pressure injuries. R12's N Advc(Advanced) -Skin Issues -V7 dated 3/1/25 and completed by Licensed Practical Nurse (LPN)-CC documents Skin Issue: Pressure ulcer/Injury, Location: Coccyx, Length (cm) (centimeters): 0.5, Width (cm): 0.5, Depth (cm): 0, Tunneling: No, Undermining: No, Presence of wound pain: Yes. Surveyor reviewed R12's medical record and was unable to locate a comprehensive assessment of R12's coccyx. R12's nurses note dated 3/11/25, at 8:49 a.m., written by Registered Nurse/Unit Manager-D documents Resident assessed for reported redness to bilateral buttocks. Resident has blanchable redness with a scant (0.5 x 0.6) denuded area on each side. Resident is continent of bowel and bladder, is clean and dry upon inspection. Barrier cream ordered to be applied BID (twice daily) with cares. Resident understands explanation of possibility of pressure area and agrees to shift weight while in chair and try to sleep on one side or the other vs on her back. Will monitor with wound rounds to prevent open area. Surveyor was unable to locate a comprehensive assessment of R12's coccyx. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R12's nurses note dated 3/12/25, at 9:46 a.m., written by Licensed Practical Nurse (LPN)-DD documents Resident is on the board for wounds to L (left) foot and an open area to coccyx. Resident is tolerating dressing changes well with no complaints of pain or discomfort. Resident is encouraged to reposition and drink fluids. Resident refused to eat breakfast this AM (morning) shift and insulin was held. Surveyor was unable to locate a comprehensive assessment of R12's coccyx. R12's nurses note dated 3/13/25, at 10:52 a.m., written by RN-AA documents Resident is being monitored for wounds. No concerns at this time. No complaints of pain noted. Taking in fluids. R12's nurses note dated 3/14/25, at 10:35 a.m., written by LPN-DD documents Resident is on the board for wounds to L foot and an open area to coccyx. Resident is tolerating dressing changes well with no complaints of pain or discomfort. Resident is encouraged to reposition and drink fluids. Resident is in a pleasant mood and ate 100% of breakfast. Surveyor was unable to locate a comprehensive assessment of R12's coccyx. R12's nurses note dated 3/16/25, at 21:19 (9:19 p.m.), written by LPN-CC documents Resident on report for area to L toe. Writer cleaned area with wound wash and patted dry. Betadine applied to gauze and toe dressing complete. Resident also had OA (open area) to coccyx. Denies pain to both areas. Resident has a CNS (culture and sensitivity) pending due to dysuria and frequency. Surveyor was unable to locate a comprehensive assessment of R12's coccyx. R12's nurses note dated 3/18/25, at 22:04 (10:04 p.m.), written by LPN-CC documents Resident on report for skin tear to L toe, OA to coccyx and positive for UTI (urinary tract infection). Resident toe dressing completed by writer. No complaints of pain. Resident states open area to coccyx does not bother her. Resident had first dose of Cipro 250 mg BID x 7 days and is tolerating well. Surveyor was unable to locate a comprehensive assessment of R12's coccyx. R12's weekly wound assessment dated [DATE] documents present on admission 1/21/25. Site documents 31) right buttocks. Under type for other documents abrasion. Length is 0.6, width 0.6, depth 0, and Stage n/a (not applicable). For describe in further detail wound site location documents abrasion on each side of gluteal cleft. Under comments documents abrasions present upon re-admission from hospital 1/21/25. Resident is continent of B & B (bowel and bladder). Abrasions are not over bony prominence. Barrier cream for protection, new seat cushion placed on WC (wheelchair). Resident reminded to shift weight often. R12's nurses note dated 3/23/25, at 6:19 a.m., written by LPN-EE documents Resident remains on report for ST (skin tear) to area between 4&5 toes on the left foot, area is open to air and resident denies pain. Also small open area to coccyx and calazinc cream applied every shift and PRN (as needed). Also on report for a UTI (urinary tract infection), resident denies any dysuria (painful urination). Temp (temperature) 97.7 Fluids enc (encouraged) and are provided at bedside. Remains on PO (by mouth) Cipro 250 mg (milligrams) Bid (twice daily)thru 3/25/25 No adverse reaction noted to ABT (antibiotic). Resident also being monitored for hypoglycemia. Resident is alert and verbal, speech is clear and is responding appropriately. Skin is warm and dry. Surveyor was unable to locate a comprehensive assessment of R12's coccyx. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R12's nurses note dated 3/24/25, at 4:45 a.m., written by LPN-EE documents Resident is on report for skin tear to left foot between 4 & 5 toes. Area is open to air and resident denies any pain to areas. Also on report for open area to coccyx, barrier cream applied per order. Resident also is taking Cipro 250 mg Bid thru 3/25/25 for a UTI. No adverse reaction noted to ABT. Resident denies any dysuria. Fluids enc and are provided at bedside. Temp 97.5. Surveyor was unable to locate a comprehensive assessment of R12's coccyx. R12's skin check dated 4/23/25 written by RN-BB documents .#003: Skin issues has not been evaluated. Location: Coccyx. Laterality/Orientation: Middle. Issue type: Pressure ulcer/injury. Wound acquired in-house. Wound is new. Undermining: No. Tunneling: No. Surveyor was unable to locate a comprehensive assessment of R12's coccyx pressure injury until 5/7/25, 14 days later, treatment for R12's coccyx press injury was not initiated until 5/7/25, and R12's skin pressure injury care plan was not revised until 6/10/25. R12's Braden Scale assessment dated [DATE] has a score of 16 which indicates mild risk for pressure injury development. R12's progress note dated 5/7/25, at 4:51 a.m., written by RN-FF documents Resident had a skin assessment done at this time and was noted to have a very small-1.0 cm x (times) 0.5 cm open area on left buttock. Wound has no peri wound redness and no drainage noted. Wound cleansed with soap and water and patted dry with a foam dressing applied. Residents nurse also at bedside and aware of the wound. Resident also noted to have a few old bruises on bilateral LE's (lower extremities) and right shin has a very small scab noted with no s/s (sign/symptom) of infection noted. Resident repositioned also at this time. R12's weekly wound assessment dated [DATE] documents in house acquired on 5/7/25. Site is documented as 23) coccyx. Type is pressure. Length is 0.8, width 0.8, depth is 0.1 and Stage is II (2). Wound bed is 100% epithelial tissue. Under comments documents NP (Nurse Practitioner)/POA (Power of Attorney)/Hospice aware of wound. Dressing orders in place. R12's quarterly MDS with an assessment reference date of 5/8/25 has a BIMS score of 11 which indicates moderate cognitive impairment. R12 is assessed as not having any behavior including refusal of care. R12 is assessed as requiring supervision or touching assistance for toileting hygiene, roll left and right, chair/bed to chair transfer and toilet transfers. R12 is assessed as being occasionally incontinent of urine and always incontinent of bowel. R12 is at risk for pressure injury development and is assessed as having one Stage 2 pressure injury which was not present upon admission. R12's progress note dated 5/8/25, at 15:04 (3:04 p.m.), written by RN/UM-D documents Writer spoke with resident POA (power of attorney) this morning to update on coccyx wound. POA stated her is concerned that [R12's first name] is more tired and having urine soaked clothes in the dirty laundry. Hospice updated of concern with NNO (no new orders). R12's nurses note dated 5/12/25, at 22:51 (10:51 p.m.), written by RN-BB documents Resident is on the board for COC (change of condition) and OA (open area) to buttocks. Dressing to buttock changed this evening due to being in the wrong place and not covering wound. Resident refused to get up for dinner, resident did get up later in the evening and was given a snack to eat (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor noted R12's weekly wound assessment from 5/14/25 through 6/11/25. R12's comprehensive assessment dated [DATE] documents for site 23) coccyx, type is pressure, length 0.4, depth 0.2, depth <0. 1 (less than 0.1) and stage is II (2). Under describe in further detail wound site location documents. Above measured wound is left of the coccyx. Resident has a small spot of denuded skin on the right buttock, intact a this time 1.0 x 1.2. Wound bed is 100% epithelial tissue. Under comments documents stable. On 6/10/25, at 9:21 a.m., Surveyor observed R12 sitting in a personal type recliner in R12's room wearing clothing with a bathrobe over the clothing. During the conversation with R12, Surveyor asked R12 if she has any skin concerns. R12 stated I have a hole in my butt which they are treating. Surveyor asked R12 how she developed the hole. R12 replied from sitting I think, I'm not used to sitting. Surveyor asked R12 if there is a cushion in her recliner. R12 replied my fanny, there is nothing extra on it, I brought in my own chair. Surveyor did not observe a cushion in R12's personal type recliner but did observe a comfort cushion in R12's wheelchair. On 6/10/25, at 10:27 a.m., Surveyor observed R12 continues to be sitting in the personal type recliner with her eyes closed. Surveyor did not observe a cushion on R12's personal type recliner. On 6/10/25, at 11:14 a.m., Surveyor observed R12 continues to be sitting in the personal type recliner. Surveyor did not observe a cushion on R12's personal type recliner. On 6/10/25, at 12:08 p.m., Surveyor observed R12 continues to be sitting in a personal type recliner eating lunch. Surveyor did not observe a cushion on R12's personal type recliner. On 6/10/25, at 1:55 p.m., Surveyor observed R12 continues to be sitting in a personal type recliner with her eyes closed and talking to herself. Surveyor did not observe a cushion on R12's personal type recliner. On 6/10/25, at 2:25 p.m., Surveyor observed R12 in bed on her back sleeping. Surveyor observed there is not a cushion in R12's personal type recliner. On 6/12/25, at 8:29 a.m., Surveyor observed Certified Nursing Assistant (CNA)-GG and CNA-HH transfer R12 from the bed into the bathroom using a sit to stand lift. CNA-GG lowered R12's product and R12 was lowered onto the toilet. At 8:32 a.m. R12 was asked if she wanted privacy and CNA-GG & CNA-HH removed their gloves and left R12's room. At 8:33 a.m. CNA-HH entered R12's room and placed gloves on. At 8:34 a. m. RN/UM-D entered R12's bathroom, dated the foam dressing and placed gloves on. RN/UM-D placed soap & water on four by four gauze, asked R12 if she was ready to stand up & asked R12 if she was able to help stand up. R12 was then raised to a standing position and wheeled out of the bathroom. RN/UM-D removed the dressing, cleansed R12's coccyx pressure injury, waved the foam dressing over the pressure injury to help dry the pressure injury and place the foam dressing over R12's coccyx pressure injury. Surveyor noted RN/UM-D completed R12's pressure injury treatment according to physician orders. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/16/25, at 12:24 p.m., Surveyor asked RN/UM-D if she is the facility's wound nurse. RN/UM-D replied yes. Surveyor asked RN/UM-D how she becomes aware if a resident develops a pressure injury. RN/UM-D informed Surveyor staff updates her if one is found during a shower check or a CNA sees a spot. Surveyor asked RN/UM-D once she is made aware of a resident having a pressure injury what does she do. RN/UM-D replied I go around do an assessment, get measurements and stage if need be. Surveyor asked RN/UM-D how often are pressure injury assessments are completed. RN/UM-D informed Surveyor she does wound rounds weekly on Wednesday. Surveyor asked R/UM-D who is responsible for revising the care plan. RN/UM-D replied that would be me or who ever puts an intervention should update, if its someone else other than me. Surveyor informed RN/UM-D R12's skin assessment dated [DATE] documents a coccyx pressure injury with measurements and Surveyor was unable to locate a RN assessment of R12's coccyx. Surveyor informed RN/UM-D there are multiple notes during March regarding an open area on R12's coccyx but no comprehensive assessments. On 4/23/25 RN-BB documents a new coccyx pressure injury but does not include measurements or description of wound bed. Surveyor was not able to locate a comprehensive assessment until 5/7/25 and treatment for the pressure injury was not ordered until 5/7/25. Surveyor informed RN/UM-D of the observations of R12 sitting on the personal type recliner without a pressure relief cushion. RN/UM-D informed Surveyor she doesn't know if they a cushion for the recliner care planned. Surveyor asked how they are providing pressure relief when R12 is sitting in the personal recliner. RN/UM-D informed Surveyor R12 they encourage repositioning and usually doesn't sit in the recliner. Surveyor informed RN/UM-D the first day of survey, Surveyor observed R12 sitting in the personal type recliner most of the day. Surveyor asked RN/UM-D if RN-BB made her aware of R12's coccyx pressure injury. RN/UM-D informed Surveyor she will have to see if there are any old emails and wouldn't know why she wouldn't of done an assessment. RN/UM-D informed Surveyor she will do some digging and get back to Surveyor. RN/UM-D did not provide Surveyor with any additional information. 3) R13 was admitted to the facility on [DATE] with diagnoses of Hypertensive Heart Disease(long term conditions developed from chronic high blood pressure), Varicose Veins(enlarged veins in legs and feet), Hyperlipidemia(high levels of fat particles in blood), Alzheimer's(progressive disease that destroys memory and other important mental functions), Dementia(loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life), Major Depressive Disorder(persistent feelings of sadness, hopelessness, and a loss of interest or pleasure in activities), and Anxiety Disorder(mental health disorder characterized by feelings of worry, fear that interfere with daily activities). R13 currently has an activated Health Care Power of Attorney(HCPOA) to assist with decision making. R13's Quarterly Minimum Data Set(MDS) completed 3/27/25 documents a Brief Interview for Mental Status(BIMS) score to be 2, indicating R13 demonstrates severely impaired skills for daily decision making. R13's MDS documents R13 has disorganized thinking, delusions, physical behavioral symptoms, rejection of care, and wandering daily. R13 requires set-up for meals. R13 requires partial/moderate assistance for showers and upper dressing. R13 requires substantial/maximum assistance for lower dressing, mobility, and transfers. R13 has no range of motion impairment. R13's current physician order document to check R13's wanderguard for placement every shift effective 10/17/24. Surveyor notes that R13's physician orders do not document to check for skin integrity under the wanderguard. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed R13's Medication Administration Records(MARS) and Treatment Administration Record(TARS). Surveyor notes that R13's MARS and TARS indicates nursing staff are not completing daily checks for R13's skin integrity under R13's wanderguard. Surveyor reviewed R13's Elopement care plan initiated 3/7/25 which does not document any intervention to check R13's skin integrity under R13's wanderguard. Surveyor reviewed R13's risk of breakdown due to chronic incontinence and reduced mobility initiated 2/17/25 which does not document any intervention to check R13's skin integrity under R13's wanderguard. On 6/10/25, at 10:39 AM, Surveyor observed R13's wanderguard placed on R13's left ankle. R13's wanderguard is directly on R13's skin with no sock underneath. Wanderguard on left ankle. Is all over the unit. Requires a lot of redirection, wanderguard is not on a sock On 6/11/25, at 2:05 PM, Surveyor observed R13 in the lounge. R13 has R13's wanderguard on left ankle, directly on the skin with no sock underneath. On 6/12/25, at 12:08 PM, Surveyor interviewed Registered Nurse Unit Manager (RN)-D in regards to skin integrity checks related to R13's placement of R13's wanderguard. RN-D stated that the nursing staff checks for placement and function of the wanderguard but does not complete actual skin checks with placement of the wanderguard. RN-D stated, we need to work on wording. On 6/12/25, at 3:24 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, and Corporate Consultant (CC)-C that there is no documentation that nursing staff have been completing daily skin checks with the placement of R13's wanderguard in order to maintain skin integrity. No further information has been provided by the facility at this time in regards to why R13 has not had daily skin checks completed due to R13's placement of R13's wanderguard directly on the skin of R13's ankle. On 6/16/25, at 10:26 AM, DON-B provided documentation to Surveyor that R13's physician orders document to check R13's wanderguard placement and skin integrity every shift effective 6/13/25. No additional information was provided. Based on observation, interview, and record review, the facility did not ensure that residents received necessary treatment and services consistent with professional standards of practice to promote healing and prevent new pressure injuries from developing for 3 (R38, R12, and R13) of 3 residents reviewed for pressure injuries. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* R38 was admitted with moisture associated skin damage (MASD) on 4/16/2025 to R38 buttocks. On 5/2/2025, R38 developed an open area on the buttocks and the facility did not reassess the area as a stage 2 pressure injury and did not revise R38's care plan until 6/10/2025. The facility did not complete a weekly skin assessment for R38 between 4/18/2025 and 5/2/2025. R38 was observed sitting in the recliner chair without pressure relief. * R12 was identified to have a pressure injury on 3/1/2025. R12 did not have comprehensive assessments completed. On 4/23/2025, R12 had another documented pressure injury and a comprehensive assessment and treatment were not implemented until 5/7/2025. There were observations on R12 sitting in the recliner chair without pressure relief. * R13 did not have daily skin checks/ assessments to monitor the skin underneath R13's wanderguard. Findings include: The facility policy titled Prevention and Treatment of Skin Breakdown/ Pressure Injury revised on 12/2024 documents: Purpose: Maintaining intact skin is integral to resident health and wellness. Care and services are delivered to maintain skin integrity and promote skin healing if skin breakdown should occur. Policy: Resident skin integrity is assessed upon admission and weekly thereafter. A skin risk assessment is completed upon admission, weekly for 4 weeks, upon significant change and quarterly thereafter. Those residents at an increased risk for impaired skin integrity are provided preventative measures to reducing [sic] the potential for skin breakdown. Those residents' who experience a break in skin integrity or wounds are provided care and service to improve the skin according to professional standards of care. Procedure: I.Skin Assessment . A resident centered care plan is implemented/ updated for skin risk with interventions based upon: - Areas of risk - Resident Assessment - Braden evaluation score of 15 or less - Clinicians' assessment/ evaluation - Resident Preferences . 3. Skin integrity is monitored, and abnormal findings are documented: - Skin is observed daily with cares. If any skin concerns are noted, they are reported to the licensed nurse. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Weekly skin audits are performed by a licensed nurse. II. Treatment of impaired pressure injury . If a resident is admitted with impaired skin integrity or new pressure injury . 1. Documentation of the skin impairment is completed in the medial record. Staging is completed as necessary by trained licensed nursing associates. 2. Standing orders/protocol for skin impairment are initiated. 5. Evaluate current pressure reduction interventions and revise resident centered care plan. 10. Weekly the licensed nurse will stage, measure, and examine the wound bed and surrounding skin. 1.) R38 was admitted to the facility on [DATE] and has diagnoses that include respiratory failure, pulmonary fibrosis, muscle weakness, and anxiety disorder. R38's Admissions Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 15, indicating that R38 has intact cognition. The MDS assessed R38 as needing maximal assistance with 1 staff member for toileting hygiene, and moderate to minimal assistance with 1 staff member for transferring and repositioning. R38's Braden Scale for Predicting Pressure Injury risk dated 4/16/2025 documents a score of 18, indicating that R38 is at mild risk for pressure injury development. R38's admission Care Area Assessment (CAA) dated 4/22/2025 for pressure injuries documents: R38 triggered area for recent hospitalization with COVID/pneumonia. (R38) was admitted to the facility for rehab with a goal to discharge back to home. (R38) required maximal assistance to moderate assistance with most activities of daily living (ADLs). (R38) is frequently incontinent of bowel and bladder . (R38) was admitted with moisture associated skin damage (MASD) and excoriations on buttocks. (R38) did not have pressure injuries on admission on [DATE]. R38's potential for impaired skin integrity related to debility, altered mobility, weakness, and fragile skin care plan was initiated on 4/16/2025 with the following interventions: -Apply moisture barrier as needed. - Apply topical medications as ordered. - Braden skin risk evaluation completed on admission, every week for 4 weeks, quarterly, and with any significant change. - Certified nursing assistants (CNAs) to observe skin with Day (AM) and Evening (HS) cares and report any abnormalities to the nurse. - Consult dietician for nutritional assessment as needed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Maintain good hygiene. Moisturize dry skin as needed. - Monitor labs and weights as ordered. - Observe for alteration in skin integrity and report to nurse practitioner (NP)/ physician assistant (PA)/ medical doctor (MD). Skin inspected by licensed staff weekly per schedule. - Pressure relieving device in wheelchair, gel cushion. - Provide adequate nutrition and hydration. Nutritional supplements and vitamins as ordered. - Toileting per elimination section of this care plan. - use lift sheet as needed to move (R38) in bed. On 5/2/2025, at 6:29 AM, in the progress notes nursing documented: Certified nursing assistant (CNA) took R38 to the bathroom and noted an open area on R38's left buttock area. No drainage, or signs of infection noted. R38's wound data assessment dated [DATE] documents: - Coccyx, MASD - 0.2 X 0.5 X <0.1 (Length X Width X Depth), partial thickness, superficial - 100% epithelial tissue, no drainage - Macerated, MASD with open area from shearing force. There are two open areas present, same size, one directly above the other. Below level of coccyx. - Redness noted upon admission, has new open areas within the redness due to shearing force. Dressing applied and will monitor for improvement. R38 continues to have weekly wound rounds completed. On 5/21/2025, 5/28/2025, and 6/4/2025 nursing documented that the area to R38's coccyx area was healed. On 6/10/2025 Surveyor reviewed the facility's list documenting the residents that have pressure injuries in the building. R38 was documenting as having a stage 2 pressure injury to the coccyx area and documented as being present on admission. Surveyor noted that R38 was documented to have MASD on the coccyx/ buttock area and on 5/2/2025 there were 2 open areas to the coccyx area. Surveyor noted that the classification of the area was still documented as MASD and not revised to state Stage 2 pressure injury. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/11/2025 in the progress notes nursing documented (R38's) previously resurfaced skin has re-opened to a scant slit in the skin at the tip of coccyx within the gluteal cleft. Coccyx, MASD. 0.4 cm X 0.2 cm X <0.1 cm, 100% epithelial tissue. Surveyor notes that the open area on the coccyx is being described as MASD and not a stage 2 pressure injury Surveyor reviewed R38's weekly skin assessments and noted that R38's prior skin assessment/check was documented to be completed on 4/18/2025 and nursing documented that R38 had redness to the buttock and groin area. Surveyor noted that there was not another skin assessment/check completed until 5/2/2025 when R38 was observed to have 2 open areas. On 6/12/2025 Surveyor reviewed R38's care plan and noted that there was no review or revisions made to R38's care plan after R38 was noted to have open area to the buttock/coccyx area on 5/2/2025 and 6/11/2025 to determine in the interventions in place were still appropriate or had to be revised to prevent further breakdown of skin. On 6/12/2025, at 10:16 AM, Surveyor observed R38 sitting in recliner chair on a bed pillow. Surveyor asked R38 if R38 had another cushion R38 was supposed to sit on while in the recliner. R38 stated that R38 put the pillow in because it felt better and that there was not another cushion. On 6/16/2025, at 8:15 AM, Surveyor interviewed registered nurse unit manager (RNUM)-D. Surveyor asked RNUM-D if R38 was admitted to the facility with a stage 2 pressure injury to the coccyx area. RNUM-D stated that R38 was admitted with MASD and then 2 open areas developed, closed, and there is a little area that has reopened recently. Surveyor asked what the classification of the open area would be. RNUM-D stated that it would be a stage 2. Surveyor shared concern that on R38 wound assessments the areas on R38 buttock/coccyx area were documented as MASD. RNUM-D stated that R38's MASD should have been reclassified as a stage 2 on 5/2/2025 when open areas were observed on R38's buttock/coccyx area. Surveyor shared that a weekly skin assessment could not be located between 4/18/2025 until 5/2/2025 when R38 was noted to have the open areas. RNUM-D reviewed R38's medical record and acknowledged that RNUM-D could not find a skin assessment or nursing progress note to reflect a skin assessment for R38 between 4/18/2025 and 5/2/2025. RNUM-D stated that there should have been a skin assessment, and if R38 refused there should still have been documentation. Surveyor shared Surveyors observations of R38 sitting on a bed pillow when sitting in R38's recliner chair because it felt better. RNUM-D stated that cushions are only put in wheelchairs and do not put in the recliner chairs because the recliner chairs are already padded. Surveyor shared that R38 did not think her recliner chair was comfortable and put in a bed pillow to sit on. RNUM-D stated would look into getting a cushion for R38's recliner chair. Surveyor asked when care plan revisions are completed. RNUM-D stated that the Kardex gets updated right away and then will do the care plan later. Surveyor shared that R38's care plan was never revised or reviewed on 5/2/2025 or 6/11/2025 when R38 was noted to have open areas. RNUM-D reviewed R38's care plan and shared that R38's Kardex probably was updated but the care plan should have been updated as well. Surveyor and RNUM-D reviewed R38's Kardex dated as of 6/16/2025 and noted the following interventions for skin: 1. Daily skin inspection. Report abnormalities to the nurse. 2. Monitor Skin observation. RNUN-D stated that there should be more interventions since R38 had open areas and an area has reopened. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/16/2025, at 3:10 PM, Surveyor informed Nursing Home Administrator (NHA)-A that R38 did not have a skin assessment/ check completed between 4/18 through 5/2/2025 and was noted to have 2 open areas to R38's coccyx area on 5/2/2025. R38's care plan or Kardex was not reviewed or revised on 5/2/2025 after R38 was noted to have developed open areas. Surveyor also shared that R38 was admitted with MASD and was not re-classified on 5/2/2025 and 6/11/2025 to indicate R38's MASD transitioned to Stage 2. Surveyor also shared that R38 was observed to be sitting in R38's recliner on a bed pillow because it felt better. NHA-A stated that R38's tasks were updated when R38's open area to the buttock was observed. Surveyor shared that no evidence of R38's care plan or Kardex and certified nursing assistant (CNA) tasks could be identified that it was revised or reviewed on 5/2/2025 or 6/11/2025 when R38 was noted to having open areas.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2.) R11's diagnoses includes diabetes mellitus (high blood sugar). R11's diabetic mellitus care plan initiated & revised on 12/15/22 documents the following interventions: *Check all of body for breaks in skin and treat promptly as ordered by doctor. Initiated 12/15/22. *Diabetes medication/insulin as ordered by doctor. Monitor/document for side effects and effectiveness. Initiated 12/15/22 & revised 3/9/23. *Fasting serum blood sugar as ordered by doctor. Initiated 12/15/22. *Monitor/document/report to MD (Medical Doctor) PRN (as needed) s/sx (signs/symptoms) of hypoglycemia: sweating, tremor, increased heart rate (Tachycardia), pallor, nervousness, confusion, slurred speech, lack of coordination, staggering gait. Initiated 12/15/22. Monitor/document/report to MD PRN for s/sx of hyperglycemia: increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abd (abdominal) pain, Kussmaul breathing (rapid, deep and consistent breathing), acetone breath (smells fruity), stupor, coma. Initiated 12/15/22. *Monitor/document/report to MD PRN for s/sx of infection to any open areas: redness, pain, heat, swelling, or pus formation. Initiated 12/15/22 Inspect feet daily for open areas, sores, pressure areas, blisters, edema or redness. Report any of the above to the nurse. Initiated 8/19/24 & revised 9/6/24. Surveyor reviewed R11's medical record and was unable to locate diabetic foot checks for R11. On 6/12/25, at 12:07 p.m., Surveyor asked Registered Nurse/Unit Manager (RN/UM)-D about diabetic foot checks. RN/UM-D informed Surveyor they do weekly shower checks and the CNA (Certified Nursing Assistant) should be documenting. Surveyor asked RN/UM-D if daily foot checks for residents with diabetes mellitus are done. RN/UM-D replied we do not. Surveyor informed RN/UM-D Surveyor was unable to locate daily diabetic foot checks for R11. On 6/12/25, at 3:15 p.m., during the end of the day meeting, Surveyor informed Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B and Corporate Nurse-C R11 has a diagnosis of diabetes mellitus and Surveyor was unable to locate daily diabetic foot checks for R11. \ Surveyor was not provided with any additional information as to why diabetic foot checks were not being completed for R11. 3.) R12's diagnosis includes diabetes mellitus (high blood sugar). (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R12's diabetic mellitus care plan initiated & revised 12/20/24 documents the following interventions: *Diabetes medication/insulin as ordered by doctor. Monitor/document for side effects and effectiveness. Initiated & revised 12/20/24. *Dietary consult for nutritional regimen and ongoing monitoring. Initiated 12/20/24. *Discuss meal times, portion sizes, dietary restrictions, snacks allowed in daily nutritional plan, compliance with nutritional regimen. Initiated 12/20/24. *Educate regarding medications and importance of compliance. Have resident verbally state an understanding. Initiated 12/20/24. *Educate resident/family/caregiver: Diabetes is a chronic disease and that compliance is essential to prevent complications of the disease, review complications and prevention with the resident/family/caregiver, Elicit a verbal understanding from the resident/family/caregiver, That nails should always be cut straight across, never cut corners. File rough edges with emery board. Initiated 12/20/24. *Educate resident/family/caregivers as to the correct protocol for glucose monitoring and insulin injections and obtain return demonstrations. Continue until comfort level with procedures is achieved. Initiated 12/20/24. *If infection is present, consult doctor regarding any changes in diabetic medications. Initiated 12/20/24. *Monitor/document/report to MD (Medical Doctor) PRN (as needed) s/sx (signs/symptoms) of hypoglycemia: sweating, tremor, increased heart rate (Tachycardia), pallor, nervousness, confusion, slurred speech, lack of coordination, staggering gait. Initiated 12/20/24. *Monitor/document/report to MD PRN for s/sx of hyperglycemia: increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abd (abdominal) pain, Kussmaul breathing (rapid, deep and consistent breathing), acetone breath (smells fruity), stupor, coma. Initiated 12/20/24. *Monitor/document/report to MD PRN for s/sx of infection to any open areas: redness, pain, heat, swelling or pus formation. Initiated 12/20/24. Surveyor noted R12's care plan does not address diabetic foot checks. Surveyor reviewed R12's medical record and was unable to locate diabetic foot checks for R12. On 6/12/25, at 12:07 p.m., Surveyor asked Registered Nurse/Unit Manager (RN/UM)-D about diabetic foot checks. RN/UM-D informed Surveyor they do weekly shower checks and the CNA (Certified Nursing Assistant) should be documenting. Surveyor asked RN/UM-D if daily foot checks for residents with diabetes mellitus are done. RN/UM-D replied we do not. Surveyor informed RN/UM-D Surveyor was unable to locate daily diabetic foot checks for R12. On 6/12/25, at 3:15 p.m., during the end of the day meeting Surveyor informed Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B and Corporate Nurse-C R12 has a diagnosis of diabetes mellitus and Surveyor was unable to locate daily diabetic foot checks for R12. Surveyor was not provided with any additional information as to why diabetic foot checks were not being completed for R12. Based on interview and record review, the facility did not ensure that residents that are diabetic received routine diabetic foot checks in accordance with professional standards of practice for 3 (R9, R11, and R12) of 3 sampled residents reviewed for diabetic foot checks. *R9 has a diagnosis of Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease(Diabetic Nephropathy) and has no documentation of diabetic foot checks. *R11 has a diagnosis of Type 2 Diabetes Mellitus with Diabetic Neuropathy and has no documentation of diabetic foot checks. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*R12 has a diagnosis of Type 2 Diabetes Mellitus with Diabetic Polyneuropathy and has no documentation of diabetic foot checks. Findings Include: The facility's undated Skin Integrity-Foot Care policy documents: Policy: It is the policy of this facility to ensure Residents receive proper treatment and care within professional standards of practice and state scope of practice, as applicable, to maintain mobility and good foot health. This policy pertains to maintaining the skin integrity of the foot. Policy Explanation and Compliance Guidelines: 1.The facility will provide foot care and treatment in accordance with professional standards of practice, including the prevention of complications from the Resident's medical conditions. a. The facility will utilize a systematic approach for the prevention and management of foot ulcers, including efforts to identify risk; stabilize, reduce, or remove underlying risk factors; monitor the impact of the interventions; and modify the interventions as appropriate. 2. Assessment of Risk b. The comprehensive assessment process will be utilized for identifying additional risk factors or conditions that increase risk for impaired skin integrity of the foot. Examples include, but are not limited to: diabetes, peripheral vascular disease, peripheral arterial disease, venous insufficiency, peripheral neuropathy, and lack of sensation in feet. 3. Interventions for Prevention and to Promote Healing a. Interventions will be based on specific factors identified in the risk assessment, skin assessment, and assessment of any foot ulcers i. As needed, licensed nurses with adequate training may perform nail care to non-diabetic Residents, or diabetic Residents who are low risk as determined by podiatrist or physician. b. Medical conditions will be managed and interventions will be implemented in accordance with professional standards of practice to prevent complications of medical conditions. 4. Monitoring b. RNs and LPNs will participate in the management of medical conditions by following physician orders, assessment of Residents, and reporting changes in condition to the Resident's physician orders, assessment of Residents, and reporting changes in condition to the Residents' physicians. Referrals to other interdisciplinary team members will be made as appropriate. 5. Modification of Interventions (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Interventions will be modified in a Resident's plan of care as needed. Considerations for needed modifications include: i. Changes in medical condition or degree of risk for developing foot ulcers ii. New onset or recurrent foot ulcer iii. Lack of progression towards healing iv. Resident non-compliance v. Changes in the Resident's goals and preferences . 1) R9 was admitted to the facility on [DATE] with diagnoses of Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease(Diabetic Nephropathy), Chronic Kidney Disease(progressive damage and loss of function in the kidneys), Paroxysmal Atrial Fibrillation(irregular heartbeats occur intermittently and spontaneously resolve within 7 days), Alzheimer's(progressive disease that destroys memory and other important mental functions), Major Depressive Disorder(persistent feelings of sadness, hopelessness, and a loss of interest or pleasure in activities), and Anxiety Disorder(mental health disorder characterized by feelings of worry, fear that interfere with daily activities). R9 currently has an activated Health Care Power of Attorney(HCPOA) to assist with decision making. R9's Annual Minimum Data Set(MDS) completed 3/25/25 documents R9's Brief Interview for Mental Status(BIMS) score to be 6, indicating R9 demonstrates severely impaired skills for daily decision making. R9's MDS documents no mood or behavior symptoms. R9 requires supervision for eating. R9 demonstrates partial/moderate assistance for showers, lower dressing, and transfers. R9 requires supervision for upper dressing and mobility. R9 has no range of motion impairment. R9's current physician orders document R9 is prescribed Metformin HCl ER Tablet Extended Release 24 Hour 1000 mg by mouth one time a day for Diabetes Mellitus effective 11/12/24. Surveyor notes there is no physician order for daily diabetic foot checks per professional standards of practice. R9's Medication Administration Records(MARS) and Treatment Administration Records(TARS) do not documents that the nursing staff are completing daily diabetic foot checks per professional standards of practice. R9's comprehensive care plan documents: R9 has Diabetes Mellitus Initiated 10/4/22 Intervention: Check all of body for breaks in skin and treat promptly as ordered by doctor (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Initiated 10/4/24 Surveyor noted there were no intervention for R9 to have completed diabetic foot checks. On 6/12/25, at 12:08 PM, Surveyor interviewed Registered Nurse (RN-Unit Manager)-D regarding diabetic foot checks. RN-D informed Surveyor that skin checks are completed one time a week with the resident's weekly shower checks. RN-D confirmed that weekly or daily diabetic foot checks are not completed. On 6/12/25, at 03:24 PM, Surveyor informed Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, and Corporate Consultant (CC)-C that daily diabetic foot checks as recommended by professional standards of practice and that they are not being completed for R9. No additional information has been provided by the facility at this time as to why daily diabetic foot checks have not been completed for R9.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 6 of 10 residents (R34, R11, R23, R2, R9, and R13) reviewed received adequate supervision and assistance devices to prevent accidents. * R34's fall on 10/29/24 was not thoroughly investigated and a root cause was not determined to help prevent additional falls. On 5/16/25, R34 fell, was transferred to the hospital, and diagnosed with a hip fracture. R34 had been observed prior to this fall coming out the bathroom by herself. The facility did not implement interventions after observing R34 coming out of the bathroom prior to R34's fall. R34 was not assessed by a Registered Nurse (RN) prior to being placed in a wheelchair after the fall even though there was an RN available. The facility's investigation did not include a root cause analysis of R34's fall to help prevent additional falls. * R11 fell from the wheelchair on 5/28/24. The facility did not conduct a thorough investigation as the facility did not investigate how R11 was seated in her wheelchair, the investigation does not include whether R11 was interviewed regarding the fall, and R11's fall care plan was not developed until 8/30/24. R11 fell on [DATE]. R11 was not transferred according to R11's plan of care when R11 fell. * R23's resident to resident altercation on 11/2/24 was not investigated and no revisions to R23's plan of care were implemented after R23's resident to resident altercation. * R2 sustained multiple falls from bed. The facility did not investigate how R2 rolled out of bed, did not determine if previous interventions were in place, did not consistently determine the root cause of R2's falls, and did not investigate how R2 fell from the bed multiple times when bilateral body pillows were in place. * R9 sustained a fall on 2/17/25. The facility did not thoroughly investigate this fall and did not determine a root cause. On 3/29/25, R9 had an unwitnessed fall. The facility did not thoroughly investigate this fall and did not investigate whether previous interventions were in place. R9's wander alert bracelet was observed on the metal bar on the back of R9's wheelchair. Per the manufacturer the wander alert bracelet should not be placed on this metal bar. * R13's intervention of fall mat was not in place and the body pillows were incorrectly placed when R13 sustained a fall on 2/4/25. On 3/29/25, R13 fell while attempting to self transfer. R13's new toileting plan was not added to the care plan until 5/19/25. On 4/1/25, R13 had a fall in another resident's bathroom. R13's care planned intervention of toileting after meals was not followed. On 5/3/25, R13 sustained a fall from bed. The facility did not thoroughly investigate this fall to determine if previous interventions were in place. During the survey, R13's body pillow was not placed correctly. R34 is being cited at severity level 3 (actual harm). R11, R23, R2, R9 and R13 are being cited at severity level 2 (potential for more than minimal harm). Findings include: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The facility's policy titled, Falls Management and Prevention, and revised December 2024 under Policy documents: Residents are assessed for their risk of falling upon admission, significant change and quarterly thereafter. Resident with risk for falling will have interventions implemented through the resident centered care plan. When a resident experiences a fall, a licensed nurse assesses the resident's condition, provides care for, safety and comfort. Under Post Fall Procedure documents 1. When a resident falls the licensed nurse is notified. The nurse completes an assessment of the resident's condition including an interview, if possible, completion of vital signs and a body assessment. 2. The medical provider is notified of the fall and resident condition. Orders, if given, are implemented. 3. The resident's representative (as applicable) is notified of the fall and the resident's condition. 4. The DON (Director of Nursing) and Administrator or designees are notified of the fall. 5. The environment of the fall is evaluated for possible contributing factors and addressed. 1.) R34 was admitted to the facility on [DATE] with diagnoses that include dementia (loss of cognitive function that interferes with a person's daily life and activities), atrial fibrillation (irregular and rapid heart beat), and hypertensive heart disease with heart failure (prolonged high blood pressure that leads to the heart inability to pump blood effectively). R34's fall risk assessment dated [DATE] has a score of 12 (a score of 10 or higher indicates high risk of falling.) R34's nurses note dated 9/14/24, at 14:11 (2:11 p.m.), written by Licensed Practical Nurse (LPN)-W documents: Resident on report for being new admit to unit s/p (status post) multiple falls, encephalopathy, and AMS (altered mental status). Resident adjusting to unit well. AandO (alert and orientated) to self and place. Makes needs known. No issues or complaints. Ate well at meal times. Checked frequently to maintain safety. VSS (vital signs stable) per resident baseline. R34's Fall CAA (care area assessment) dated 9/18/24 under analysis of finds for nature of problem documents: Fall CAA triggered r/t (related to) recent fall at home with UTI (urinary tract infection), AMS (alerted mental status)/hospitalization. admitted for rehab with goal to dc (discharge) home. Resident requires moderate assist with most ADL (activities of daily living). BIMS (Brief Interview for Mental Status)-8. On scheduled diuretic, anticoagulant, antihtn (antihypertensive). Occasionally incontinent of bowel and bladder. No falls during look back. Remains a fall risk d/t (due to) cognitive impairment with poor safety awareness. Under the care plan considerations it documents: Fall CAA triggered r/t recent fall at home with UTI, AMS/hospitalization. admitted for rehab with goal to dc home. Resident requires moderate assist with most ADL. BIMS-8. On scheduled diuretic, anticoagulant, antihtn. Occasionally incontinent of bowel and bladder. No falls during look back. Remains a fall risk d/t cognitive impairment with poor safety awareness. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R34's falls care plan initiated and revised 9/18/24 documents the following interventions: *Fall risk evaluation on admission, quarterly, and PRN (as needed). Post fall evaluation PRN. Initiated 9/18/24. *Labs when ordered, report abnormal findings to NP/PA/MD (Nurse Practitioner/Physician Assistant/Medical Doctor). Initiated 9/18/24. *Monitor for side effects of medication: *Cardiac medication as ordered. Monitor weekly vital signs and labs as ordered. *Psychotropic medications as ordered. BIMS (brief interview mental status) evaluation, sleep log, and behavior monitoring per protocol. *Narcotic pain medication as ordered. Monitor for side effects such as dizziness, lethargy, increased confusion, decreased respiration, and report to NP/PA/MD. Initiated 9/18/24. *Toileting per urinary/bowel section of this care plan. Initiated 9/18/24. *Fall risk. Initiated 9/27/24. *Bed in low position, call light within reach. Initiated 9/27/24. *Encourage [R34's first name] to be in common areas for supervision d/t (due to) frequent self transferring. She often refuses. Initiated 5/29/25. *Frequent safety checks to prevent falls. [R34's first name] self transfers and is non-compliant with call light d/t (due to) memory issues. Initiated and revised 5/29/25. R34's nurses note dated 10/29/24, at 22:20 (10:20 p.m.), written by Registered Nurse (RN)-BB documents: Writer was doing HS (hour sleep) med pass when CNA (Certified Nursing Assistant) answered a bathroom call light coming from residents' room. CNA yelled out to writer that resident was on the floor from doorway. Writer went into residents' room and found resident on the floor sitting straight up on bottom near residents' foot of bed. Writer asked resident what happened resident stated she just slid out of bed when trying to get up. Writer asked resident what she was trying to do and resident stated trying to get up to go by husband that was in the living room area of their room. Resident stated she did not have pain anywhere and did not hit head. Writer did a full Neurology assessment determined all WNL (within normal limits), Writer then took residents Vitals B/P (blood pressure): 106/69, HR (heart rate): 75, 02(oxygen): 98% RA (room air), T (temperature):97.7, R (respirations): 18. Resident was then Hoyered off the floor by writer and CNA into residents w/c (wheelchair). Neuro checks were then initiated. R34's progress note dated 10/31/24, at 10:03 a.m., written by Nursing Home Administrator (NHA)-A documents: IDT (interdisciplinary team) met to review fall from 10/29/24. Nursing, Soc. (Social) Services, therapy, and admin (Administrator) were in attendance. Documentation was reviewed. MD and patient representative were contacted. Neuro checks were initiated. Resident had moved from her private room to a shared room with her husband that date. Immediate intervention was to transfer resident to the bed on left side of room, which is similar to her previous bedroom set-up. Surveyor noted R34's fall care plan was not revised to include this intervention. Surveyor reviewed the facility's fall investigation for R34's fall on 10/29/24. The facility's fall investigation includes a fall statement from the CNA who found R34 on the floor but does not include any other staff statements or indications other staff who may have seen R34 were interviewed, how was R34 positioned in bed, and the root cause of this fall. R34's quarterly MDS (Minimum Data Set) with an assessment reference date of 4/14/25 has a BIMS (Brief Interview for Mental Status) score of 2 which indicates severe cognitive impairment. R34 is assessed as refusing care and wandering for 1 to 3 days during the assessment period. R34 is assessed as requiring set up for toileting hygiene, supervision for roll left and right, and chair/bed to chair transfer. R34 is occasionally incontinent of urine and continent of bowel. R34 is assessed as not having any falls since prior assessment period. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tudor Oaks Health Center	S77 W12929 McShane Dr Muskego, WI 53150

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R34's fall risk assessment dated [DATE] has a score of 19 (a score of 10 or higher indicates the resident is at high risk of falling). R34's nurses note dated 5/16/25, at 03:36 (3:36 a.m.), written by Registered Nurse (RN)-FF documents: Resident in [Room Number], [R34's name] was found on the floor in her room. Resident told nurse she was getting up to go to the bathroom and noted the floor was coming up to her. Resident hit the side of her head and has a bruised area that is 1.5cm (centimeter) x (times) 4.3cm and is raised. Resident C/O (complained of) left hip pain. Per nurse caring for resident the resident could not bear weight on her left leg. Nurse then went to see resident who was already in a w/c (wheelchair) and continued to c/o of left hip pain and resident was noted to have a low B/P (blood pressure) of 75/38 with a heart rate of 57. Resident denies being lightheaded or dizzy at this time. Message sent to Dr [Name] also at this time and will be sending resident out for evaluation. Will be sending resident out for evaluation at this time. The nurses note dated 5/16/25, at 05:54 (5:54 a.m.), written by Licensed Practical Nurse (LPN)-F documents: UWF (unwitnessed fall): CNA found res on the floor at 0250 (2:50 a.m.), sitting/lying in front of her bed with w/c (wheelchair) to her left, where it had been all NOC (night). Res (Resident) was witnessed walking in room per CNA who res was assigned and found, coming from BR (bathroom) earlier in NOC and was assisted back to bed w/(with) safety precautions in place and call light on chest. Rounds completed per CNA at 0100 (1:00 a.m.) and res toileted; per writer at 0200 (2:00 a.m.) and res asleep. Safety precautions/call light in place w/ BR light on. Injuries noted-left brow hematoma, c/o (complained of) left hip pain/disc (discomfort) noted. RN notified and escorted to room per writer and assessed. Writer initiated neuros checks per protocol. [Name] Ambulance called at 0345 (3:45 a.m.). V/S (vital signs) and res stable w/hypotension noted. BP increased as time went on per EMT (emergency medical technician) taking last BP before leaving unit at 0430 (4:30 a.m.). APAPx1 (acetaminophen times one) per pain/disc noted to left hip-7/10 and ineffective prior to leaving-6/10. RN notified MD/DON (Medical Doctor/Director of Nursing). Writer updated POA (Power of Attorney) son [Name] at 0354 (3:45 a.m.) and directed to have res transferred to [Name] hospital for eval/tx (evaluation/treatment), and POA will meet res there, appreciative for being notified per writer. Res was able to move all extremities w/ (with) noticeable, and c/o left hip pain noted. Writer will report off to AM (morning) RN to call [Hospital Name] for updated report. R34's nurses note dated 5/16/25, at 10:57 a.m., by RN-GG documents: Per SW (Social Worker) who spoke with son, resident is being admitted with hip fx (fracture). Surgery will be completed tomorrow. Son talked with resident's husband and explained what is happening. R34's progress note dated 5/16/25, at 16:21 (4:21 p.m.), written by Nursing Home Administrator (NHA)-A documents: IDT (interdisciplinary team) met to review fall from this am. Nursing, Soc. (Social) Services, and Admin (Administrator) were present. Documentation was reviewed. MD and patient representative were notified. Resident was noted to be hypotensive immediately after fall. She was transported to ER (emergency room) and admitted with hip fracture. Will assess resident for change of condition upon return, and update care plan as needed. Surveyor reviewed R34's fall investigation for R34's fall on 5/16/25. The check off sheet for falls documents: non compliant with call light; transfers. R34's fall care plan does not address R34 being non compliant with call light or transfers. The fall investigation was not thorough as this investigation does not include a root cause to help prevent further falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R34 was readmitted to the facility on [DATE]. R34's fall care plan was not revised until 5/29/25. R34's significant change MDS with an assessment reference date of 5/24/25 has a BIMS score of 2 which indicates severe cognitive impairment. R34 is assessed as being dependent for toileting hygiene, roll left and right, chair/bed to chair transfer, and toilet transfer. R34 is assessed as always incontinent of urine and frequently incontinent of bowel. R34's fall CAA (care area assessment) dated 5/28/25 under analysis of findings for nature of problem documents: Fall CAA triggered r/t (related to) resident here for LTC (long term care). Recent fall at facility with femur fx (fracture)/hospitalization with surgical repair. readmitted for rehab with goal to stay LTC (long term care). Resident has dementia with poor safety awareness. BIMS-2. Resident is dependent on staff for most ADL (activities daily living). On scheduled antihtn (antihypertensive), diuretic, anticoagulant, antidepressant, PRN (as needed) opiate. Under care plan considerations documents Fall CAA triggered r/t resident here for LTC. Recent fall at facility with femur fx/hospitalization with surgical repair. readmitted for rehab with goal to stay LTC. Resident has dementia with poor safety awareness. BIMS-2. Resident is dependent on staff for most ADL. On scheduled antihtn, diuretic, anticoagulant, antidepressant, PRN opiate. On 6/12/25 at 7:24 a.m., Surveyor observed R34 in bed on the left side, there is a heels up pad and the call pad is within reach. Surveyor observed R34's bed is at a low position but not at the lowest position. On 6/12/25 at 10:04 a.m., Surveyor observed R34 in bed on the right side. There is a heels up pad and the call pad is within reach. Surveyor observed R34's bed is at a low position but not at the lowest position. On 6/16/25 at 8:32 a.m., Surveyor met with Registered Nurse/Unit Manager (RN/UM)-D to discuss R34. Surveyor asked RN/UM-D when R34 is in bed what position should R34's bed be in. RN/UM-D explained R34's bed should be in a low position, not the lowest position, as R34 self transfers from the bed and the bed should be locked. Surveyor inquired what frequent checks are. RN/UM-D informed Surveyor they round on residents more frequently than they normally do every two hours and if the call light is on they should get in there quick. Surveyor asked RN/UM-D who should Surveyor speak to regarding R34's fall investigations for R34's falls on 10/29/24 and 5/16/25. RN/UM-D informed Surveyor Surveyor should speak with DON-B and NHA-A as they track falls more than she does. On 6/16/25 at 8:39 a.m., Surveyor observed R34 sitting in a wheelchair in her room. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 6/16/25 at 12:05 p.m., Surveyor met with DON-B and Corporate Nurse (CN)-C to discuss R34's falls. Surveyor informed DON-B and CN-C R34's fall on 10/29/24 was not thoroughly investigated as there was only the staff statement from the CNA who found R34 but no other staff statements or indications other staff that may have seen R34 were interviewed, there is no indication as to how R34 was in bed, was she on the edge or in the middle of the bed, and root cause was not identified to help prevent further falls. R34's fall on 5/16/25, RN-FF's nurses note documents R34 was in the wheelchair. There was no RN assessment of R34 prior to R34 being transferred into the wheelchair. LPN-F's nurses note documents R34 was found coming out of the bathroom by herself earlier in the shift. There is no evidence staff increased rounds/checks on R34 after R34 was observed ambulating by herself or implemented any additional interventions to prevent R34 from getting up by self. Surveyor inquired if R34 fell at 2:50 a.m. why wasn't the ambulance called for almost an hour at 3:45 a.m. The facility's investigation does not include a root cause. DON-B did not provide Surveyor with any additional information regarding R34's falls on 10/29/24 and 5/16/25. 2.) R11 was originally admitted to the facility on [DATE]. R11's diagnoses include anxiety disorder, depressive disorder, and polyneuropathy (general term for peripheral nervous system disorders that impact nerve functions in multiple areas of the body). R11's mobility care plan initiated 8/6/24 includes an intervention of GG - Chair/Bed-to-Chair Transfer - EZ stand and 2 assist. Initiated 8/28/24 and revised on 8/30/24. R11's falls care plan initiated and revised on 8/20/24 documents the following interventions: *Call light within reach at all times. Initiated 8/30/24. *Fall risk evaluation on admission, quarterly, and PRN (as needed). Post fall evaluation PRN. Initiated 8/30/24. *Monitor for side effects of medication: *Cardiac medication as ordered. Monitor weekly vital signs and labs as ordered. *Psychotropic medications as ordered. BIMS (brief interview mental status) evaluation, sleep log, and behavior monitoring per protocol. *Narcotic pain medication as ordered. Monitor for side effects such as dizziness, lethargy, increased confusion, decreased respirations, and report to NP/PA/MD (Nurse Practitioner/Physician Assistant/Medical Doctor). Initiated 8/30/24. *Resident to wear proper and non slip footwear. Initiated 8/30/24. R11's fall risk assessment dated [DATE] has a score of 5 (a score of 10 or higher is high risk). R11's Quarterly MDS with an assessment reference date of 5/24/24 documents BIMS (Brief Interview for Mental Status) score of 15, which indicates that R11 has intact cognition. R11 is assessed as not having any behaviors. R11 is assessed as requiring substantial/maximal assistance for toileting hygiene, chair/bed to chair transfer, and toilet transfer. R11 is frequently incontinent of bowel and bladder. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R11's nurses note dated 5/27/24 at 9:37 a.m., written by Licensed Practical Nurse (LPN)-DD documents: Resident had an unwitnessed fall @ (at) 0845 (8:45 a.m.) in room [Number]. Resident was placed in WC (wheelchair) by CNA (Certified Nursing Assistant) [Name] to get ready for a shower. CNA stated resident was weak so she proceeded to go get the EZ stand. CNA stated resident was safely sitting in wheel chair when she left the room and when coming back into the room resident was found on knees with lower legs behind buttock. Resident was safely lowered flat to the floor with pillow behind head so writer could take vital signs and start neuro check. Resident was able to move arms and legs and stated she did not hit her head when asked. Resident is alert and orientated and rated pain an 8 on a scale from 1-10 10 being the worst pain. Pain is located in legs and residents normal edema is present. POA (Power of Attorney), DON (Director of Nursing), Doctor, [Managed Care Name] were notified. Residents shower was completed with no noted skin issues. R11's progress note dated 5/28/24, at 10:33 a.m., written by Nursing Home Administrator (NHA)-A documents: IDT(Interdisciplinary team) met to review unwitnessed fall from 5/27/24. Nursing, SS (Social Service), admin (Administrator), and therapy present. Resident had been transferred into her wheelchair and was waiting for CNA to return for shower. When CNA returned to her room, resident was on her knees. MD and family were notified. Resident was unable to state what she was trying to do. Nursing will check orthostatic blood pressures and request lab work as resident said that she felt weak. Resident is currently receiving PT (physical therapy) intervention. Surveyor reviewed the facility's fall investigation for R11's fall on 5/27/24. The facility did not conduct a thorough investigation as the facility did not investigate how R11 was seated in her wheelchair, the investigation does not include whether R11 was interviewed regarding the fall, did not determine a root cause, and R11's fall care plan was not developed until 8/30/24. R11's quarterly MDS with an assessment reference date of 8/21/24 has a BIMS score of 14 which indicates intact cognition. R11 is assessed as not having any behaviors. R11 is assessed as requiring partial/moderate assistance for toileting hygiene, chair/bed to chair transfer, and toilet transfer. R11 is frequently incontinent of bowel and bladder. R11's fall risk assessment dated [DATE] has a score of 7 which indicates low risk. R11's nurses note dated 10/5/24, at 22:52 (10:52 p.m.), written by Registered Nurse (RN)-BB documents: CNA assigned to resident came to writer and mentioned that resident had fallen and was on the floor during transferring. Writer took vital cart into resident room and assessed resident ROM (range of motion) which was WNL (within normal limits). Denied hitting head or any injuries. Resident states CNA was inexperienced and unable to transfer resident right and she slid to the floor. Resident was lifted off the floor via Hoyer, vitals were taken B/P (blood pressure): 123/69, HR (heart rate): 62, T (temperature): 96.8, R (respirations): 20, 02 (oxygen): 93% RA (room air). R11's progress note dated 10/7/24, at 16:47 (4:47 p.m.), written by NHA-A documents: IDT (interdisciplinary) met to review fall from 10/5/2024. Nursing, Soc. (Social) Services, Therapy and Admin were present. Documentation was reviewed. MD and patient representative were notified. Neuro checks were not necessary as fall was witnessed and resident did not hit her head. Therapy will provide resident specific transfer training with CNA that was assigned. In addition, resident specific transfer training will be arranged for all CNAs that have been hired since September 1. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Surveyor reviewed the facility's investigation which included only a fall statement dated 10/5/24 from CNA-SS, the CNA who was with R11 when R11 fell. R11 was not transferred according to R11's plan of care as the mobility care plan indicates R11 is transferred with an EZ stand and 2 assist. R11's fall CAA (care area assessment) dated 12/3/24 documents under analysis of findings section: Fall CAA triggered r/t (related to) resident here for LTC (long term care). Dx (diagnoses) of COPD (chronic obstructive pulmonary disease), DM (diabetes mellitus) (high blood sugar) with neuropathy. Resident is dependent to supervision with ADLs (activities daily living). On scheduled antihtn (antihypertensive), diuretic, diabetic meds, anticoagulant and non narcotic pain meds. Frequently incontinent of bladder and occasionally incontinent of bowel. 1 fall without injury in the last quarter. Under the care plan considerations it documents: Fall CAA triggered r/t resident here for LTC. Dx of COPD, DM with neuropathy. Resident is dependent to supervision with ADLs. On scheduled antihtn, diuretic, diabetic meds, anticoagulant and non narcotic pain meds. Frequently incontinent of bladder and occasionally incontinent of bowel. 1 fall without injury in the last quarter. On 6/11/25 at 10:40 a.m., Surveyor spoke with R11 who was sitting in a wheelchair with the call light in reach in R11's room. Surveyor asked R11 if she remembers her fall in October. R11 informed Surveyor the CNA was new and she told the CNA when she had me situated she was not right and was going down. Surveyor asked R11 what she meant by she was not right. R11 informed Surveyor she had her on the edge of the chair, went down with both legs under her. Surveyor asked R11 if the CNA was using a gait belt. R11 replied no. Surveyor asked R11 if the CNA was using a mechanical lift. R11 replied no. Surveyor asked R11 if there is anything else she remembers. R11 replied all I remember is I laid there for quite a while with my legs under me. She finally went and got help. On 6/16/25 at 12:01 p.m., Surveyor met with Director of Nursing (DON)-B and Corporate Nurse (CN)-C regarding R11's falls. Surveyor informed DON-B the facility did not conduct a thorough investigation as the investigation didn't include a root cause, how R11 was seated in the wheelchair, or whether R11 was interviewed regarding the fall. Surveyor also informed DON-B and CN-C there is not a fall care plan until 8/30/24. CN-C reviewed R11's care plans and informed Surveyor there was not a care plan prior to 8/30/24. Surveyor informed DON-B and CN-C R11 had a fall on 10/5/24 with a CNA. According to R11's care plan, R11 should have been transferred with an EZ stand and 2 assist. 3.) R23's diagnoses includes Alzheimer's Disease, dementia, depressive disorder, and anxiety disorder. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Surveyor reviewed R23's care plans and noted the following: Elopement risk initiated and revised 4/25/24; PASAAR (Pre admission Screening and Resident Review) initiated 4/25/24; Psychosocial Well Being, Adjustment New Admission, Unfamiliar with staff routine, environment initiated 4/25/24; Advanced Directives initiated 4/25/24; Discharge Planning initiated 5/15/24; Nutrition Alteration initiated 4/29/24 and revised 2/13/25; Communication Problem initiated and revised 5/2/24; Falls initiated and revised 5/2/24; Pain initiated and revised 5/2/24; Oral/Dental Health Problems initiated and revised 5/2/24; Potential for Impaired Visual Function initiated and revised 5/2/24; Potential for Constipation initiate [NAME] revised 5/2/24; Potential Fluid Deficit initiated and revised 5/2/24; Impaired Cardiac Status initiated and revised 5/2/24; Hospice Care initiated 5/13/24 and revised 6/4/24; Risk for Ineffective Peripheral Tissue Perfusion initiated 6/25/24; AROM (active range of motion) Restorative Nursing Program initiated and revised 6/26/24; Transfer Restorative Nursing Program initiated and revised 6/26/24, Self Care initiated and revised 9/10/24, Bowel and Bladder initiated and revised 5/19/25, Chronic/Progressive decline in Intellectual functioning initiated and revised 4/25/24; Mobility initiated and revised 9/10/24; Potential for Impaired Skin Integrity initiated and revised 2/17/25; Feelings of sadness, emptiness, anxiety, uneasiness, depression characterized by ineffective coping, low self esteem, tearfulness, motor agitation, withdrawal from care/activities initiated 4/25/24 and revised 5/2/24; Activities initiated 11/14/24 and revised 2/13/25; Cognition initiated and revised 5/29/25; Anti-anxiety medication initiated and revised 5/12/25; and Antidepressant medication initiated 5/12/25. R23's Annual MDS (minimum data set) with an assessment reference date of 5/13/25 has a BIMS (brief interview mental status) score of 3 which indicates severe cognitive impairment. R23 is assessed as not having any behavior other than wandering 1 to 3 days during the assessment period. R23 receives hospice services. R23's nurses note dated 11/2/24, at 12:31 p.m., documents Resident has a red mark to L (left) cheek and a bruised scratch to L neck. Skin is intact with no bleeding. Noted bruised scratch to L neck. Both areas were cleaned with an alcohol wipe. Scratches occurred from another resident. Both residents were separated. R23's nurses note dated 11/2/24, at 13:15 (1:15 p.m.), documents: POA (Power of Attorney) updated @ (at) 1316 (1:16 p.m.). R23's nurses note dated 11/2/24, at 15:09 (3:09 p.m.), documents: Writer went to check on residents L cheek and L neck scratches. No marks noted to L cheek. Noted scratch to L lower neck. Skin remains intact. R23's nurses note dated, 11/3/24 at 03:31 (3:31 a.m.), documents: Resident is on report for incident that occurred on 11/2/24 with another resident. Resident has small red scratch to left side of neck. Skin is intact. No mark noted on left cheek. Resident has been sleeping well this noc (night) and voices no C/O's (complaint of) of any pain. No Bx's (behaviors) this noc. Surveyor noted none of R23's care plans were revised and/or a resident to resident care plan was not initiated following R23's incident on 11/2/24. On 6/11/25 at 3:10 p.m., during the end of the day meeting with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B, Surveyor requested any investigation the facility did for R23's resident to resident altercation which occurred on 11/22/24. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 6/16/25 at 9:06 a.m., Surveyor received a statement that is not signed or dated which documents: Re: Incident 11/2/24 Resident #1 was showing signs of distress and was in the hallway calling out. She had already received medication for pain and anxiety. [R23's first name], being the compassionate soul that she is, went over to the resident in an attempt to console her. Resident #1, not recognizing the gesture due to her dementia and distress, reached out to grab [R23's first name] shirt. With this motion [R23's first name] received a small scratch on the left side of her neck. The residents were moved apart. At the time, [R23's first name] apologized saying that she was just trying to help out. She was not negatively affected by the interaction. This was not interpreted as a resident-to-resident altercation - it was not confrontational, intentional or willful. The behavior did not continue. It was not felt to be reportable. On 6/16/25 at 12:12 p.m., met with Director of Nursing (DON)-B and Corporate Nurse (CN)-C. Surveyor asked DON-B if DON-B knew who the other resident involved in the resident to resident altercation with R23 was. DON-B replied that was my question, believe it was [Name of R13]. Surveyor inquired if there was an investigation as Surveyor only received a statement which Surveyor read to DON-B and CN-C. DON-B informed Surveyor that was NHA-A's note. CN-C informed Surveyor Surveyor should speak with NHA-A or Director of Social Services (DSS)-K. On 6/16/25, at 12:18 p.m., Surveyor asked DSS-K if she was aware of an altercation on 11/2/24 with R23 and another Resident. DSS-K replied vaguely and explained NHA-A was more involved. Surveyor asked DSS-K if she knew who the other resident was. DSS-K informed Surveyor she thinks it was R295. Surveyor asked DSS-K if there was an investigation. DSS-K informed Surveyor when they talked about it there was a misunderstanding as R295 didn't do anything intentionally, she was anxious and R23 was trying to help. Surveyor informed DSS-K the altercation may not have had to be reported to the state agency but should have been investigated. On 6/16/25, at 2:46 p.m., Surveyor showed NHA-A the statement Surveyor was provided and asked who wrote this statement as it's not dated or signed. NHA-A informed Surveyor she did. Surveyor asked who was the other resident involved[TRUNCATED]

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tudor Oaks Health Center	S77 W12929 McShane Dr Muskego, WI 53150

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on interview and record review, the facility did not ensure staff postings displayed were accurate to the actual staffing of the facility. Review of staffing schedules and required staff postings from 5/9/2025 - 6/9/2025 revealed 14 of 30 days had discrepancies between the documents. This resulted in inaccuracies with the total number and the actual hours worked for licensed and non-licensed staff directly responsible for resident care each shift. This deficient practice has potential to affect 41 out of 41 residents. Findings include: The facility policy titled Nurse Staffing Posting Information with no initiated or reviewed/revised date documents: Policy: It is the policy of this facility to make nurse staffing information readily available in a readable format to resident, staff, and visitors at any given time. Policy Explanation and Compliance guidelines: 1. The nurse staffing sheet will be posted on a daily basis and will contain the following information: . d. The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: i. Registered Nurses ii. Licensed Practical Nurses . iii. Certified Nursing Aides . 4. A copy of the schedule will be available to all supervisors to ensure the information posted is up-to-date and current. a. The information shall reflect staff absences on that shift due to callouts and illnesses. After the start of each shift, actual hours will be updated to reflect such. Surveyor reviewed the schedules and staff postings from 5/9/2025 through 6/9/2025. Surveyor compared the actual staffing schedules with the staff positings and noted the following inaccuracies: 5/17/2025 AM SHIFT: Staff Posting: 1 registered nurse (RN), 2 licensed practical nurses (LPNs), 6 certified nursing assistants (CNAs); Staff Schedule: 0 RNs, 2 LPNs, 5 CNAs PM SHIFT: Staff posting: 6 CNAs; Staff schedule: 5 CNAs (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	5/18/2025: AM SHIFT: Staff Posting: 1 RN, 1 LPN, 6 CNAs; Staff Schedule: 2 LPNs, 5 CNAs PM SHIFT: Staff Posting: 6 CNAs; Staff Schedule: 5 CNAs 5/19/2025: AM SHIFT: Staff Posting: 6 CNAs; Staff Schedule: 5 CNAs PM SHIFT: Staff Posting: 6 CNAs; Staff Schedule: 5 CNAs 5/20/2025: AM SHIFT: Staff Posting: 6 CNAs; Staff Schedule: 5 CNAs PM SHIFT: Staff Posting: 6 CNAs; Staff Schedule: 5 CNAs 5/21/2025: PM SHIFT: Staff Posting: 2 RNs, 1 LPN; Staff Schedule: 1 RN, 1 LPN Night (NOC) SHIFT: Staff Posting: 5 CNAs (documents 1 CNA orientating); Staff schedule: 4 CNAs listed, none are documented as being orientated. 5/25/2025: NOC SHIFT: Staff Posting: 2 RNs, 1 LPN; Staff Schedule: 2 RNs, 0 LPNs 5/28/2025: AM SHIFT: Staff Posting: 6 CNAs; Staff Schedule: 5 CNAs NOC SHIFT: Staff Posting: 1 RN, 1 LPN; Staff Schedule: 2 RNs, 1 LPN 5/29/2025: AM SHIFT: Staff Posting: 2 RNs; Staff Schedule: 1 RN, 1 LPN PM SHIFT: Staff posting: 2 RNs, 1 LPN; Staff Schedule: 1 RN, 1 LPN 5/30/2025: AM SHIFT: Staff Posting: 6 CNAs; Staff Schedule: 5 CNAs NOC SHIFT: Staff Posting: 1 RN, 1 LPN; Staff Schedule: 1 RN, 2 LPNs 5/31/2025: (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	AM SHIFT: Staff Posting: 2 LPNs, 6 CNAs; Staff Schedule: 1 LPN, 1 LPN documented as calling off at 6:30AM, 5 CNAs NOC SHIFT: Staff Posting: 1 RN, 2 LPNs; Staff Schedule: 1 RN, 1 LPN 6/5/2025: AM SHIFT: Staff Posting: 6 CNAs; Staff Schedule: 4 CNAs 6/7/2025: NOC SHIFT: Staff Posting: 5 CNAs; Staff Schedule: 4 CNAs 6/8/2025: AM SHIFT: Staff Posting: 6 CNAs; Staff Schedule: 5 CNAs (down to 4 CNAs after 11:00am) 6/9/2025: AM SHIFT: Staff Posting: 6 CNAs; Staff Schedule: 4 CNAs Surveyor noted that the staffing total hours for all the dates indicated above are not accurate and that there was discrepancies in the staff schedules and staff postings for 14 of 30 days reviewed between 5/9/2025 through 6/9/2025. On 6/16/2025, at 10:59 AM, Surveyor interviewed Scheduler-V who stated NOC (night) shift posts the new staff posting for the day and nursing is in charge of documenting the staffing changes throughout the day. The staff postings are given to Scheduler-V and Scheduler-V files the postings and schedules. Surveyor asked if Scheduler-V reviews the staff postings and confirms with the schedules the accuracy of both. Scheduler-V stated Scheduler-V used to but has not been recently. Surveyor shared concerns of the above days where the staff postings did not match what was shown on the schedule for actual staffing. Scheduler-V stated that Scheduler-V would have to start reviewing the staff postings with the schedules again. On 6/16/2025, at 11:24 AM, Surveyor informed Nursing Home Administrator (NHA)-A of the above dates and the discrepancies between the staff postings and staff schedules. NHA-A stated that Scheduler-V reviews all the staff postings with the staff schedules. Surveyor informed NHA-A that Scheduler-V stated Scheduler-V has not been comparing the staff postings with the staff schedules. NHA-A stated that Scheduler-V should be comparing the staff postings with the staff schedules and will be doing some reeducation. NHA-A stated that education will be done with nursing staff as well because the staff postings should be adjusted accordingly throughout the day as changes occur. No additional informtion was provided.

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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** Based on interview and record review the facility did not ensure 3 (R11, R34, & R13) of 5 residents drug regimen were free of unnecessary drugs. * R11 is prescribed Eliquis (Apixaban) 2.5 mg (milligrams), an anticoagulant, for history of pulmonary embolism (condition where one or more arteries in the lungs are blocked by a blood clot). There is no monitoring for signs/symptoms of anticoagulant complications. * R34 is prescribed Rivaroxaban 15 mg, an anticoagulant, for blood clots. There is no monitoring for signs/symptoms of anticoagulant complications. * R13 is prescribed Eliquis (Apixaban) 2.5 mg, an anticoagulant, for history of pulmonary embolism. There is no monitoring for signs/symptoms of anticoagulant complications. Findings include: The facility's policy titled, High Risk Medications - Anticoagulants and not dated under policy documents This facility recognizes that some medications, including anticoagulants, are associated with greater risks of adverse consequences that other medications. This policy addresses the facility's collaborative, systematic approach to managing anticoagulant therapy for efficacy and safety. Under Policy Explanation and Compliance Guidelines documents 4. The resident's plan of care shall alert staff to monitor for adverse consequences. Risks associated with anticoagulants include: a. Bleeding and hemorrhage (bleeding gums, nosebleed, unusually bruising, blood in urine or stool). b. Fall in hematocrit or blood pressure. c. Thomboembolism (a blood clot that breaks loose, travels through the bloodstream, blocks a different blood vessel obstructing blood flow). 1.) R11's diagnosis includes personal history of pulmonary embolism. R11's physician orders include: Eliquis Tablet 2.5 mg (Apixaban)/ Give 1 tablet by mouth two times a day related to personal history of pulmonary embolism; order date 4/23/21. R11's anticoagulant therapy care plan initiated & revised 9/18/24 documents the following interventions: *Labs as ordered. Report abnormal labs results to the MD (medical doctor). Initiated 9/18/24. *Monitor/document/report to MD PRN (as needed) s/sx (signs/symptoms) of anticoagulant complications: blood tinged or frank blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, SOB (shortness of breath), loss of appetite, sudden changes in mental status, significant or sudden changes in v/s (vital signs). Initiated 9/18/24. *Resident/family/caregiver teaching to include the following: Take/give medication at the same time each day, Use soft toothbrush, Use electric razor, Avoid activities that could result in injury, Take precautions to avoid falls, Signs/symptoms of bleeding, Avoid foods high in Vitamin K. These include greens such as spinach and turnips, asparagus, broccoli, cabbage, Brussels sprouts, milk, and cheese. Initiated 9/18/24. Surveyor reviewed R11's medical record which included R11's MAR/TAR (medication administration record/treatment administration record), progress notes, and assessments. Surveyor was unable to locate evidence the facility was monitoring R11 for signs/symptoms of anticoagulant complications. (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 12:09 p.m. Surveyor informed Registered Nurse/Unit Manager-D R11 is prescribed an anticoagulant and asked if R11 is monitored for complications. RN/UM-D replied oh ya, bleeding bruising, anything like that. Surveyor asked RN/UM-D where Surveyor would be able to locate monitoring in R11's medical record. RN/UM-D informed Surveyor there's not an order, doesn't think its in there, and it's a nursing judgement. Surveyor informed RN/UM-D Surveyor was unable to locate evidence the facility was monitoring R11 for complications of R11's prescribed Eliquis. On 6/16/25 Surveyor noted R11's anticoagulant therapy care plan was revised by RN/UM-D to include an intervention initiated 6/13/25 for daily skin inspection; report abnormalities to the nurse. 2.) R34's diagnoses includes atrial fibrillation (irregular and rapid heart rate) and hypertensive heart disease with heart failure (prolonged high blood pressure that leads to the heart's inability to pump blood effectively). R34's physician orders include: Rivaroxaban oral tablet 15 mg (milligrams) (Rivaroxaban). Give 1 tablet by mouth in the evening for blood clots. Give with dinner; order date 5/21/25. R34's anticoagulant therapy care plan initiated & revised 9/18/24 documents the following interventions: *Labs as ordered. Report abnormal lab results to the MD (medical doctor). Initiated 9/18/24. *Monitor/document/report to MD PRN (as needed) s/sx (signs/symptoms) of anticoagulant complications: blood tinged or frank flood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, SOB (shortness of breath), loss of appetite, sudden changes in mental status, significant or sudden changes in v/s (vital signs). Initiated 9/18/24. *Resident/family/caregiver teaching to include the following: Take/give medication at the same time each day, Use soft toothbrush, Use electric razor, Avoid activities that could result in injury, Take precautions to avoid falls, Signs/symptoms of bleeding, Avoid foods high in Vitamin K. These include greens such as spinach and turnips, asparagus, broccoli, cabbage, Brussels sprouts, milk, and cheese. Initiated 9/18/24. Surveyor reviewed R34's medical record which included R34's MAR/TAR (medication administration record/treatment administration record), progress notes, and assessments. Surveyor was unable to locate evidence the facility was monitoring R34 for signs/symptoms of anticoagulant complications. On 6/12/25, at 12:09 p.m. Surveyor informed Registered Nurse/Unit Manager-D R34 is prescribed an anticoagulant and asked if R34 is monitored for complications. RN/UM-D replied oh ya, bleeding bruising, anything like that. Surveyor asked RN/UM-D where Surveyor would be able to locate monitoring in R34's medical record. RN/UM-D informed Surveyor there's not an order, doesn't think its in there, and it's a nursing judgement. Surveyor informed RN/UM-D Surveyor was unable to locate evidence the facility was monitoring R34 for complications of R34's prescribed Rivaroxaban. 3.) R13 was admitted to the facility on [DATE] with diagnoses of Hypertensive Heart Disease(long term conditions developed from chronic high blood pressure), Varicose Veins(enlarged veins in legs and feet), Hyperlipidemia(high levels of fat particles in blood), Alzheimer's(progressive disease that destroys memory and other important mental functions) Dementia(loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life), Major Depressive Disorder(persistent feelings of sadness, hopelessness, and a loss of interest or pleasure in activities), and Anxiety Disorder(mental health disorder characterized by feelings of worry, fear that interfere with daily activities). (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R13's Quarterly Minimum Data Set(MDS) completed 3/27/25 documents R13's Brief Interview for Mental Status(BIMS) score to be 2, indicating R13 demonstrates severely impaired skills for daily decision making. R13's MDS documents R13 has disorganized thinking, delusions, physical behavioral symptoms, rejection of care, and wandering daily. R13 requires set-up for meals. R13 requires partial/moderate assistance for showers and upper dressing. R13 requires substantial/maximum assistance for lower dressing, mobility, and transfers. R13 has no range of motion impairment. Surveyor reviewed R13's current physician orders which document that R13 is prescribed Eliquis Tablet 2.5 mg(Apixaban) 2 times a day for history of Pulmonary Embolism; effective 5/26/21. Surveyor notes that R13's physician orders does not have an order to monitor bleeding, bruising, severe headache, blood in the urine or stools, changes in mental status, or significant vital signs. Surveyor reviewed R13's comprehensive care plan. R13's care plan does not document R13 being prescribed Eliquis, an anticoagulant, including interventions to monitor signs/symptoms of the anticoagulant. On 6/12/25, at 12:08 PM, Surveyor interviewed Registered Nurse Unit Manager (RN)-D who stated that nursing monitors for bruising, bleeding based on nursing judgment, however, there is no documentation that nursing staff are monitoring for bleeding, bruising every shift, daily. On 6/12/25, at 3:24 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B and Corporate Consultant (CC)-C that R13 has not been monitored for signs of bleeding and bruising for R13 being on an anticoagulant on a daily basis. Surveyor also shared that R13's care plan does not have documentation of R13's anticoagulant including interventions to monitor signs/symptoms of the anticoagulant. The facility provided no additional information as to why the facility has not been monitoring daily for signs/symptoms of R13's anticoagulant like, but not limited to, bleeding or bruising, severe headache, blood in the urine or stools, changes in mental status, or significant vital signs.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility did not store, prepare, distribute and serve food in accordance with professional standards for food service safety for 2 of 2 resident unit refrigerators in the facility. The facility did not ensure food was stored in a safe manner and, kitchen staff member had beard hair exposed and uncovered while preparing food, which had the potential to affect all 41 Residents currently living in the facility. *Temperature logs were not maintained for unit refrigerator/freezers. *Multiple food items were observed undated on the metal racks located in the facility's freezer. *Hand scoops were observed left in the ready to use sugar, flour, and rice flour bins. *Cook-Q was observed not wearing a beard hair guard on 6/11/25 while preparing food in the kitchen. Findings include: Temperatures Not Documented for Unit Refrigerators and Freezers The facility's undated policy General HACCP Guidelines for Food Safety documents: a.Take the internal temperatures of each unit b. Periodically, take internal temperatures of foods in the unit . On 6/12/25, at 7:30 AM, Surveyor observed Unit 1 refrigerator. Surveyor observed 4 large tubs of ice cream that are undated in the freezer, 1 yogurt not dated in the refrigerator, no thermometer in the freezer or refrigerator, dripping water from the freezer into the refrigerator and no documented temperature logs on or near the freezer and refrigerator. Surveyor also observed Unit 2 refrigerator. Surveyor observed all items dated, but no documented temperature logs on or near the freezer and refrigerator. The facility was unable to provide documentation that the facility was maintaining temperature logs for the unit refrigerators and freezers. On 6/12/25, at 9:41 AM, Surveyor informed Executive Chef (EC)-L that the facility has no documentation that the refrigerators/freezer on the units temperatures were being monitored. On 6/16/25, at 8:52 AM, Dietary Manager (DM)-R stated that the kitchen does not maintain temperatures of the unit refrigerators/freezers and does not maintain food items to be stored in a safe manner in the unit refrigerator and freezers. DM-R stated that is the responsibility of the nursing department. Food Storage (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's undated Storage policy documents: Scoops must be provided for bulk foods(such as sugar, flour, and spices). Scoops should be kept covered in a protected area near the containers rather than in the containers. Scoops should be washed and sanitized on a regular basis. The facility's Accepting Food Deliveries undated policy documents: 4. Perishable foods will be properly covered, labeled, and dated and promptly stored in the refrigerator or freezer as appropriate. On 6/10/25, at 8:50 AM, during the initial tour of the kitchen with Bistro (B)-N, Surveyor observed unopened packages of Ribeye, Bags of Fries, Bags of Onion Rings, Bags of Tamale Pie Filling, Bag of [NAME] Chicken, Bags of Onion Rings, and 2 Pork Loins with no dates located on the freezer metal racks. Items were located freely on a metal rack and not on top of a box with similar items. B-N was not aware of and undated items in the freezer, removed some of the undated items, and stated the freezer would be checked for more undated items. Surveyor also observed on 6/10/25, at 8:50 AM scoops in the sugar and flour bin touching the sugar and flour. On 6/11/25, at 7:53 AM, Surveyor conducted another tour with Executive Chef (EC)-L in the freezer. Surveyor shared that there were 2 pork loins undated. Surveyor asked if EC-L observed any dates on the pork loin packaging. I don't see one, I have been doing healthcare for 1 year and I haven't known freezer items to be dated. they are frozen. Surveyor also observed on 6/11/25, at 7:53 AM, that the sugar, flour, and rice flour scoops are located in the bin. Surveyor observed the bin to be dirty on the outside with dried food items on the bins. On 6/12/25, at 7:35 AM, Surveyor conducted a 3rd tour of the kitchen coolers and freezer. In the first cooler, Surveyor observed a beef top round thawing with no date. Surveyor observed in the freezer a bag of pancakes undated, 5 bags of potatoes undated, 1 onion ring bag undated, 2 boneless pork loins undated, and 1 bag of white chicken undated. Surveyor also observed the scoop in the sugar bin and all 3 flours bins along with being dirty on the outside, sticky food droppings on the lids. On 6/12/25, at 7:50 AM, B-N stated that cooks are responsible for dating the items in the freezer and others are responsible for dating the items when stocking the orders. On 6/12/25, at 9:33 AM, Surveyor interviewed [NAME] (Cook)-M. Cook-M stated that the items are dated by supervisors when the order arrives. Cook-M stated Cook-M dates when preparing the food items and puts the items in the cooler or freezer. Usually use a range of 5 days, will write the date on masking tape. Cook-M knows everything needs to be dated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/12/25, at 9:41 AM, Surveyor shared with EC-L a list of undated items in the freezer and the concern that the items were unpacked from the boxes, the box with a date is no longer present, and the bags of items are undated. EC-L did not want the list of all items located in the freezer that were undated from Surveyor. Surveyor also shared that the scoops were left in the sugar and flour bins that were also dirty on the outside with dried food on the bin. On 6/12/25, at 10:59 AM, Surveyor observed the sugar and 3 flour bins with the scoops located inside. The facility acknowledged that there is a required Cleaning and Sanitation of Dining and Food Service Areas, however, regular cleaning of the sugar and flour bins are not on the cleaning schedule. On 6/16/25, at 8:52 AM, shared the concern with Dietary Manager (DM)-R the concerns that items in the freezer were observed to be undated and the scoops were observed in the sugar and flour bins and the bins were observed to be dirty on the outside. Surveyor shared the concern that when the original packaging is not there, and no date on the food packaging, no one knows what the expiration date is. DM-R understands the concerns and provided no additional information. Hair Restraint Use The facility's undated Personal Hygiene and Health Reporting policy and procedure documents: b. Hair should be neat and clean. Hair restraints must be worn around exposed foods, in the kitchen or food service areas and dining areas. c. Beards and mustaches should be closely cropped and neatly trimmed. When around exposed foods, beards must be restrained using beard covers. On 6/11/25 at 10:59 AM, Surveyor observed [NAME] (Cook)-Q arrive into the kitchen, and wash hands. Cook-Q had a baseball hat on. Surveyor observed no beard guard on Cook-Q. Surveyor observed Cook-Q has facial hair(growth of a beard) and hair on chin, and Cook-Q also has a mustache. Surveyor observed Cook-Q put gloves on and chopped up lemons. Washed hands, put new gloves on, took out rolls from the oven. Working on chopping up other vegetables. On 6/11/25, at 11:30 AM, Surveyor shared the concern with Executive Chef (EC)-L that Cook-Q did not have a beard guard on. EC-L stated, That's a 2 day growth; Didn't think it was an issue. On 6/12/25, at 9:33 AM, Surveyor observed Cook-Q is completely shaved on this date. On 6/12/25, at 9:41 AM, Surveyor shared the concern with EC-L the observation of Cook-Q not wearing a beard guard. ECL disagrees with the beard guard issue and stated that it is only 2 days of beard growth. On 6/16/25, at 8:52 AM, Surveyor shared the concern with Dietary Manager (DM)-R the observation of Cook-Q not having a beard guard on. No additional information was provided as to why the facility did not store, prepare, distribute and serve food in accordance with professional standards for food service safety.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2.) R12's diagnoses includes dementia (loss of cognitive function that interferes with a person's daily life and activities), atrial fibrillation (irregular and rapid heart beat), depressive disorder, diabetes mellitus (high blood sugar), and malignant neoplasm of colon (cancer). R12's significant change MDS (minimum data set) with an assessment reference date of 2/6/25 has a BIMS (brief interview mental status) score of 12 which indicates moderate cognitive impairment. Hospice care is checked for while a resident. R12's nurses note dated 2/7/25 documents Resident is being monitored for readmission. Resident is now on [Name] hospice. Resident out for breakfast today. VSS (vital signs stable). Taking in fluids. Denies pain. BGL (blood glucose level) 186 before breakfast. R12's hospice care plan initiated 2/13/25 documents the following interventions: *Establish and coordinate POC (plan of care) and services between LTC (long term care) and Hospice Team. Maintain communication to fulfill POC and inform of changes. Initiated 2/13/25. *Hospice related medications and supplies to be provided by hospice services. Initiated 2/13/25. *Medications as ordered by Hospice/MD (Medical Doctor) order. Initiated 2/13/25. *Will update and review as changes occur. Initiated 2/13/25. R12's nurses note dated 5/1/25, at 15:45 (3:45 p.m.), documents: Called [Name] hospice to update on residents COC (change of condition) by being very lethargic, refusing cares, and refusing meals. Hospice nurse is to be giving writer a call back regarding when they can come out to see resident. R12's nurses note dated 5/1/25, at 23:03 (11:03 p.m.), documents: Resident on the board for COC. Hospice nurse came out this evening to assess resident and when they arrived residents was being helped out of bed and dressed for the evening. Resident was awake and alert when hospice assessed. They expressed could be resident slowly declining but no concern at the time. Resident up for dinner, ate 75% of meal. Fell asleep at dining table and when writer asked if she wanted to go back to her room she said no she just want to be. An hour later resident was heard yelling and moaning from dining room, resident was very lethargic and writer check residents blood sugar twice from two separate glucometers getting BS (blood sugar) of 279. Resident was not responding to any questions at this time and unable to open eyes, vitals were taken and all WNL (within normal limits). Once resident woke up a little, still not responding with words was able to give bilateral hand grasp equal in strength, pick up both arms with no drift, smile was equal and able to stick out tongue. Resident was taken to the bathroom per resident's request by CNA and writer and slowly started to talk but only in one word. Resident is still responding only in one words and express feeling off and just sleepy. Writer taken residents BS (blood sugar) again at 9 PM before HS (hour sleep) insulin and BS was 465. Surveyor was unable to locate hospice communication note regarding hospice visit on 5/1/25. (continued on next page)

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	525279	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tudor Oaks Health Center	S77 W12929 McShane Dr Muskego, WI 53150

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R12's Quarterly MDS with an assessment reference date of 5/8/25 has a BIMS (brief interview mental status) score of 11 which indicates moderate cognitive impairment. Hospice care is checked for while a resident. On 6/11/25, at 10:25 a.m., Surveyor reviewed the facility's hospice agreement with [Name] at home hospice dated July 26, 2023. Surveyor noted this agreement is not signed by the hospice representative. Nursing Home Administrator (NHA)-A received a signed agreement on 6/16/25 which was originally signed by the hospice representative on 7/27/23. On 6/11/25, at 11:08 a.m. Surveyor reviewed R12's hospice binder located on a shelf behind where Health Unit Coordinator (HUC)-T is located. Surveyor noted R12's hospice binder contains the first names of the hospice team, hospice agreement dated 2/5/25 signed by R12's POA (power of attorney) and hospice team member [Name], RN (Registered Nurse) on 2/4/25, the hospice discharge criteria, hospice benefit election, informed consent and Medicare/Medicaid benefit election signed by R12's POA on 2/4/25. An email from Nursing Home Administrator (NHA)-A dated 2/6/25 which documents to please make sure that daily skilled documentation continues to be completed on the following residents. Surveyor noted R12 is not on this list of residents. There is a calendar with scheduled visits for February 2025, March 2025, & April 2025. Surveyor noted there is not calendar indicating when R12's scheduled hospice visits are after April 2025. There are hospice notes dated 2/10/25 regarding shower/sponge bath, 4/12/25 PRN (as needed) visit due to change in condition by a hospice RN and the last notation is dated 5/30/25. There are no further hospice communication notes after 5/30/25. Surveyor reviewed R12's medical record and noted under the document section of R12's medical record there are two notes. There are hospice visit reports dated 3/1/25 and 5/25/25. Surveyor was unable to locate any additional communication notes from hospice. On 6/11/25, at 11:29 a.m., Surveyor spoke with Hospice Aide (HA)-LL who Surveyor had observed wheel R12 out of activities and into the shower room for a shower. HA-LL informed Surveyor she comes three times a week. She gives R12 a shower twice a week, does R12's nails, sits with R12 in activities and often will take R12 to her hair appointment and sit with R12. On 6/11/25, at 3:10 p.m., during the end of the day meeting with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B Surveyor inquired where Surveyor would locate hospice notes. DON-B informed Surveyor there is a hospice binder kept at the HUC station and hospice started emailing their notes which are being uploaded under documents. Surveyor asked DON-B if hospice communication notes are not in the binder or under the document section of the resident's medical record is there anywhere else Surveyor should look. DON-B replied no. Surveyor asked who is the facility's hospice liaison. NHA-A stated think it's always the DON. DON-B indicated she just started then stated sure, they (hospice) stop in by her. On 6/12/25 at 9:15 a.m. Surveyor interviewed HUC-T regarding hospice communication notes. HUC-T informed Surveyor [Name] hospice gives her the visit forms and she uploads them right way into the resident's medical record. Surveyor asked about [Hospice Name], which is R12's hospice,. HUC-T informed Surveyor they put their notes in the binder. Surveyor inquired if the notes get uploaded into the medical record. HUC-T replied no. Surveyor asked HUC-T if anyone is responsible to ensure hospice is providing their hospice notes. HUC-T informed Surveyor she knows hospice give a report to nursing on what cares they did but doesn't know if they specifically as for a sheet. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/25, at 12:14 p.m. Surveyor asked Registered Nurse/Unit Manager (RN/UM)-D who is the facility's hospice liaison. RN/UM-D informed Surveyor she doesn't know if there is one designated. Surveyor asked RN/UM-D the process for communication with hospice. RN/UM-D informed Surveyor they typically tell the nurse on duty what they did, if there are any orders they write telephone orders or they will send the orders to the pharmacy. Surveyor asked RN/UM-D if hospice leaves any paperwork. RN/UM-D informed Surveyor they should be going to their binders and put their paper work in there unless it as an order. Surveyor asked if hospice attends the interdisciplinary team meetings. RN/UM-D replied they typically do may be one person. Surveyor asked if hospice social worker or chaplain comes into the facility. RN/UM-D replied yes and informed Surveyor sometimes there is music therapy or massage therapy. Surveyor was not able to locate any notes from the hospice social worker or chaplain. Surveyor asked if hospice provides a schedule when they are coming in. RN/UM-D informed Surveyor sometimes they give the CNA (Certified Nursing Assistant) a schedule but can't say it's consistent. Surveyor informed RN/UM-D the last schedule in R12's hospice binder is from April. On 6/12/25, at 9:30 a.m., Surveyor rechecked R12's hospice binder and noted the last note in the binder is still dated 5/30/25. No additional information was provided. 3.) R23's diagnoses includes Alzheimer's Disease, Anxiety Disorder and Depressive Disorder. R23's physician orders includes Hospice eval (evaluation) & tx (treat) dated 5/13/24. R23's social service note dated 5/13/24 at 13:59 (1:59 p.m.) written by Social Service (SS)-Y documents Resident signed on with [Name] Hospice Services. R23's hospice care plan initiated 5/13/24 & revised 6/4/24 documents the following interventions: *Ancillary services (PT/OT) (physical therapy/occupational therapy) for resident comfort as determined by MD/NP (medical doctor/nurse practitioner), Hospice, LTC (long term care). Initiated & revised 5/22/24. *DME (durable medical equipment) and hospice related medications and supplies to be provided by hospice service. Initiated & revised 5/22/24. *Establish and coordinate POC (plan of care) and services between LTC and hospice team. Maintain communication to fulfill POC (plan of care) and inform of changes. Initiated & revised 5/22/24. *Establish and coordinate POC and services between [Facility name] nursing staff and hospice team. Maintain communication to fulfill POC and inform of changes. Initiated 5/22/24. *Hospice related medications and supplies to be provided by hospice service. Initiated 5/22/24. *Hospice staff to document provisions of care for LTC staff. Will update and review as changes occur. Initiated & revised 5/22/24. *Hospice staff to document provisions of care for [Facility name] nursing staff. Will update and review as changes occur. Initiated 5/22/24. *Medications as ordered per hospice/MD order. Initiated 5/22/24. *Medications as ordered. Initiated & revised 5/22/24. R23's social service note dated 6/6/24, at 10:23 a.m., written by SS-Y documents: Writer met with resident's dtr/POA (daughter/power of attorney) [Name], DON (Director of Nursing), and [Name] Hospice team to discuss POC (plan of care). Hospice team will be bringing in volunteer to spend more time with res (resident) when becoming restless/agitated. No concerns were noted at this time. Hospice and IDT (interdisciplinary team) will continue to follow and assist resident and family with needs. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R23's annual MDS (minimum data set) with an assessment reference date of 5/13/25 has a BIMS (brief interview mental status) score of 3 which indicates severe cognitive impairment. Hospice care is checked for while a resident. On 6/11/25, at 11:24 a.m., Surveyor reviewed R23's [Name] Hospice binder. Surveyor noted this binder contains [Hospice name] team form which has not been filled out, a note tab with interdisciplinary progress notes starting 6/13/24 to 3/13/25 and section for bowel movement tracker which has not been completed. Surveyor noted there are no hospice communication notes after 3/13/25. On 6/11/25, at 3:10 p.m., during the end of the day meeting with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B, Surveyor inquired where Surveyor would locate hospice notes. DON-B informed Surveyor there is a hospice binder kept at the HUC (health unit coordinator) station and hospice started emailing their notes which are being uploaded under documents. Surveyor asked DON-B if hospice communication notes are not in the binder or under the document section of the resident's medical record is there anywhere else Surveyor should look. DON-B replied no. Surveyor asked who is the facility's hospice liaison. NHA-A stated think it's always the DON. DON-B indicated she just started then stated sure, they (hospice) stop in by her. On 6/12/25, at 9:15 a.m., Surveyor interviewed HUC-T regarding hospice communication notes. HUC-T informed Surveyor [Name] hospice gives her the visit forms and she uploads them right way into the resident's medical record. Surveyor asked about [Hospice Name], which is R23's hospice,. HUC-T informed Surveyor they put their notes in the binder. Surveyor inquired if the notes get uploaded into the medical record. HUC-T replied no. Surveyor asked HUC-T if anyone is responsible to ensure hospice is providing their hospice notes. HUC-T informed Surveyor she knows hospice give a report to nursing on what cares they did but doesn't know if they specifically as for a sheet. On 6/12/25, at 12:14 p.m., Surveyor asked Registered Nurse/Unit Manager (RN/UM)-D who is the facility's hospice liaison. RN/UM-D informed Surveyor she doesn't know if there is one designated. Surveyor asked RN/UM-D the process for communication with hospice. RN/UM-D informed Surveyor they typically tell the nurse on duty what they did, if there are any orders they write telephone orders or they will send the orders to the pharmacy. Surveyor asked RN/UM-D if hospice leaves any paperwork. RN/UM-D informed Surveyor they should be going to their binders and put their paper work in there unless it as an order. Surveyor asked if hospice attends the interdisciplinary team meetings. RN/UM-D replied they typically do may be one person. Surveyor asked if hospice social worker or chaplain comes into the facility. RN/UM-D replied yes and informed Surveyor sometimes there is music therapy or massage therapy. Surveyor was not able to locate any notes from the hospice social worker or chaplain. Surveyor asked if hospice provides a schedule when they are coming in. RN/UM-D informed Surveyor sometimes they give the CNA (Certified Nursing Assistant) a schedule but can't say it's consistent. On 6/12/25, at 10:03 a.m., Surveyor observed R23 sitting in a wheelchair in her room with Hospice Registered Nurse (RN)-MM. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/25, at 10:06 a.m., Surveyor spoke with Hospice RN-MM. Hospice RN-MM informed Surveyor this is her first visit at the facility and explained she is a visit nurse and not the case manager. Surveyor inquired if she leaves any hospice communication notes with the facility. Hospice RN-MM informed Surveyor her directions are there is apparently a white [name of hospice] binder she is to look for and write a brief summary of the visit. Hospice RN-MM informed Surveyor that there is also an email sent to DON [Name] (Previous Director of Nursing-II), Director Social Services-K, R23's daughter who is R23's POA and R23's case manager. Surveyor asked if there is a hospice care plan. Hospice RN-MM replied yes, have to look at it before she goes to the facility. Surveyor asked if the care plan is in her hospice computer. Hospice RN-MM replied yes. No additional information was provided. Based on interview and record review, the facility did not ensure hospice collaboration and communication processes were established to ensure continuity of care between hospice and the facility for 3 (R2, R12, and R23) of 4 residents reviewed for hospice services. *R2's current hospice plan of care, visit notes, and schedule of hospice providers were not available to facility staff. The facility did not have a facility hospice care plan developed. The facility did not designate a staff member to coordinate the plan of care with the hospice provider. *R12's current hospice plan of care, visit notes, and schedule of hospice providers were not available to facility staff. The facility did not designate a staff member to coordinate the plan of care with the hospice provider. The facility did not designate a staff member to coordinate the plan of care with the hospice provider. *R23's current hospice plan of care, visit notes, and schedule of hospice providers were not available to facility staff. The facility did not have a facility hospice care plan developed. The facility did not designate a staff member to coordinate the plan of care with the hospice provider. Findings include: The facility's undated Coordination of Hospice policy and procedure documents: Policy: When a Resident chooses to receive hospice care and services, the facility will coordinate and provide care in cooperation with hospice staff in order to promote the Resident's highest practicable physical, mental, and psychosocial well-being. Policy Explanation and Compliance Guidelines: 1. The facility maintains written agreements with hospice providers that specify the care and services to be provided and the process for hospice and nursing home communication of necessary information regarding the Resident's care. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The facility and hospice provider will coordinate a plan of care and will implement interventions in accordance with Resident's needs, goals, and recognized standards of practices in consultation with the Resident's attending physician/practitioner and Resident's representative, to the extent possible. 3. The plan of care will identify the care and services that each entity will provide in order to meet the needs of the Resident and his/her expressed desire for hospice care. a. The hospice provider retains primary responsibility for the provision of hospice care and services that are necessary for the care of the Resident's terminal illness and related conditions. b. The facility retains primary responsibility for implementing those aspects of care that are not related to the duties of the hospice. 4. The facility will communicate with hospice and identify, communicate, follow and document all interventions put into place by hospice and the facility. 5. The facility will monitor and evaluate the Resident's response to the hospice care plans. 6. The facility will maintain communication with hospice as it relates to the Resident's plan of care and services to ensure each entity is aware of their responsibilities. 7. The plan of care will include directives for managing pain and other uncomfortable symptoms and will be revised and updated as necessary. 1) R2 was admitted to the facility on [DATE] with diagnoses of Unspecified Protein-Calorie Malnutrition (deficiency of both protein and energy), Peripheral Vascular Disease(circulatory condition in which narrowed blood vessels reduce blood flow to limbs), Unspecified Dementia(loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life), Major Depressive Disorder(persistent feelings of sadness, hopelessness, and a loss of interest or pleasure in activities), and Anxiety Disorder(mental health disorder characterized by feelings of worry, fear that interfere with daily activities). R2's Significant Change Minimum Data Set(MDS) completed 5/20/25 documents R2's Brief Interview for Mental Status(BIMS) score to be 2, indicating R2 demonstrates severely impaired skills for daily decision making. R2 has no mood symptoms. R2 displays physical and verbal symptoms and rejection of care. R2 has no range of motion impairment. R2 requires set-up for eating. The MDS also documents that R2 requires dependent care for showers and substantial/maximum care for dressing, mobility, and transfers. R2's current physician orders document R2 is being treated by hospice effective 5/14/25. Surveyor reviewed R2's comprehensive care plan. R2's comprehensive care plan did not document that R2 is receiving hospice services. Surveyor reviewed R2's hospice agreement signed on 4/16/24. R2's hospice agreement documents: (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan of Care means a written care plan established, maintained, reviewed and modified, if necessary, at intervals identified by the Interdisciplinary Team(IDT). The plan of care must reflect hospice patient and family goals and interventions based on the problems identified in the hospice patient assessments. The plan of care will reflect the participation of the hospice, facility and the hospice patient and family to the extent possible. Specifically, the plan of care includes: -an identification of the hospice services, including interventions for pain management and symptom relief, needed to meet such hospice patient's needs and the related needs of hospice patient's family -a detailed statement of the scope and frequency of such hospice services -measurable outcomes anticipated from implementing and coordinating the plan of care -drugs and treatment necessary to meet the needs of the hospice patient -medical supplies and appliances necessary to meet the needs of the hospice patient -IDT documentation of the hospice patient's or representative's level of understanding, involvement and agreement with the plan of care. Hospice and facility will jointly develop and agree upon a coordinated plan of care which is consistent with the hospice philosophy and is responsive to the unique needs of hospice patient and his or her expressed desire for hospice care. The Plan of Care will identify which provider is responsible for performing the respective functions that have been agree upon and included in the plan of care. Coordination of Care -Facility shall participate in any meeting, when requested, for the coordination, supervision and evaluation by hospice of the provision of facility services. Hospice and facility shall communicate with one another regularly and as needed, for each particular hospice patient. Each party is responsible for documenting such communications in its respective clinical records to ensure that the needs of hospice patients are met 24 hours per day. Design of Plan of Care -In accordance with applicable federal and state laws and regulations, facility shall coordinate with hospice in developing a plan of care for each hospice patient. Hospice retains primary responsibility for development of the plan of care. Modifications to Plan of Care -Facility will assist with periodic review and modification of the plan of care. Facility will not make any modifications to the plan of care without first consulting hospice. Hospice retains the sole authority for determining the appropriate level of hospice care provided to each hospice patient. Coordination and Evaluation (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inpatient Clinical Records -Hospice shall periodically review hospice patients' inpatient clinical records to determine that they include a record of all inpatient services furnished and events regarding care that occurred at facility. On 6/11/25, at 7:34 AM, Surveyor reviewed R2's hospice binder located at the facility's nursing station. R2's binder conatined R2's certification for hospice 5/14/25-7/12/25, consent and election of benefit statement, list of medications, hospice contacts with phone numbers, a nurse initial visit and assessment dated [DATE], and an aide care plan report. R2's binder does not contain a documented hospice plan of care or hospice visit notes. There was no schedule when hospice providers will be at the facility to provide service to R2. Surveyor notes R2's electronic medical record(EMR) did not contain a documented hospice care plan or hospice visit notes. On 6/11/25, at 2:03 PM, Surveyor interviewed Unit Secretary (US)-T. US-T is not aware of any schedule from hospice being provided to facility staff when hospice providers will be providing cares to R2. On 6/11/25, at 3:19 PM, Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B explained the hospice binders are located at the nurse's stations. NHA-A explained that hospice providers email hospice visit notes and the documentation gets 'uploaded' in the Resident's EMR. Surveyor asked who is the facility designated liaison between the facility and hospice providers. NHA-A stated it has always been the Director of Nursing. DON-B stated DON-B started employment in February but was not aware that DON-B is the designated liaison between the facility and hospice providers. DON-B stated that sometimes hospice will stop in by DON-B or the Social Worker. On 6/12/25, at 12:08 PM, Surveyor interviewed Registered Nurse Unit Secretary (RN)-D in regards to the communication between R2's hospice provider and the facility. RN-D does not know if there is a facility designated hospice liaison. RN-D stated that hospice should be placing visit notes in the hospice binder. RN-D stated that all hospice disciplines come in and provide care to R2 and sometimes hospice provides an aide schedule, but it is not consistent. On 6/12/25, at 3:24 PM, Surveyor shared the concern with NHA-A, DON-B, and Corporate Consultant (CC)-C that there is no collaboration between R2's hospice and facility. Surveyor explained R2's hospice binder and EMR does not contain documentation of hospice visit notes, or a hospice care plan. Surveyor also shared the concern that the facility has not implemented a hospice care plan and the facility has not had a designated hospice liason. The facility has not provided further information as to why there is no collaboration between R2's hospice provider and the facility and that there is no coordinated person plan of care with interventions in accordance with R2's needs, goals, and preferences.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tudor Oaks Health Center	S77 W12929 McShane Dr Muskego, WI 53150

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not maintain an infection prevention and control program designed to reduce the transmission of disease and infection. * The facility was not computing baseline rates of infections for prevalent infections. * The eye wash station was not flushed weekly. * R12 has Stage 2 coccyx pressure injury. R12 was not placed on EBP (enhanced barrier precautions) staff was observed not wearing the appropriate PPE (personal protective equipment) during personal care & treatment observations and hand hygiene concerns were identified during R12's treatment observation. * Hand hygiene concerns were identified during R23's medication administration. * R24 was not placed on EBP. R24 has a heel pressure injury. * R38 was not placed on EBP. R38 has a Stage 2 coccyx pressure injury. * R3's catheter collection bag and tubing was observed during multiple observations to be laying directly on the floor. This has the potential to affect the 41 residents currently residing in the facility. Findings include: The facility's policy titled, Infection Prevention and Control Program and not dated under policy documents This facility has established and maintains 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 as per accepted national standards and guidelines. Under Policy Explanation and Compliance Guidelines documents 1. The designed Infection Preventionist is responsible for oversight of the program and serves as a consultant to our staff on infectious diseases, resident room placement, implementing isolation precautions, staff and resident exposures, surveillance and epidemiological investigations of exposures of infectious diseases. 2. All staff are responsible for following all policies and procedures related to this program. 3. Surveillance: a. A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable disease for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon a facility assessment and accepted national standards. b. The Infection Preventionist serves as the leader in surveillance activities, maintains documentation of incidents, findings and any corrective actions made by the facility and reports surveillance findings to the facility's Quality Assessment and Assurance Committee. The facility's policy titled, Hand Hygiene and noted dated under policy documents All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's policy titled, Enhanced Barrier Precaution and dated March 2024 under Policy documents It is the policy of American Baptist Homes of the Midwest to reduce transmission of multidrug-resistant organisms through an infection control intervention designed that employs targeted gown and glove use during high contact resident activities known as Enhanced Barrier Precautions (EBPs). Under the procedure section it documents: 1. EBPs are used in conjunction with standard precautions and expand the use of PPE (personal protective equipment) to donning (placing on) of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs (multidrug resistant organisms) to staff hands and clothing. 4. 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 chronic wounds include, but are not limited to pressure ulcers, diabetic foot ulcers, unhealed surgical wounds and venous stasis ulcers. 8. EBPs employ target gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gowns are applied prior to performing the high contact resident care activity (as opposed to before entering the room). b. Personal protective equipment (PPE) is changed before caring for another resident. c. Face protection may be used if there is a also a risk of splash or spray. 9. For residents whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities: a. Dressing, b. Bathing/showering, c. Transferring, d. Providing hygiene, e. Changing linens. f. Changing briefs or assisting with toileting. g. Device care or use: central lines, urinary catheter, feeding tube, tracheostomy/ventilator, h. Wound care: any skin opening requiring a dressing. 15. Signs are posted on the door or wall outside the resident room indicating the type of precautions and PPE required. 1.) On 6/11/25, at 12:09 p.m., Surveyor reviewed the infection control binder provided by Infection Preventionist (IP)-Z. Surveyor noted the facility is calculating one rate of infection and not baseline rates of infection for the facility's prevalent infections. Infection rates are as follows: January 2025 the HAI (Healthcare Associated Infection) rate documents 20.21/1000 patient days. January 2025 Monthly Infection Rates Total (Community and Facility Acquired) documents 22.23/1000 patient days. February 2025 the HAI rate documents 3.77/1000 patient days. February 2025 Monthly Infection Rates total (Community and Facility Acquired) documents 4.52/1000 patient days. March 2025 HAI rate documents 4.41/1000 patient days. March 2025 Monthly Infection Rates total (Community and Facility Acquired) documents 6.62/1000 patient days. April 2025 HAI rate documents 5.85/1000 resident days. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	April 2025 Monthly Infection Rates (Community and Facility Acquired) documents 10.23/1000 resident days. May 2025 infections rates were not calculated. On 6/12/25, at 10:48 a.m., Surveyor met with IP-Z to discuss the facility's infection control program. During this interview Nursing Home Administrator (NHA)-A was also present. During the interview, Surveyor informed IP-Z Surveyor had reviewed her infection control binder and noted one rate of infection based on 1000 resident days. Surveyor asked IP-Z if she is calculating baseline rates of infections based on their prevalent infections. IP-Z informed Surveyor looks like its the over all rate. Surveyor informed IP-Z they should be calculating individual baseline rates of infection for their prevalent infections. On 6/16/25, at 9:55 a.m., IP-Z informed Surveyor they retroactively figured out the individual rates of infections for their prevalent infections on Friday going back to January 2025. 2.) On 6/12/25, at 12:41 p.m., during the water management interview with Environmental Services Director (ESD)-NN Surveyor inquired if there are any eye wash stations at the facility and how often the eye wash station is flushed. ESD-NN informed Surveyor he believes Environmental Supervisor (ES)-OO has the documentation. On 6/12/25, at 1:11 p.m., ES-OO provided Surveyor with the weekly eye wash inspection form which states to run water for 15 seconds to see that there is a proper flow and that running water does not appear dirty or cloudy. Water temperature is tepid. Surveyor reviewed this weekly log and note for May 2025 the week of 5/4/25 to 5/10/25 and 5/18/25 to 5/24/25 the log does not indicate the eye wash station was flushed. Surveyor informed ES-OO the log for the week of 5/4/25 to 5/10/25 does not indicate the eye wash station was flushed. ES-OO stated I was probably gone, ya I was gone. Surveyor asked when she is not working is there anyone else responsible for flushing the eye wash station. ES-OO replied no, could of assigned someone. Surveyor then asked ES-OO if she knows why the eye wash station was not flushed during the week of 5/18/25 to 5/24/25. ES-OO replied no I don't know. Surveyor noted during May 2025 the eye wash station was not flushed during 2 of the 4 weeks. 3.) R12 has a Stage 2 coccyx pressure injury. R12's quarterly MDS (minimum data set) with an assessment reference date of 5/8/25 has a BIMS (brief interview mental status) score of 11 which indicates moderate cognitive impairment. R12 is assessed as requiring supervision or touching assistance for toileting hygiene, roll left and right, chair/bed to chair transfer and toilet transfers. R12 is assessed as being occasionally incontinent of urine and always incontinent of bowel. R12 is at risk for pressure injury development and is assessed as having one Stage 2 pressure injury which was not present upon admission. On 6/10/25, at 9:21 a.m., Surveyor observed R12 sitting in a personal type recliner in R12's room wearing clothing with a bathrobe over the clothing. During the conversation with R12, Surveyor asked R12 if she has any skin concerns. R12 stated I have a hole in my butt which they are treating. On 6/10/25, at 10:37 a.m., Surveyor did not observe an EBP (enhanced barrier precaution sign) on or around R12's door frame. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/11/25, at 11:34 a.m., Surveyor observed Certified Nursing Assistant (CNA)-J and CNA-GG in R12's room with gloves on. Neither CNA-J or CNA-GG are wearing gowns. The sit to stand lift was placed in front of R12, the belt was connect around R12's legs and staff placed a sling around R12 and hooked the sling to the lift. R12 was raised off the bed and wheeled into the bathroom. CNA-J lowered R12's pants & product and R12 was lowered onto the toilet. Staff informed R12 they would give her a couple minutes and closed the accordion bathroom door. CNA-J & CNA-GG removed their gloves and cleansed their hands. Surveyor did not observe an EBP (enhanced barrier precaution sign) on or around R12's door frame. On 6/11/25, at 11:41 a.m., CNA-J and CNA-HH entered R12's room and placed gloves on. Neither CNA-J or CNA-HH placed a gown on. CNA-J asked R12 if she was ready and R12 was raised off the toilet. CNA-J wiped R12's perineal area with a disposable wipe, applied barrier cream and R12's incontinence product and pants were pulled up. R12 was wheeled out of the bathroom, CNA-HH informed R12 she was going down and R12 was lowered into the wheelchair. CNA-HH & CNA-J removed the sling from around R12, removed their gloves and cleansed their hands. On 6/12/25, at 7:28 a.m., Surveyor asked Certified Nursing Assistant (CNA)-PP if there are any residents on the unit who are on isolation precautions. CNA-PP replied no, there are no residents on isolation. On 6/12/25, at 8:23 a.m., Surveyor observed R12 in bed on her back stating hurry I have to go to the bathroom. Surveyor observed R12's pants were down at her knees, wearing sneakers, and there is a sit to stand lift in R12's room. On 6/12/25, at 8:26 a.m., CNA-HH entered R12's room, cleansed her hands, and placed gloves on. CNA-HH was not wearing a gown. CNA-HH assisted R12 with sitting on the edge of the bed. R12 was telling CNA-HH to hurry. CNA-HH placed the sling around R12 and connected the sling to the lift. At 8:29 a.m. CNA-HH removed her gloves and cleansed her hands. CNA-HH informed R12 I'll tell her to hurry and left R12's room. CNA-HH returned a few seconds later with CNA-GG. CNA-HH and CNA-GG cleansed their hands and placed gloves on. Neither CNA-HH or CNA-GG are wearing a gown. CNA-HH informed R12 she was going up and R12 was raised off the bed, wheeled into the bathroom and CNA-GG lowered R12's incontinence product. R12 started to urinate as she was lowered onto the toilet. CNA-HH removed R12's incontinence product. At 8:32 a.m. R12 was asked if she wanted privacy and CNA-GG & CNA-HH removed their gloves and left R12's room. At 8:33 a.m. CNA-HH entered R12's room and placed gloves on. CNA-HH was not wearing a gown. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At 8:34 a.m. RN/UM-D entered R12's bathroom, dated the foam dressing and placed gloves on. RN/UM-D was not wearing a gown. RN/UM-D placed soap & water on four by four gauze, asked R12 if she was ready to stand up & asked R12 if she was able to help stand up. R12 was then raised to a standing position and wheeled out of the bathroom. RN/UM-D removed the dressing and cleansed R12's coccyx pressure injury. RN/UM-D did not remove her gloves and perform hand hygiene. RN/UM-D waved the foam dressing over the pressure injury to help dry the pressure injury and place the foam dressing over R12's coccyx pressure injury. Using a disposable wipe, RN/UM-D wiped R12's frontal perineal area. RN/UM-D and CNA-HH pulled up R12's incontinence product & pants, R12 was wheeled out of the bathroom and lowered into the wheelchair. RN/UM-D removed her gloves and cleansed her hands. CNA-HH changed R12's shirt, brushed her hair, gathered the garbage, removed her gloves and cleansed her hands. On 6/12/25, at 8:44 a.m., Surveyor asked RN/UM-D if there are any residents on isolation. RN/UM-D informed she believes [name of R6] is on enhanced barrier precautions. R6 is the only one. On 6/12/25, at 9:10 a.m., Surveyor asked CNA-HH if any resident is on isolation. CNA-HH replied just [room number] with body fluids. Surveyor noted this is not R12's room. On 6/12/25, at 10:48 a.m., during the infection control interview with Infection Preventionist (IP)-Z & NHA-A present, Surveyor asked IP-Z if they have residents on EBP. IP-Z replied yes. Surveyor asked IP-Z how they determine when a resident is placed on EBP. IP-Z informed Surveyor they follow the guidance, they have a non healing wound, artificial tube, Foley. Surveyor asked IP-Z if EBP signs are posted. IP-Z informed Surveyor for resident dignity the signs are in the room and caddy's (for PPE) are in the room. Surveyor asked if residents with pressure injuries, stage 2, 3, or 4 should they be placed on EBP. IP-Z replied yes. Surveyor asked who is responsible to place a resident on EBP if they are admitted with a pressure injury or develop a pressure injury. IP-Z informed Surveyor she would be the one reviewing the admission information. Surveyor informed IP-Z R12 has a Stage 2 coccyx pressure injury and Surveyor did not observe an EBP sign or caddy and staff were observe during personal cares and treatment observation not wearing the appropriate PPE. IP-Z informed Surveyor she will place R12 on EBP and may not have captured that one. R12's nurses note dated 6/12/25, at 12:09 p.m. written by IP-Z documents EBP initiated. Primary nursing staff updated. On 6/12/25, at 1:47 p.m., Surveyor observed an EBP sign and cart in R12's bathroom. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4.) On 6/12/25, at 8:02 a.m., Surveyor observed Registered Nurse/Unit Manager (RN/UM)-D prepare R23's medication. RN/UM-D removed R23's blister packs from the drawer and placed gloves on. Surveyor observed RN/UM-D did not perform any hand hygiene prior to placing gloves on. RN/UM-D dispensed Buspirone 5 mg (milligrams) one tablet onto her gloved hand and then placed the tablet into the medication cup. RN/UM-D repeated this process for Gabapentin 100 mg 2 capsules, Senna 8.6 mg one tablet, Memantine 10 mg one tablet, Klor Con M 10 ER 1 tablet, and Sertraline 50 mg one tablet. RN/UM-D with her gloved hands, opened a drawer in the medication cart and removed Acetaminophen 500 mg bottle. RN/UM-D poured two tablets of Acetaminophen into her gloved hands and placed the tablets into the medication cup. RN/UM-D opened the drawer of the medication cart and removed a metamucil fiber packet, opened the packet and emptied the packet into a Styrofoam cup. At 8:06 a.m., RN/UM-D removed her gloves, approached R23 stating to R23 she gave her the wrong flavor drink and left the dining room where RN/UM-D had been preparing R23's medication. At 8:08 a.m. RN/UM-D placed the vanilla ensure on the table, mixed 8 ounces of water with the fiber and then administered R23's medication one tablet at a time with the fiber drink after. At 8:16 a.m. Surveyor observed RN/UM-D cleanse her hands. On 6/12/25, at 8:52 a.m., Surveyor observed RN/UM-D place gloves on, asked R23 to remove her glasses and placed R23's glasses on top of the medication cart. RN/UM-D did not perform hand hygiene prior to placing her gloves on. RN/UM-D administered one drop of Polyvinyl alcohol 1.4% lubricating drops in R23's right eye and then one drop in R23's left eye. RN/UM-D handed R23 her eye glasses and removed her gloves. RN/UM-D then placed the eye drops in the medication cart. Surveyor did not observe RN/UM-D perform any hand hygiene during this observation. On 6/12/25, at 11:12 a.m., Surveyor asked IP-Z what is expectation for hand hygiene during medication pass. IP-Z informed Surveyor before starting medication pass, after any contamination and when exiting the room. Surveyor informed IP-Z of Surveyor's observation during medication pass with RN/UM-D. 5.) R38 was admitted to the facility on [DATE] and has diagnoses that include respiratory failure, pulmonary fibrosis, muscle weakness, and anxiety disorder. R38's Admissions Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 15, indicating that R38 is cognitively intact. The MDS documents that R38 requires maximal assistance with 1 staff member for toileting hygiene, and moderate to minimal assistance with 1 staff member for transferring and repositioning. R38's admission Care Area Assessment (CAA) dated 4/22/2025 for pressure injuries documents: R38 triggered area for recent hospitalization with COVID/pneumonia. (R38) was admitted to the facility for rehab with a goal to discharge back to home. (R38) required maximal assistance to moderate assistance with most activities of daily living (ADLs). (R38) is frequently incontinent of bowel and bladder . (R38) was admitted with moisture associated skin damage (MASD) and excoriations on buttocks. (R38) did not have pressure injuries on admission on [DATE]. On 5/2/2025, at 6:29 AM, in the progress notes nursing documented certified nursing assistant (CNA) took R38 to the bathroom and noted an open area on R38's left buttock area. No drainage, or signs of infection noted. R38's wound data assessment dated [DATE] documents: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Coccyx, MASD - 0.2 X 0.5 X <0.1 (Length X Width X Depth), partial thickness, superficial - 100% epithelial tissue, no drainage - Macerated, MASD with open area from shearing force. There are two open areas present, same size, one directly above the other. Below level of coccyx. -Redness noted upon admission, has new open areas within the redness due to shearing force. Dressing applied and will monitor for improvement. On 6/10/2025 Surveyor reviewed the facility's list documenting the residents that have pressure injuries in the building. R38 was documenting as having a stage 2 pressure injury to the coccyx area. On 6/11/2025, at 3:42 PM Surveyor noted R38 in R38's bedroom. Surveyor noted that R38 did not have an enhanced barrier precaution (EBP) sign in room to notify staff/ visitors that personal protective equipment (PPE) is needed when providing care for R38. Surveyor also noted that PPE was not readily available to staff or visitors to put on when providing care for R38. Surveyor reviewed R38's medical record and did not note an order for R38 to be on EBP for stage 2 pressure injury to coccyx area. On 6/12/2025, at 8:06 AM, Surveyor interviewed licensed practical nurse (LPN)-W. Surveyor asked LPN-W what policy is for when someone is on EBP. LPN-W stated that if a resident has a foley catheter, any drains, and certain kinds of wounds the resident gets put on EBP. Surveyor asked what wound would require a resident to be put on EBP. LPN-W stated not specifically sure which wounds would require EBP, LPN-W stated that most definitely infected wound require EBP. Surveyor asked who determines when a resident needs to be on EBP. LPN-W stated that the infection preventionist (IP) would determine if a resident should be on EBP. Surveyor asked how staff know someone is on EBP. LPN-W stated that there would be an order included on the resident's medical record and documented on a banner, the resident will also have an EBP sign and PPE located in the resident's room. On 6/12/2025, observed staff assisting R38 with cares. Staff did not put on PPE when providing care for R38. On 6/12/2025, at 11:37 AM, A Surveyor interviewed infection preventionist (IP)-Z who stated residents that have pressure injuries should be on EBP and a EBP sign is placed in the room along with a bin of PPE. IP-Z stated that admissions are reviewed to determine if a resident would require EBP. If a resident develops a pressure injury or any situation that may require EBP it could have been missed and would need to evaluate and review. On 6/12/2025, at 3:14 PM, Surveyor shared concern with nursing home administrator (NHA)-A and director of nursing (DON)-B of Surveyors observations that R38 did not have EBP initiated when noted to have a stage 2 pressure injury to R38's coccyx area on 5/2/2025. NHA-A and DON-B agreed that R38 should be on EBP for R38's Pressure injury. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	6.) R24 was admitted to the facility on [DATE] and has diagnoses that include Alzheimer's, Dementia, severe protein-calorie malnutrition, muscle weakness, cognitive communicative deficit, and weakness. R24's admission Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 5, indicating that R24 has severely impaired cognition. The MDS documents that R24 has modified independence with 1 staff member for repositioning, and maximal assistance with 1 staff member for putting on and taking off footwear and lower body dressing. R24 had no pressure injuries noted on the admission skin assessment. On 5/20/2025, at 11:45 AM in the progress notes nursing documented nursing notified (R24) had bleeding to the right heel. Nursing noted a 1 cm X 1 cm blister that had opened at the bottom that had opened and was bleeding. On 5/21/2025, R24's weekly wound assessment documented: - Right heel pressure injury, Stage 2 - 1.1 cm X 1.1 cm X <0.1 cm (length X width X depth), scant serous drainage, 100% epithelial tissue. - Nursing informed that (R24) had popped blister to the right heel. No flap present appears as stage 2. Dressing order placed, heels up in device while in bed, and gripper socks until healed. On 6/10/2025, Surveyor reviewed the facility's list documenting the residents that have pressure injuries in the building. R24 was documenting as having a stage 2 pressure injury to the right heel. On 6/10/2025, at 11:26 AM, Surveyor observed R24 sitting in a wheelchair in the unit's dining/activity area. Surveyor walked past R24's bedroom and noted that there was not an enhanced barrier protection (EBP) sign indicating personal protective equipment (PPE) was required when providing cares for R24, Surveyor noted that there was not PPE readily available for staff or visitors to put on when providing cares for R24. Surveyor reviewed R24's medical record and did not note an order for R24 to be on EBP for stage 2 pressure injury to the right heel. On 6/12/2025, at 8:06 AM, Surveyor interviewed licensed practical nurse (LPN)-W. Surveyor asked LPN-W what policy is for when someone is on EBP. LPN-W stated that if a resident has a foley catheter, any drains, and certain kinds of wounds the resident gets put on EBP. Surveyor asked what wound would require a resident to be put on EBP. LPN-W stated not specifically sure which wounds would require EBP, LPN-W stated that most definitely infected wound require EBP. Surveyor asked who determines when a resident needs to be on EBP. LPN-W stated that the infection preventionist (IP) would determine if a resident should be on EBP. Surveyor asked how staff know someone is on EBP. LPN-W stated that there would be an order included on the resident's medical record and documented on a banner, the resident will also have an EBP sign and PPE located in the resident's room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525279	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tudor Oaks Health Center	S77 W12929 McShane Dr Muskego, WI 53150

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/12/2025, at 9:00 AM, Surveyor observed certified nursing assistance (CNA)-X assist R24 with getting washed up and dressed for the day. CNA-X did not put on appropriate PPE when providing care for R24. Surveyor asked CNA-X how staff are notified or know when someone requires EBP. CNA-X stated that the infection preventionist (IP)-Z will notify staff when a resident requires EBP and make sure the appropriate sign and PPE gets put into the resident's room. On 6/12/2025, at 11:37 AM, A Surveyor interviewed infection preventionist (IP)-Z who stated residents that have pressure injuries should be on EBP and a EBP sign is placed in the room along with a bin of PPE. IP-Z stated that admissions are reviewed to determine if a resident would require EBP. If a resident develops a pressure injury or any situation that may require EBP it could have been missed and would need to evaluate and review. On 6/12/2025, at 3:14 PM, Surveyor shared concern with nursing home administrator (NHA)-A and director of nursing (DON)-B of Surveyors observations that R24 did not have EBP initiated when noted to have a stage 2 pressure injury to R24's right heel area on 5/20/2025. NHA-A and DON-B agreed that R24 should be on EBP for R24's Pressure injury. The facility's policy titled Catheter Care Policy, with no implementation or reviewed/revision date document, documents . 1. Catheter care will be performed every shift and as needed by nursing personnel; 2. Privacy bags will be available and catheter drainage bags will be covered at all times while in use; 3. Privacy bags will be changed out when soiled, with a catheter change or as needed; 4. Leg bags may be used for ambulatory residents or per resident request; . 9. Ensure drainage bag is located below the level of the bladder to discourage backflow of urine. 7.) R3 was admitted to the facility on [DATE] with diagnoses that included unspecified dementia without behavioral disturbance, malignant neoplasm (cancer) of bladder, and obstructive and reflux uropathy (blockage of urine flow). R3's admission MDS (Minimum Data Set) dated 4/7/25 documents a BIMS (Brief Interview for Mental Status) score of 13, indicating R3 has intact cognition; requires partial/moderate assistance with bed mobility, substantial/maximal assistance for toileting hygiene and toilet transfers, and is unable to ambulate; has an indwelling catheter placed for urinary needs and is frequently incontinent of bowel. R3's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 4/7/25 documents under the Care Plan Considerations section, Urinary CAA triggered because resident admitted for long term care (LTC)/Hospice care. (R3) requires max to moderate assist with most activities of daily living (ADL). On scheduled diuretic, PRN (as needed) anti-anxiety. (R3) has an indwelling foley catheter in use, frequently incontinent of bowel. On 6/10/25 at 10:00 am, Surveyor observed R3 sitting in wheelchair. Surveyor observed R3's catheter bag hanging on the bottom of the wheelchair with no privacy cover and catheter tubing resting on the floor. Surveyor noted there was no barrier between the catheter tubing and catheter bag and the floor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525279	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tudor Oaks Health Center	S77 W12929 McShane Dr Muskego, WI 53150

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/10/25 at 11:53 am, Surveyor observed R3 sitting in wheelchair. Surveyor observed R3's catheter bag hanging on the bottom of the wheelchair with no privacy cover and catheter tubing resting on the floor. Surveyor noted there was no barrier between the catheter tubing and catheter bag and the floor. On 6/10/25 at 2:14 pm, Surveyor observed R3 sitting in wheelchair. Surveyor observed R3's catheter bag hanging on the bottom of the wheelchair with no privacy cover and catheter tubing resting on the floor. Surveyor noted there was no barrier between the catheter tubing and catheter bag and the floor. Surveyor interviewed R3 and asked if R3 was aware there was not a cover on the catheter bag. R3 did not understand what Surveyor was referencing when asked about the catheter bag being visible to others. On 6/11/25 at 7:48 am, Surveyor observed R3 laying supine (on their back) in bed. Surveyor observed R3's catheter tubing and catheter bag to be resting on the floor with no privacy cover. Surveyor noted there was no barrier between the catheter tubing and catheter bag and the floor. On 6/11/25 at 3:32 pm, Surveyor observed R3 sitting in wheelchair. Surveyor observed R3's catheter bag inside a privacy bag and catheter tubing dragging on the floor. Surveyor noted there was no barrier between the catheter tubing and the floor. On 6/12/25 at 8:23 am, Surveyor interviewed certified nursing assistant (CNA)-X regarding the care provided to residents with a catheter. CNA-X replied with catheter care, we empty it once per shift and drain it at the end of the shift and report any changes in smell or color to nurse. CNA-X stated (R3) has a privacy bag underneath her wheelchair which we put it in. On 6/12/25 during the daily exit meeting, Surveyor informed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B of Surveyor's observations of R3's catheter bag being uncovered and catheter bag and tubing resting on the floor without a barrier between the catheter bag, tubing, and floor for protection against possible infection. NHA-A and DON-B understood Surveyor's concerns. On 6/16/25, at 1:58 pm, Surveyor interviewed Infection Preventionist (IP)-Z regarding the expectations to prevent infections for residents using a catheter. IP-Z replied the resident should have indication for use, orders for routine peri-care and catheter care, orders for catheter exchange, foley bag covers. Surveyor asked what the expectation would be if catheter tubing or catheter bag is observed resting on the floor. IP-Z replied that staff should pick up catheter tubing and catheter bag off the floor and keep it contained. No additional information was provided.