STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525281	A. Building B. Wing	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters Edge Health and Rehabilitation Center	3415 N Sheridan Rd Kenosha, WI 53140

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 0745 Level of Harm - Actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon observation, interview and record review, the facility did not ensure 1 (R106) of 1 residents reviewed received medically related social services to address individual Resident needs in order to maintain the highest practicable physical, mental, and psychosocial well-being.*R106 was not provided medically related social services to address the emotional distress R106 was expressing that affected R106's mental and psychosocial well-being, resulting in R106 left the facility Against Medical Advice(AMA) without medically needed medications.Findings Include:The facility's Facility assessment dated [DATE] documents that the facility can provide person-centered/directed care: psycho/social/spiritual support including mental health and behavior.R106 was admitted to the facility on [DATE] with diagnoses of Hemiplegia and Hemiparesis Following Cerebral Infarction(complete paralysis on one side of body and partial/incomplete weakness on one side following stroke), Hyperlipidemia(high levels of fat particles in the blood), Metabolic Encephalopathy(brain dysfunction resulting from underlying condition that disrupts the metabolic processes), Depression(mood disorder that causes persistent feelings of sadness and loss of interest), Delusional Disorder(delusions are a specific symptom of psychosis related to thought disorder or mood disorder), and Visual Hallucinations(sensory experiences where a person sees objects, people, or scenes that are not actually present). R106 discharged from the facility on 9/17/25.R106's Quarterly MDS completed 7/23/25 documents R106's BIMS score is 12, indicating R106 demonstrates moderately impaired skills for daily decision making. R106's PHQ-9 score is 10, indicating R106 has moderate depressive symptoms. R106's MDS documents hallucinations and delusions. R106's MDS document verbal and physical behaviors, and rejection of care 1-3 days. R106 has upper extremity ROM impairment on one side. R106 is set-up for eating and upper body dressing and supervision for showers. R106 requires partial/moderate assistance for lower body dressing. R106 is independent for mobility and transfers.R106's care card instructing nursing staff in the care of R106 as of 8/25/25 documents:-R106's triggers for wandering/eloping are over stimulation. R106's behaviors are de-escalated by walking with R106.-If reasonable discuss R106's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to R106.-Distract R106 from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Resident prefers: (this is blank)-Locomotion: R106 can walk independentlyR106's applicable comprehensive care plan focused problems document:.R106 is an elopement risk/wanderer due to history of attempts to leave facility unattended.Initiated 1/22/25 .R106 has expressions due to hallucinations and paranoia.Triggers unknown at this time.R106 blocks door.Initiated 5/1/25 Revised 5/20/25R106 was last evaluated by Psychiatric Nurse Practitioner (Psych NP)-JJ on 7/28/25. Psych NP-JJ documented that R106 was suspicious during the visit and R106 has been paranoid about police officers being in the facility.Surveyor notes that R106 was involved in two separate resident-to resident altercations while at the facility. Multiple staff reported that R106 would barricade R106's door so no residents would wander in.On 8/26/25, at 10:22 AM, Surveyor interviewed R106 who stated that R106 does not want to be at the facility.On 8/28/25, at 10:25 AM, Surveyor spoke with (continued on next page)

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

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

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F 0745 Level of Harm - Actual harm Residents Affected - Few	R106 again. R106 stated that everyone keeps stealing. The facility will not allow R106 off the unit and feels trapped. R106 does not want to be at the facility.On 9/17/2025, at 12:45, Social Worker Assistant (SWA)-D documented:.This writer was notified by staff the police were in R106's room to deliver R106 court papers for his upcoming guardianship hearing. While this writer and the police was in the room. R106 became somewhat agitated regarding the guardianship reporting R106 does not need a guardian. Then R106 began reporting to the officer there are people in the facility stealing from him. This writer asked R106 what was stolen from him, and R106 reported it was R106's backpack. This writer opened the resident's linen closet, moved a blanket and there was R106's backpack. R106 then began reporting it was not R106's backpack. This writer has seen R106 with that backpack for months. This writer explained to R106 the police now have his statement that someone is stealing from him, and it will be addressed immediately with the administrator. R106 appeared to understand the police's knowledge, and it was being handled by management.This writer and the officer proceeded to the administrator's office to report the incident.While this writer was speaking with Nursing Home Administrator (NHA)-A, another staff member came and reported the nurse on 2 North needed assistance immediately. This writer and multiple other staff members went to the unit.It was reported that R106 became physically and verbally aggressive. Staff intervened and was able to redirect R106. This writer immediately called the police. Multiple staff members remained on the unit to ensure everyone was safe until the police arrived. The police arrived and worked with the facility in attempts to ensure the safety of the staff and the other residents. The crisis center was notified to assess R106, Adult Protective Services(APS) was contacted to assess R106. The crisis center, and APS reported that R106 can make decisions for R106 and if wants to leave the facility he may leave. This writer asked R106 if R106 would like to leave the facility and R106 reported yes. This writer explained Against Medical Advice(AMA) to R106, and R106 signed the AMA documents. This writer and other staff remained with R106 while R106 gathered R106's belongings and exited the building to ensure the safety of others.On 9/17/25, at 4:59 PM, Licensed Practical Nurse (LPN)-ZZ documented:. Acute hallucinations, delusions, confusion, agitation and aggression. Nurses observation of R106: R106 became agitated and aggressive after being served court documents by the sheriff. R106 was observed shouting, swearing, and attempting to physically approach another patient. R106 was not easily redirected and became increasingly agitated as staff intervened. R106 was noted yelling, That man is in my room. Despite staff efforts, R106's agitation continued to escalate. Call placed to NP, DON and administration to advise. New order place to send to emergency room for eval and treatment. R106 is R106's own person and refused. Social service and crisis intervention called.On 9/17/2025, at 5:55 PM, Nursing Home Administrator (NHA)-A documented:.At approximately 1:10 PM, writer was called up to the unit due to change of condition and agitation following services of guardianship paperwork. Sheriff immediately returned to room and facility called police for assistance. Police and staff members remained with resident until APS arrival who interviewed R106. R106 decided to discharge from facility AMA. Risks and benefits up to and including possible injury and death of AMA discharge discussed with R106. R106 signed AMA form in presence of APS worker and police officers. APS provided card to R106 to call later when R106 arrived at his destination. R106's ride arranged for pick up and was taken to motel per R106's preference. R106 packed up belongings and left facility.On 9/17/2025, at 6:52 PM, NHA-A documented:.R106's brother and provider are aware of R106's choice to sign out AMA this afternoon.Surveyor was provided R106's guardianship document and SWA-D email documents.On 6/12/25, the petition for permanent guardianship and protective placement was filed in the circuit court.On 6/12/25, the examining physician's or psychologist's report for adult guardianship was submitted to the circuit court. The actual report was completed by Medical Director (MD)-J and not a psychologist.On 6/17/25, an order appointing guardian ad Litem or Attorney was entered into circuit court. Court documents document the guardianship hearing was to be 7/24/25.On 7/25/25, an email sent by APS to SWA-D documents R106 contesting the guardianship and protective placement and another hearing is scheduled for 9/3/25.On 9/3/25, APS sent SWA-D an email that the (continued on next page)

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F 0745 Level of Harm - Actual harm Residents Affected - Few	guardianship and protective placement was dismissed by the court and a new petition was re-filed and waiting for new court date.On 8/8/25, Business Office Manager (BOM)-TTT sent SWA-D an email stating that the pending guardianship was only of person and not estate.On 9/11/25, a new petition was filed in court for permanent guardianship and protective placement was filed in the circuit court along with a guardian ad Litem or Attorney was appointed. The new court hearing is scheduled for 10/14/25.Surveyor notes there is no documentation by social services in regard to R106's pending guardianship. There is no documentation that SWA-D as R106's primary social worker provided psychosocial support and advocated for R106 during the guardianship process. SWA-D did not assist R106 in exercising R106's rights.On 9/23/2025, at 10:22 AM, NHA-A informed Surveyor that the facility did what they could. NHA-A stated R106's brother wanted nothing to do with R106. NHA-A stated that if R106 stepped off the property, R106 would be in imminent danger and could be declared as at risk, however, NHA-A stated that Nurse Practitioner (NP)-K called a ride for R106. NHA-A stated R106 ended up in an emergency room in Milwaukee and the facility lost track of R106.On 9/24/2025, at 9:25 AM, NP-K was not in the facility at the time of R106's incident. NP-K was outside and saw R106 at the bus stop. NP-K stated NP-K ethically had to do something. NP-K stated R106 had no place to go, no bus pass, no money, no medications. Shelters were not able to take. NP-K was told R106 was not allowed back in the building. NP-K stated NP-K's husband came and got R106 and transported R106 to the motel. NP-K stated NP-K was informed R106 grabbed a nurse which made R106 a danger to other residents. NP-K did not know the whole situation. NP stated had everything been explained to R106, NP-K believed it all could have been avoided. NP-K believed that R106 would have been able to understand everything and was rational about things. NP-K stated, It would not have happened if it had been explained to R106, the process of everything.On 9/24/2025, at 10:31 AM, Surveyor interviewed SWA-D in regard to R106. Surveyor asked SWA-D what SWA-D did to assist R106 with the guardianship process. SWA-D stated SWA-D did not have any part of it. SWA-D stated the guardianship was applied for before SWA-D started there. SWA-D stated it is all new to SWA-D about SWA-D's role with guardianship about how it works. SWA-D confirmed SWA-D did not contact R106's guardian ad Litem to help advocate for R106. SWA-D shared the concern that R106 had expressed to Surveyor that R106 did not want to be at the facility and was feeling trapped. Surveyor shared the concern that with R106's diagnosis of paranoid delusions and hallucinations, that emotional support was not provided to R106 during the guardianship process.On 9/25/2025, at 11:45 AM, Surveyor interviewed adult protective services (APS)-WWW in regard to R106. APS-WWW stated that APS received the referral on 5/8/25 for guardianship for R108. APS-WWW stated that APS had to find a guardian which took a long time. A brother from out of state agreed and file in June the petition for guardianship. The Guardian ad Litem appeared for R106 in July and stated R106 wanted to contest. Time limits ran out on 9/3/25 as advised by corporate counsel. APS-WWW refiled on 9/3/25 and got a new court hearing date of 10/14/25. On 9/17/25 when APS-WWW visited R106, APS-WWW informed Surveyor APS-WWW stated that after talking to R106 APS-WWW felt that R106 had regained capacity and was not as confused. APS-WWW stated APS-WW would have expected SWA-D to educate and keep R106 informed of the process of guardianship and communicate with Guardian ad Litem and APS-WWW in regard to any updates with behavior and cognition. APS-WWW believes that R106 may have regained R106's capacity. APS-WWW stated R106 felt like the facility was keeping R106 and was not working on discharge plans. APS-WWW stated APS-WWW felt bombarded by two staff in particular at the time the papers were served. To add to all the confusion that day. SWA-D and SWE was telling APS-WWW on that day that the facility did not want R106 and why couldn't APS just move R106 to another facility. APS-WWW tried to explain the process of guardianship and the law and was told the law is wrong. APS-WWW stated a few days later, received a phone call from SWA-D requesting the guardianship paperwork again. SWA-D was questioning this as the facility had already been provided the documents and R106 was no longer there. APS-WWW stated that felt was suspicious. APS-WWW stated that R106 had a duffel and two garbage bags full of belongings and walked to the bus stop. (continued on next page)

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F 0745 Level of Harm - Actual harm Residents Affected - Few	APS-WWW watched from the car for a few minutes and R106 appeared to be appropriate at the bus stop, so APS-WWW left. APS-WWW confirmed that the SWA-D could have done more to advocate and assist with the process for R106. APS-WWW confirmed that R106 was extremely agitated that day and felt bad for R106. APS-WWW described the situation as very chaotic. And R106 was clearly in distress per APS-WWW.On 9/29/2025, at 11:56 AM, SWA-D stated APS-WWW stressed to R106 the importance of staying at the facility but could not force R106 to stay. SWA-D informed Surveyor that SWA-D was unaware of any medication issues. SWA-D was sad the way R106 left the facility and didn't sleep that night. On 9/30/2025, at 8:20 AM, Surveyor interviewed NP-K. NP-K stated R106 was a very smart man, R106 had a plan. R106 wanted to get on the bus, go to department of motor vehicles, get an identification card and go to the bank.NP-K stated it was about 6:00 PM, after hours when R106 was at the bus stop. NP-K stated R106 tripped over R106's big bag of belongings. NP-K stated that 911 assessed R106 at the bus stop. NP-K stated that the facility can see the bus stop from the cameras. R106 had been out there for quite a bit. NP-K was told by the facility NP-K could not talk with R106. NP-K felt NP-K needed to get help for R106. Surveyor and NP-K reviewed R106's medications together. NP-K reviewed R106's blood sugars and stated that R106's blood sugars were creeping up. NP-K stated that a diagnosis of diabetes can go either way. R106 was receiving Insulin inject 26 units one time a day. R106 was receiving Januvia 50mg one time a day for diabetes. R106 was also receiving 75 mg of Seroquel one time a day. NP-K confirmed that it is very significant that R106 did not have insulin, nothing to monitor R106's blood sugars, and stopping Seroquel instead of tapering is extremely dangerous. NP-K stated any reasonable person without these medications and others would be at risk.On 9/30/2025, at 10:05 AM, SW-E is unaware that R106 received any medication information or access to a pharmacy to get medications.On 9/30/2025, at 10:28AM, SWA-D informed Surveyor that SWA-D did not provide R106 with any copies of physician orders to take with R106 when R106 left AMA. On 9/30/2025, at 11:40 AM, Surveyor shared with Director of Nursing (DON)-B the serious concern that R106 was not provided medically related social services concerning R106 not receiving assistance with the guardianship process resulting in R106 leaving AMA with no medications or access to list of medications. Surveyor explained with R106' diagnoses of depression, delusional disorder, and visual hallucinations, R106's expressions or indications of distress that affected R106's mental and psycho-social well-being, like R106's resident-to-resident altercations, or barricading R106's self in room were not identified. R106's need for emotional support and not providing services to help R106 achieve the highest practicable psychosocial well-being resulted in R106 being impulsive and leaving the facility AMA without access to important medications. No further information was provided at this time.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on observation, record review and interview, the facility did not ensure privacy and confidentiality for 12 of 20 residents. On 9/24/25, at 12:46 PM, R112's person health information was observed unprotected on an unattended medication cart computer screen, in the hall in view of anyone walking in the hallway. On 9/23/25, at 1:30 PM, Surveyor observed, from the hallway, Licensed Practical Nurse (LPN)-KK move R45's gown up, check R45's enteral feeding tube's placement, flush the tube and administer medication via the enteral tube. R45's room door was not closed. On 9/25/25, at 11:19 AM, Surveyor observed on top of the 2 South medication cart is a 2 South sheet with approximately eleven resident's names with personal information such as their blood pressure, vital signs, types of liquids received, seizure monitoring, fall risk, no male care givers, etc. This sheet was in view of anyone passing the 2 South medication cart. Findings include: The facility's policy titled Maintenance of Electronic Clinical Records, dated 11/11/24, states, A complete and accurate electronic clinical record .maintaining the confidentiality of the residents' information. The facility's policy titled Health Insurance Portability and Accountability Act (HIPAA) Sanctions, dated 5/12/25, last reviewed 7/9/25, states, All employees will be educated on relevant policies and procedures for which they are expected to comply, including this sanctions policy. 1) On 9/24/25, at 12:46 PM, R112's health information was observed on a computer screen on top of an unattended unlocked medication cart in the hallway on the second floor, south wing of the facility. No staff were observed around the medication cart. The information visible included R112's medications and reasons for the medication to be used. The medication cart was observed to be facing the elevators to the facility, approximately 25 feet from the elevators. Surveyor observed a resident sitting in a Broda chair approximately 6 feet from the medication cart during the time it was unattended. Surveyor overheard Certified Nursing Assistant (CNA)-SS tell Registered Nurse (RN)-QQ that RN-LL was out on break. Surveyor notes R112 to be severely impaired for cognitive skills and is unable to be interviewed. 2) On 9/23/25, at 1:30 p.m., Surveyor observed Licensed Practical Nurse (LPN)-KK with R45 who was in bed. Surveyor observed the room door open and the privacy curtain was not pulled. Surveyor observed LPN-KK move R45's gown up, check the placement of R45's enteral feeding tube stating 10 of air, checking your tummy. After checking R45's feeding tube placement, LPN-K administered R45's medication individually and flushed in between each medication. After LPN-KK finished administering R45 her medication, LPN-KK connected and started R45's tube feeding. Throughout the observation, LPN-KK did not provide R45 with privacy during treatment. On 9/29/25, at 12:47 p.m., Surveyor asked R45 when the nurse is checking her feeding tube and administering medication through the tube does she want her room door open or closed. R45 replied closed, I prefer it closed because have to pull my dress up, referring to her gown. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/30/25, at 8:40 a.m., Surveyor asked DON-B when a nurse is checking placement of a resident's feeding tube and administering medication what is her expectation regarding the resident's room door. DON-B replied I would suggest the room door to be closed or the curtain drawn. Surveyor informed DON-B of Surveyor standing in the hallway and being able to observe R45's tube feeding placement being checked and medications being administered. 3) On 9/25/25, at 11:19 a.m. Surveyor observed Licensed Practical Nurse-MM take the vital sign machine, which was next to the 2 south medication cart, and wheel the vital sign machine down the hallway. Surveyor observed on top of the medication cart was a 2 South Sheet with approximately 11 residents names with personal information such as their blood pressure, vital signs, types of liquids received, seizure monitoring, fall risk, no male care givers, etc. This sheet was in view of anyone passing the medication cart. On 9/25/25, at 12:56 p.m., Surveyor asked DON-B about personal information being left on top of a medication cart unattended. DON-B informed Surveyor it should not be laying out. Surveyor informed DON-B of the observation of the 2 South sheet on top of the 2 South medication cart with approximately eleven residents name and personal information unattended.

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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 7 (R11, R1, R3, R9, R120, R41, and R90) of 7 residents reviewed were notified of the reason for transfer/discharge and bed hold policy in writing to the resident and/or their representative. Residents were not notified of the rate to reserve the resident's bed because it was not documented in the transfer and bed hold notice. The transfer and bed hold notice did not document the email address for the The State Survey Agency and for the Long Term Care Ombudsman. The transfer and bed hold notice also did not contain documentation of the name , address(mail and email) and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities and mental disorders. The ombudsman was not notified of the transfer/discharge. *R11's transfer and bed hold notice dated 8/25/25 was not provided to R11's representative in writing and R11's transfer and bed hold notice did not contain the bed-hold reserve rate and the name, address(mail and email) and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities. The ombudsman was not notified of the transfer/discharge. *R1 was sent to the hospital on 2/4/25, 3/12/25, and 6/22/25. R1 was not provided a proper transfer/discharge and bed hold notice in writing and the ombudsman was not notified of the transfer/discharge. *R3 was not provided a proper transfer/discharge and bed hold notice in writing and the ombudsman was not notified of the transfer/discharge. *R9 was sent to the hospital on 8/6/25 and 9/8/25. R9 was not provided a proper transfer/discharge and bed hold notice in writing and the ombudsman was not notified of the transfer/discharge. *R120's against medical advice(AMA) discharge on [DATE] was not communicated to the ombudsman. *R41 was transferred to the hospital on 3/11/25 and their Power of Attorney for Healthcare (POA-HC) was not provided a proper written transfer notice and bed-hold information. The Ombudsman was not notified of this transfer to the hospital. *R90 was transferred to the hospital on 6/30/25. R90 was not provided a proper written transfer notice and bed-hold information. The Ombudsman was not notified of this transfer to the hospital. Findings Include: The facility's Bed Hold Notice Upon Transfer policy and procedure revised 10/29/24 documents: .Policy: At the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident and/or the resident representative written notice which specifies the duration of the bed-hold policy and addresses information explaining the return of the resident to the next available bed. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy Explanation and Compliance Guidelines: Bed Hold Notice Upon Transfer 1.Before a resident is transferred to the hospital or goes on therapeutic leave, the facility will provide to the resident and/or the resident representative written information that specifies: a. The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility b. The reserve bed payment policy in the state plan policy 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. 5.The facility will keep a signed and dated copy of the bed-hold notice information given to the resident and/or representative in the resident's medical record. 1) R11 was admitted to the facility on [DATE]. R11 currently has a legal guardian. R11 was transferred to the hospital on 8/23/25. R11's Transfer and Bed Hold Information dated 8/25/25 does not contain the room reserve rate, or the name, address (mail and email) and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities. The form states that a verbal consent to hold a bed was obtained. On 9/24/2025, at 9:58 AM, Surveyor interviewed Social Worker Assistant (SWA)-D and asked what role SWA-D has in the bed hold policy. SWA-D stated the process is all new to SWA-D but SWA-D calls families to get a bed hold. SWA-D will call them to ask if the resident is returning after the resident has been discharged . If the resident is responsible for themselves, will attempt to reach resident by cell phone or the social worker at the hospital. SWA-D does not notify the ombudsman when discharged to the hospital, to the community and AMA. SWA-D only obtains verbal consents for the transfer/bed hold notice and does not mail it to the representative. On 9/24/2025, at 11:59 AM, Social Worker (SW)- E told Surveyor that SW-E does not send any discharge information to the ombudsman on discharges. SW-E stated Business Office Manager (BOM)-TTT will send out the transfer/bed hold notice either by mail or email to the representative. On 9/24/2025, at 1:02 PM, Surveyor interviewed BOM-TTT in regard to the transfer/bed hold notices. BOM-TTT stated BOM-TTT will mail to the Health Care Power of Attorney (HCPOA) or guardian the transfer/bed hold notice in an envelope and include a stamped envelope for the HCPOA or guardian to mail back. When BOM-TTT receives the transfer/bed hold notice back, it is scanned in. If the transfer/bed hold notice is scanned in, the original is kept in medical records. *) (continued on next page)

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Waters Edge Health and Rehabilitation Center	3415 N Sheridan Rd Kenosha, WI 53140

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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	R1 admitted to the facility on [DATE] and has diagnoses that include diffuse Traumatic Brain Injury, Acute and Chronic Respiratory Failure with Hypoxia, Protein-Calorie Malnutrition, Tracheostomy status, Neuromuscular Dysfunction of Bladder, Anxiety Disorder, Chronic Pain Syndrome, Colostomy status, contractures of muscle, unspecified convulsions, Hypotension, Stage 4 pressure injuries, history of pulmonary embolism, gastrostomy status, Anemia, Encephalopathy, history of venous thrombosis and embolism and Extended Spectrum Beta Lactamase (ESBL) resistance. R1 was hospitalized for change in condition on 2/4/25, 3/12/25 and 6/22/25. There was no evidence R1's Mother/Guardian was provided the hospital transfer and bed hold notice information and no evidence the Ombudsman was notified. The facility forms titled Transfer and Bed Hold Information has a section to elect Yes I would like a bed hold or No I would not like a bed hold. Surveyor noted for the effective date of discharge/transfer on 2/4/25, 3/12/25 and 6/22/25 – there was no evidence the form was provided to R1's Mother/Guardian, neither form had an election indicated and neither of the forms were signed by R1's Mother/Guardian. On 9/24/25 at 2:45 PM, Surveyor informed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B of the concern there is no evidence R1's Mother/Guardian receive the bed hold and transfer notice information from the above hospitalizations. In addition, there is no evidence the Ombudsman was notified. 3) R3 was admitted to the facility on [DATE] and is their own person. On 5/20/25, R3 experienced a change of condition. R3 was admitted to the hospital on [DATE] and returned to the facility on 5/26/25. Surveyor reviewed R3's Electronic Medical Record (EMR) for documentation that R3 was given a bed hold and transfer notice. Surveyor noted a bed hold and transfer notice was not scanned into the EMR. On 9/24/25, facility provided Surveyor with R3's Transfer and Bed Hold Information form dated 5/21/25 which documented, in part: . [Facility] is transferring/discharging: [R3] to [Hospital] . Surveyor noted the section documenting, Yes I would like a bed hold is checked yes. Surveyor noted the section requiring a resident's signature documents: Verbal Consent. Surveyor noted R3 did not sign the transfer and bed hold form per the facility policy. Surveyor noted that R3 was not provided a copy in writing of the bed hold and transfer notice per the facility policy. Surveyor noted that R3's transfer and bed hold form was not scanned into R3's EMR per facility policy. Surveyor noted the facility did not provide documentation that the Ombudsman was notified of R3's hospitalization. On 9/24/25 at 2:52 PM, Surveyor informed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B of the concern that R3 did not sign and receive in writing the bed hold and transfer notice from R3's hospital transfer on 5/20/25. In addition, the facility did not provide documentation that the Ombudsman was not notified of R3's hospitalization. 4) R9 was admitted to the facility on [DATE] and has a Guardian of Person and Estate in place. R9 was hospitalized on [DATE] due to increased restlessness, confusion and low oxygen saturation. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no evidence R9's Guardian was provided the hospital transfer and bed hold notice information and no evidence the Ombudsman was notified. R9 was re-admitted to the facility on [DATE] and then sent back out to the hospital on 9/6/25 for hypoxemia. There was no evidence R9's Guardian was provided the hospital transfer and bed hold notice information and no evidence the Ombudsman was notified. 5) R120 was admitted to the facility on [DATE] and discharged on 6/14/25. R120 is their own person. R120's nurses note dated 6/14/25, at 11:00 a.m. and written by Licensed Practical Nurse (LPN)-JJJ documents Resident signed AMA form and left facility his care giver came and got him with his electric scooter, and he drove the electric scooter across the street to his apartment. On 9/25/25, at 7:32 a.m., Surveyor informed Social Worker (SW)-E Surveyor had reviewed R120's discharge and noted R120 left AMA on 6/14/25. Surveyor asked SW-E if the Ombudsman was notified of R120's discharge. SW-E informed Surveyor when a resident signs out AMA they should notify the Ombudsman and APS (Adult Protective Services). Surveyor asked how this notification is done. SW-E replied either by phone or email. SW-E informed Surveyor she knows she notified APS. Surveyor inquired about the Ombudsman. SW-E informed Surveyor the system at the facility is the social worker for what ever floor the resident resided on notifies the Ombudsman. Surveyor noted R120 did not reside on SW-E's floor. On 9/25/25, at 7:44 a.m., Surveyor asked SWA-D when a resident is discharged who is notified. SWA-D replied the family, if AMA contact APS and let people in the company know. Surveyor asked SWA-D who notifies the Ombudsman. SWA-D informed Surveyor when she was in training in May she asked SW-E who notifies the Ombudsman, and SW-E said she did. Surveyor asked SWA-D if SW-E notifies the Ombudsman when a resident is discharged for the entire facility. SWA-D nodded to indicate yes. Surveyor asked SWA-D if she notified the Ombudsman when R120 was discharged on 6/14/25. SWA-D replied no. Surveyor informed SWA-D Surveyor had spoke with SW-E about Ombudsman notification when a resident is discharged and SW-E told Surveyor she does the first floor, and you (SWA-D) do the second floor. SWA-D replied guess I will start doing it. 6) R41 was admitted to the facility on [DATE] for rehab services and has an activated POAHC. Surveyor reviewed the medical record. There was not a bed-hold or transfer notice for the 3/11/25 transfer to the hospital. On 9/23/25, at 3:05 PM, Surveyor requested R41's bed hold and transfer notice. On 9/24/2025, at 8:25 AM, Surveyor received a Transfer and Bed -Hold Information form dated 3/12/25. It does not include the required transfer notice information or the right to appeal, the name and contact information of the State Ombudsman. There is no evidence that the notice was provided in writing. The information provided was a verbal consent for a bed-hold by a staff member. The form does not document who was verbally notified. There was no evidence the State Ombudsman was notified of the transfer to the hospital on 3/11/25. 7) R90 was admitted to the facility on [DATE] for wound care. R90 is their own person. R90 Minimum Data Set (MDS) assessment documents a hospital stay from 6/30/25 – 7/8/25. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/22/2025, at 10:36 AM, Surveyor interviewed R90. R90 could not recall details of their hospitalization. Surveyor reviewed the medical record. There was not a bed-hold or transfer notice for the 6/30/25 transfer to the hospital. On 9/23/25, at 3:05 Surveyor requested R90 bed-hold and transfer notice. On 9/24/2025, at 8:25 AM, Surveyor received a Transfer and Bed -Hold Information form dated 7/12/25, It does not include the required transfer notice information of the right to appeal, the name and contact information for the State Ombudsman, or that it was provided in writing at the time of transfer. The information provided was a verbal consent for a bed-hold by a staff member. The form does not document who was verbally notified. There was no evidence the State Ombudsman was notified of the transfer to the hospital on 6/30/25.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview and record review the facility did not ensure that residents environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents for 4 of 12 (R60, R11, R41 and R90) residents reviewed for falls. R60 had a fall from bed while staff was providing cares which resulted in a laceration requiring sutures. The care plan was not revised with recommended interventions and staff were not educated following the fall. R11 had multiple falls. Observations found fall precaution interventions were not implemented and the facility did not complete thorough investigations of his falls. Following the falls, there was no evidence of an RN assessment. R41 had 6 falls while residing in the facility. The facility did not thoroughly investigate each fall to determine a root cause analysis to implement appropriate interventions to prevent further falls. R90 had a fall from bed. The facility did not thoroughly investigate the fall to determine a root cause analysis to implement appropriate interventions to prevent further falls. Findings include: The facility policy titled “Fall Prevention Program” dated 10/8/24 documents (in part) … .Each resident will be assessed for fall risk minimally upon admission, quarterly, annually and with change of condition and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. 3. The nurse will acknowledge the resident's fall risk and initiate interventions on the resident's baseline care plan, with consideration of the resident's level of risk and individual needs. 4. The nurse will refer to the facility's Fall Care Plan template as a guide in determining potential initial interventions . 8. Each resident's risk factors, and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. a. Interventions will be monitored and reevaluated post fall as needed for effectiveness. b. The plan of care an Kardex will be revised as needed. 9. When any resident experiences a fall, the facility will: f. Review the resident's care plan and update as indicated. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	g. Document all evaluations/assessments and actions taken. h. Obtain witness statements to aide in root cause determination and injury review. i. Monitor residents' condition and response to interventions as per standard of practice. 1) R60 admitted to the facility on [DATE] and has diagnoses that include chronic kidney disease stage 3, chronic obstructive pulmonary disease, morbid obesity, asthma, dysphagia, anxiety disorder, major depressive disorder, hypertension, gout, gastroesophageal reflux disease and hereditary and idiopathic neuropathy. R60's admission MDS (Minimum Data Set) dated 8/3/25 documents: functional limitation in range of motion lower extremity (hip, knee, ankle, foot) - impairment on both sides. Roll left and right: The ability to roll from lying on back to left and right side and return to lying on back on the bed-partial/moderate assistance. R60's Admission/readmission/routine Head to Toe Evaluation dated 7/28/25 documents: Fall Risk evaluation-High risk. R60's BIMS (Brief Interview for Mental Status Score) dated 7/28/25 documents a score of 15, indicating no cognitive impairment. On 9/22/25 at 12:04 PM, Surveyor observed R60 lying in bed on her back, with the bed positioned against the wall on the left side. During initial interview, R60 reported she had a fall a few weeks ago. “The aid was rolling me over on my left side. I guess she forgot to lock the wheels on the bed because when she rolled me over and I put my hand on the wall to support myself, the bed moved and I rolled right out of bed onto the floor, landing on my face.” R60 pointed to her left eye, stating “I had 9 stitches.” Surveyor observed a scar above her left eyebrow. Surveyor reviewed R60's care plan on 9/22/25 which documented: The resident has an ADL (Activity of Daily Living) self-care performance deficit r/t (related to) (blank) - date initiated 7/28/25. Intervention: Bed Mobility - the resident requires moderate assistance by 1 staff to turn and reposition in bed every 2-3 hours and as necessary - date initiated 7/28/25, revision on 8/19/25. The resident is at risk for falls, accidents and incidents r/t (blank) - date initiated 7/28/25. Intervention: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance –date initiated 7/28/25. Facility progress notes documented: On 9/1/25 at 6:28 PM, resident fell with CNA (Certified Nursing Assistant) in room while check and changing resident and she (CNA) unlocked bed to move bed with resident on side and she fell between bed and wall and gashed her head open above left eyebrow and sent out via hospital, family and NP (Nurse Practitioner) notified of occurrence. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/1/25 at 6:28 PM, called to room. Resident noted to be on the floor face down.stated CNA was in the room doing her (R60's) cares and when she was on her side (left side), she (R60) started moving away from the wall and the patient fell between the bed and the wall. Patient noted to have blood coming from the face. Face wiped clean and it was noted to be a laceration to the upper left brow 2 cm (centimeters) x 4 cm. Notably in pain and anxious. 911 called and writer stayed on the floor with patient until EMS (Emergency Medical Services) arrived. While waiting for EMS, ROM (Range of Motion) applied to all extremities with no new issues noted. Neuros initiated. DON (Director of Nursing), POA (Power of Attorney) and on call NP were notified of incident. Further intervention is to change patient from 1 assist with cares to a 2 assist with cares for safety and decrease risk for falls. EMS took her to ER (Emergency Room). On 9/1/25 at 10:26 PM hospital called and reported the CT (Computerized Tomography) negative. Stitches in place to left upper brow will be returning when transport becomes available. The hospital ED (Emergency Department) notes dated 9/1/25 document (in part) XXX[AGE] year-old female who presents to the ED with a fall. The patient was being cleaned up in her bed at her living facility, the bed started to roll, and she tried to turn and rolled out of bed. Hit her left forehead and left arm. Complains of pain in these areas. There is a large 4.5 cm laceration on the left forehead. X-rays negative for fractures. CT head negative for acute intracranial abnormality. Surveyor was provided R60's fall investigation which documented: Witnessed Fall with head injury 9/1/25 1850 (6:50 PM). Incident description: Nurse was called due to resident falling out of bed during a check and change. Resident stated she was getting changed by the CNA when the bed fell away from the wall, and she landed on the ground and hit her head. Resident was taken to hospital via ambulance due to hitting her head and getting a face laceration to forehead above the left eyebrow. Injuries observed at time of incident: No injuries observed at time of incident. Level of pain numerical: 10 LOC (Level of Consciousness): Alert, oriented to person, place. Notes: Resident fell out of bed during check and change and hit her head. Injuries report post incident: No injuries observed post incident. Predisposing environmental factors: Check mark other Predisposing situation factors: Check mark other Other info: During check and change fell out of bed. 9/2/25 IDT (Interdisciplinary Team) met to discuss recent fall. Resident was receiving incontinence cares when she rolled out of bed. CNA was in providing cares per CP (Care Plan) of 1 assist. Resident was rolled in bed and kept rolling and rolled off the bed. CP reviewed and updated for assist of 2 when cares are provided. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Fall investigation form signed by CNA-WW 9/1/25: Factors observed at the time of the fall: Circle all that apply: (circled) Environmental factors/other - (handwritten) “unlocked bed.” What could have been done differently to prevent this fall? Leave the bed locked. CNA-WW statement: I grabbed what I needed for cares. I was almost done with the resident. I helped her turn towards me, wheels locked on bed. (R60) then I needed to turn towards wall. The blankets were stuck between bed and wall when I turned the bed into the unlock position at that time (R60) slightly pushed against the wall the whole bed moved and (R60) fell slowly to the floor, smacking her head causing lac (laceration). Immediately went for help. On 9/10/25 at 7:00 AM, NP note/assessment: Currently in bed lying supine. Nine sutures present just above the left eyebrow that are clean, dry and intact. Some scabbing present. Skin pink. No swelling present. Sutures present for one week and are ok to remove per ER MD (Medical Doctor). Nine sutures successfully removed, and the patient tolerated well. No bleeding present. Area cleansed followed by TAO (triple antibiotic ointment). Surveyor noted on 9/22/25, there were no new interventions added to R60's care plan following the 9/1/25 fall. On 9/24/25 while reviewing R60's care plan, Surveyor noted the following revisions that were not present upon Surveyor's initial review of the care plan on 9/22/25: Bed Mobility: The resident requires moderate assistance by 2 staff to turn and reposition in bed every 2-3 hours and as necessary - date initiated 9/1/25, created on 7/28/25, revision on 9/22/25. Ensure Bed locks are engaged – date initiated 9/23/25. Surveyor noted these care plan revisions were added to R60's care plan after the start of survey on 9/22/25. On 9/23/25 at 10:25 AM, Surveyor asked CNA-FF where she would look to see how to care for a patient, for example how they transfer, continence, etcetera. CNA-FF reported they use the Kardex. Surveyor asked if staff has a paper copy to carry with them or is it in the residents' room. CNA-FF reported the Kardex is in the binder at the nurses' station and proceeded to show Surveyor a white binder containing residents' Kardex. Surveyor noted the resident Kardex in the binder were last updated on 5/13/25 and R60 did not have a Kardex in the binder. Surveyor asked CNA-FF if a resident does not have a Kardex what would you do and how would you know what is necessary to care for the resident? CNA-FF stated, “If they are a new admit, I'm old school - I would ask the nurse in report.” On 9/23/25 at 12:59 PM, Surveyor spoke with DON-B with Nursing Home Administrator (NHA)-A present. Surveyor reviewed R60's fall investigation and asked what was done following R60's fall. DON-B stated, “We updated her care plan to be a 2 person with bed mobility and we did informal education with the CNAs on the unit to let them know she is now a 2 person.” Surveyor asked if any fall education was provided to any other staff after R60's fall. NHA-A stated, “Only the CNAs on the unit, and we updated her care plan.” Surveyor advised DON-B and NHA-A that R60's care plan was not revised to indicate 2-person bed mobility or the intervention to keep bed brakes locked until after the start of survey (interventions were added to care plan on 9/22/25 and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9/23/25). Surveyor asked and confirmed the fall investigation provided is the complete investigation. Surveyor advised the Kardex binder on the unit does not include a Kardex for R60 and in fact all other residents' Kardex had not been updated/were dated effective 5/13/25. 2) R11 was admitted to the facility on [DATE] with diagnoses of autistic disorder, repeated falls, unspecified intellectual disabilities, epilepsy, mood disorder, dementia, and anxiety. R11's admission Minimum Data Set (MDS) completed 7/9/25 documents R11 demonstrates severely impaired skills for daily decision making and both short and long term memory impairment. The MDS documents R11 does not have range of motion impairment. R11 requires substantial/maximum assistance for dressing and hygiene, supervision for transferring, eating and mobility. R11's Fall Care Area Assessment (CAA) completed 7/3/25 documents a fall CAA was triggered due to behaviors of wandering occurring daily, taking antianxiety, and antidepressant medications. The CAA documents R11 has ongoing use of psychotropic medications, weakness present that relies on staff for assist, rarely to never understood or understands. R11's Fall Risk Evaluation Document: - 7/3/25 score of 18 – in progress (not complete) - 7/31/25 score of 29 - 9/17/25 score of 27 A score of 10 or higher indicates the Resident is at high risk of falling. R11's Kardex dated 9/24/25 documents: - Allow resident to remain standing if R11 chooses - Antiroll back on wheelchair - Dycem in wheelchair to prevent slipping out - Encourage resident to keep hands free when up ambulating - Gripper socks or slippers with non skid bottoms at night. - Lock wheelchair after standing to prepare for sitting back down - Offer soothing music to assist resident with sleep hygiene - Resident to have a wedge cushion so R11 will not slip out while self propelling - Staff to ambulate resident to allow R11 to stretch R11 legs when R11 attempts to stand. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Staff to engage resident while propelling R11 in wheelchair either by holding hand or walking along side R11 R11's comprehensive care plan for Falls documents, The resident is at risk for falls, accidents, and incidents r/t (related to) SHUFFLING ON FEET OCCASIONALLY initiated on 7/5/25, revised 7/7/25. Interventions - Allow resident to remain standing if R11 chooses. Initiated 8/11/25. - Anticipate and meet the resident's needs. Initiated 7/22/25. - Antiroll back on wheelchair. Initiated 7/25/25 - Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Initiated 7/5//25 - Dycem in wheelchair to prevent slipping out. Initiated 7/11/25. - Educated nurses on locking med (medication) cart wheels when med cart not in use. Initiated 8/11/25. - Encourage resident to keep hands free when up ambulating. Initiated 9/22/25. - Gripper socks or slippers with non-skid bottoms at night. Initiated 7/22/25. - Guardian updated to bring in sodas for resident to curb expressing self by putting self on the floor. Initiated 7/28/25. - Lock wheels after standing to prepare for sitting back down. Initiated 7/21/25. - Offer soothing music to assist resident with sleep hygiene. Initiated 7/31/25. - Resident to have a wedge cushion so R11 will not slip out while self-propelling. Initiated 7/12/25. - Staff to attempt to ambulate resident to allow R11 to stretch legs when R11 attempts to stand. Initiated 7/10/25. - Staff to engage resident while propelling R11 in wheelchair either by holding hand or walking along side R11. Initiated on 7/30/25. The resident has a behavior problem r/t (related to) intellectual disabilities (BITES, HITS, KICKS, THROWS ITEMS, PUTTING SELF ON FLOOR, AND PACES). Initiated 7/5/25, revision on 9/11/25. - I like to be approached forward, does not like people behind R11. Initiated 9/12/25. - I like to touch hair. Is very soothing to me. Please offer me the manikin head so that I can play with their hair instead of accidently pulling at staffs hair. Initiated 8/25/25. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident. Initiated 7/5/25. Revision on 9/11/25. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Initiated 7/5/25. Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. Initiated 7/9/25 - Offer to hold residents hand for comfort. Initiated 7/22/25. - Praise any indication of the residents progress/improvement in behavior. Initiated 7/9/25. - Resident does not like fitted sheet on bed, only flat sheet and pillows. Initiated 8/7/25 - Resident enjoys to sit in dining room by window with blinds up to look out towards the water and have radio with R11. Initiated 7/22/25. - Resident likes to fidget with the cord to the radio and extension cord. Initiated 9/12/25 - Resident starts to tap fingers or feet when overstimulated. Allow resident time and offer a hand to hold. Initiated 7/9/25. - The resident enjoys calling and talking to sister (POA) [power of attorney]. Initiated 7/21/25 - The resident likes to touch their forehead to staff forehead for stimulation and calming (the resident initiates this only when reaching for your hand to touch their neck or when they reach their hand to staff's neck). Initiated 7/9/25 On 9/23/25, at 1:00 PM, Surveyor reviewed R11's 17 falls along with the facility's fall packets (investigations) of each fall from July 2025 to present (2025). 1 On 7/10/25, at 10:00 AM, R11 had a witnessed fall in the dining room while attempting to self ambulate. No injuries reported. All notifications completed. No Registered Nurse (RN) assessment completed. All staff statements collected and included in the packet. The root cause determined to be R11's poor safety awareness and attempts to self-ambulate. The care plan was updated and the intervention was initiated to have staff offer R11 to ambulate when R11 is attempting to stand up. 2 On 7/11/25, at 2:00 PM, R11 had a witnessed fall by the nurses' station while self-propelling in the wheelchair R11 scooted out of the wheelchair and onto the floor. No injuries reported. All notifications completed. No RN assessment completed. All staff statements included in the packet. The root cause determined to be R11 slid out of the wheelchair. The care plan was updated and the intervention of adding a dycem to the wheelchair. 3 On 7/12/25, at 1:34 PM LPN (Licensed Practical Nurse)-FFF documents a progress note that R11 had 2 witnessed falls. The first in R11's room at 11:00 AM and the second in the dining room at approximately 12:00 PM and it was witnessed by activity staff. No injuries noted and POA (power of attorney) made aware. There is not an investigation for this fall. The care plan was not reviewed and no updates to R11's care plan were made. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4 On 7/12/25, at 12:00 PM, R11 had a witnessed fall in the doorway of R11 room. R11 attempting to propel forward in R11 wheelchair and fell forward from R11 momentum. No injuries reported. All notifications completed. No RN assessment completed. 1 missing staff interview about the fall from CNA-DDD. The root cause determined to be R11 momentum carried R11 out of the wheelchair and on to the floor while self-propelling. The care plan was reviewed, and the intervention was added of placing a wedge cushion on the wheelchair Surveyor notes that of the two falls above for 7/12/25, the fall in the dining room was not investigated. 5 On 7/18/25, at 8:20 PM, R11 had a witnessed fall in the dining room. R11 was in the wheelchair reaching for R11's stereo and the wheelchair rolled back and R11 fell. No injuries reported. All notifications completed. No RN assessment completed. All staff statements included in the packet. The root cause determined to be the wheelchair rolled back as the resident attempted to stand and reach for the stereo. The care plan was reviewed and the intervention of anti-roll backs added to the wheelchair. 6 On 7/19/25, at 12:15 PM, R11 had a witnessed fall in the dining room. R11 was stood from the wheelchair, R11 fell before staff could reach R11. No Interdisciplinary note was made and there was no review of the care plan and no interventions implemented. 7 On 7/21/25, at 08:23 AM, R11 had a witnessed fall in R11's room. The fall was witnessed by R11's peer, but no interview of name of the peer was included in the fall investigation. All notifications completed. No RN assessment completed. The root cause was determined to be R11 fell when he attempted to sit in the chair in R11's room. The care plan was updated and the intervention of locking R11's wheelchair at bedside was placed. 8 On 7/22/25, at 10:15 AM, R11 had a witnessed fall in the dining room. All notifications completed. No RN assessment completed. The root cause was determined to be R11 was not an active participant in the activity and attempted to ambulate away. The care plan was reviewed and the intervention of keeping R11's radio near R11 at all times if he does not want to be an active participant in an activity was placed. 9 On 7/22/25, at 4:00 PM, R11 had an unwitnessed fall in R11's room. All notifications completed. A neurological assessment was completed. No RN assessment completed. The root cause was determined to be R11 may express R11's needs and wants by placing R11 on the floor. The care plan was reviewed and the intervention of providing sodas to R11 to make R11 happy was placed. 1 On 7/30/25, at 11:30 AM, R11 has a witnessed fall in the hallway. All notifications completed. No RN assessment completed. The root cause was determined to be R11 placed R11's feet down while being pushed in the wheelchair. The care plan was reviewed and updated with the intervention of having a second staff member walk along side of R11 or hold R11's hand while being pushed in the wheelchair. 1 On 7/31/25, at 3:05 AM, R11 had a witnessed fall in the hallway. All notifications completed. No RN assessment completed. The root cause was determined to be R11 was attempting to self-ambulate and fell. The care plan was reviewed and updated the intervention of offering soothing music at night to help with sleep was placed. On 8/10/25, at 2:25 AM, R11 had a witnessed fall by the nurses station on the unit. All notifications (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	completed. No RN assessment completed. The root cause was determined to be R11 fell when trying to move past the med cart and the cart moved causing the fall. The care plan reviewed and updated, the intervention implemented was the staff was educated to keep nurses cart wheels locked. On 8/10/25, at 01:05 AM, R11 had a witnessed fall in the dining room. All notifications completed. RN assessment completed. The root cause was determined to be R11 fell when trying to stand when being asked to sit. The care plan was reviewed and updated and the intervention implemented was to allow R11 to stand if he chooses to do so 1 On 8/23/25, an emergency department note documents R11 had an unwitnessed fall and low oxygen status. It documents the facility staff are not sure what happened. There is no documentation that the facility completed a thorough investigation of this fall. On 9/12/25, at 10:50 PM, a progress note by LPN-GGG documents R11 had a fall at the doctor's office and received 2 sutures. A fall investigation was not completed. 1 On 9/17/25, at 6:45 AM, R11 had a witnessed fall in R11's room. All notifications completed. No RN assessment completed. The root cause was determined to be R11 fell when ambulating with both hands full. The care plan was reviewed and updated and the intervention implemented was to encourage R11 to have less items in hands so that R11 can stabilize or reach for assistance. 1 On 09/25/2025, at 12:54 PM, Surveyor observed R11 sitting in the hallway in a wheelchair. R11 has a table with R11's stereo in front. R11 was holding on to an extension cord and grabbing out at CNA-CCC. R11 then stood up, and CNA-CCC told R11 to sit down. R11 did not sit down and stepped toward CNA-CCC, Then R11 fell. R11 did not hit head. R11's wheelchair was not locked. LPN-ZZ told Unit manager (UM)-F to go and get an RN. LPN ZZ trying to get vitals signs. The RN-QQ responded and assessed. On 9/25/24, at approximately 1:00 PM, LPN-ZZ documented in a progress note R11 had a witnessed fall in the hallway. R11 attempted to stand and walk without assistance, when reaching for R11's designated CNA-CCC, R11 fell. All notifications completed. RN QQ documented “Staff came to report R11 on [Unit R11 resides] had a fall and they needed writer to come assess R11. R11 had put self back in w/c (wheelchair) MAEW (Moves All Extremities Well) no apparent injury” as the assessment for R11's fall. All notifications completed. R11 was on direct (1:1) supervision by CNA-CCC and will continue to be directly supervised. Surveyor noted CNA-CCC did not attempt to ambulate R11 and did not lock R11's wheelchair per care plan. Surveyor made the following observations of R11's care plan not being implemented: 1.Dycem and wedge cushion not in wheelchair 9/22/25 at 1:02 PM 9/23/25, at 7:24 AM 9/23/25 at 10:38 AM (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9/24/25 at 7:06 AM On 9/24/25, at 9:50 AM, Surveyor observed the Kardex for R11 at the nurses station. The last update to the Kardex is documented as 7/30/25. The dycem and wedge cushion is included in the current Kardex. On 9/24/25, at 9:52 AM, Surveyor interviewed CNA-DDD about R11's dycem and wedge cushion in the wheelchair. CNA-DDD stated R11 must have removed it and it is usually left in the chair. LPN-ZZ states LPN-ZZ will call laundry to see if it was sent there to be cleaned. On 9/24/25, at 9:53 AM, Surveyor conducted observed R11's room and did not see a wedge cushion or dycem. 2. Medication cart wheels unlocked 9/22/25 at 1:04 PM 9/23/25 7:21 AM and 10:38 AM 9/25/25, at 7:45 AM and at 10:22 AM On 9/24/25, at 1:21 PM, Surveyor Interviewed DON-B . DON-B states DON-B and NHA-A are responsible for making sure the fall packets are completed. DON-B stated its expected that facility and agency staff follow the Kardex for the residents. DON-B states DON-B is unsure why the dycem was sent to laundry when it can be wiped down. DON-B stated there should be a second cushion in case one gets soiled and is sent to be cleaned. DON-B states DON-B will look into the cushion and dycem that was to be observed missing from R11's chair. DON-B stated the fall from the doctor's office should have been investigated and was not. Surveyor asked DON-B about the unwitnessed fall on 8/23/25. DON-B states DON-B is not sure and will have to look into it. No further information was provided from DON-B or the facility regarding incomplete investigations and/or no investigations of R11's falls, and as to why R11 did not have R11's wedge cushion and dycem in R11's wheelchair per R11's care plan. On 9/25/25, at 7:36 AM, Surveyor observed CNA-EEE trying to pull R11 backwards multiple times to get R11 to go into R11's room to eat breakfast. R11 ‘s care plan documents an intervention to not approach R11 from behind. On 9/25/25, at 7:40 AM, Surveyor interviewed CNA-EEE. CNA-EEE states CNA-EEE is unsure if the dycem is in the wheelchair as R11 was already in the wheelchair when CNA-EEE arrived to work today. Surveyor noted there is a normal cushion in the chair and not a wedge cushion. On , Surveyor observed the medication cart wheels to be in the unlocked position and the cart moves when pushed. On 9/25/25, at 1:34 PM, Surveyor interviewed DON-B. DON-B states the RN assessment should be included in the fall packets but a progress note is also acceptable. DON-B stated if an LPN writes a post fall evaluation, an RN must sign off on it or write another progress note after stating they agree with the assessment. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) On 9/23/25, at 1:30 PM, Surveyor noted there were 10 occurrences where R11 had put self on the floor. These occurrences do not have any fall investigations. 1 On 7/12/25, at 2:45 PM, A note written by LPN-FFF documents “…Difficult to redirect, pushing through staff in an attempt to get past. When R11 unable to get through, R11 sat down on the floor between staff and attempt to scoot past…” On 8/2/25, at 11:19 AM, A note written by RN-NN documents “…the patient [R11] would sit on the floor and proceed to drink the soda that R11 had taken… When R11 did stand up with staff help R11 would only take a few short steps before pulling self down again. This time patient [R11] sat in the other patients doorway . When R11 is unsuccessful, patient will place self on the floor in hopes to sneak past staff and get into the room…” 3 On 8/3/25, at 7:54 PM, A note written by Agency Nurse-MMM documents “…R11 placed self on the floor during this shift.” On 8/4/25, at 8:10 PM, A note written by LPN-HHH documents “R11 entering other resident's rooms, when attempting to redirect, R11 puts self on floor…” 5 On 8/12/25, at 5:39 AM, A note written by RN-III documents “…R11 is currently sitting on the floor near the exit after setting self purposefully on the floor.” 6 On 8/12/25, at 6:35 PM, A note written by LPN-HHH documents “…R11 did not want the items, R11 put self on floor, assisted R11 off of the floor and was able to bring back to R11's room…” 7 On 8/15/25, at 6:16 AM, A note [NAME]

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that drugs and biological's used in the facility were labeled in accordance with currently accepted professional principles and include the expiration date when applicable for 4 of 4 medication carts observed effecting a pattern of residents residing in the facility. *On [DATE] at 12:01 p.m. during the medication administration task Surveyor observed R129's Novolin R insulin pen was not dated when opened. *On [DATE], at 11:33 a.m., Surveyor observed in the front 2 South medication cart in the top drawer a bottle of artificial tears lubricant eye drops for R2 not dated when opened. *On [DATE], at 11:49 a.m., in the top drawer left section of the 1 North back medication cart Surveyor observed approximately 33 small pink pills laying in the drawer. *On [DATE], at 11:53 a.m., Surveyor observed in the 1 North back medication cart a purple plastic basket containing 6 insulin pens not separated, not labeled with a resident's name and/or not dated when open for R125, R130, R53, & R81. *On [DATE], at 12:36 PM, Surveyor observed 1 bottle of blood glucose test strips that was not labeled when opened in the 2 North medication cart. *On [DATE], at 1:25 PM, Surveyor observed loose blood glucose test strips sitting in a medication cup with no expiration date or labeled when opened date, and all Over the Counter (OTC) medications were not labeled with opened dates in the 1 South medication cart. Findings include: The facility's policy titled, Insulin Pen and last reviewed/revised [DATE] under Explanation and Compliance Guidelines documents 2. Insulin pens must be clearly labeled with the resident name, physician name, date dispensed, type of insulin, amount to be given, frequency, and expiration date. 3. If the label is missing, the pen will not be used; a new pen must be ordered from the pharmacy. 9. Insulin pens should be disposed of after 28 days or according to manufacturer's recommendation. The facility's policy titled, Medication Storage and last reviewed/revised [DATE] under Policy documents It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medications rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light ventilation, moisture control, segregation, and security. 1.) On [DATE], at12:01 p.m., Surveyor observed Registered Nurse (RN)-LL place gloves on, cleansed the top of R129's Novolin R insulin pen, attached a needle and prime the pen with 2 units. RN-LL then dialed 2 units of Novolin R. Surveyor noted insulin pen is not dated when opened. At 12:03 p.m. Surveyor asked RN-LL if she was going to administer R129 her insulin. RN-LL replied yes. Surveyor asked RN-LL how she knew R129's insulin is not expired as the insulin pen is not dated. RN-LL (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	informed Surveyor R129 was recently admitted . Surveyor asked if insulin pens should be dated when opened. RN-LL replied we are suppose to 2.) On [DATE], at 11:33 a.m., Surveyor observed in the front 2 South medication cart, in the top drawer, a bottle of artificial tears lubricant eye drops marked with only a resident's first name and not dated when opened. On [DATE], at 11:40 a.m., Surveyor asked Licensed Practical Nurse (LPN)-MM when eye drops are open should the bottle be dated with the date opened. LPN-MM replied I don't know for sure then stated should be dated. Surveyor showed LPN-MM the artificial tears bottle marked with only a residents first name & not dated. Surveyor asked about the first name. LPN-MM informed Surveyor it is probably R2. 3.) On [DATE], at 11:49 a.m., in the top drawer left section of the 1 North back medication cart Surveyor observed approximately 33 small pink pills laying in the drawer towards the back of the drawer. On [DATE], at 12:06 p.m. Surveyor showed Licensed Practical Nurse (LPN)-Y the 33 small pink pills laying in the back of the drawer of the 1 North back medication cart. Surveyor asked if these pills should just be laying in the drawer. LPN-Y replied no and informed Surveyor he just cleaned the medication cart last week. 4.) On [DATE] at 11:53 a.m. Surveyor observed in the 1 North back medication cart in the top drawer a purple plastic basket. Inside this plastic basket were the following: *A used Lyumjev (insulin lispro-aabc) kwik insulin pen for R125 not dated when opened. *A used Novolog flex insulin pen that is not labeled with a resident's name and not dated when opened. *A used Ozempic pen with the pharmacy label partially removed with the only portion of the label on the pen is the number [PHONE NUMBER]-12. The Ozempic pen is dated when opened. *A used Lantus Solostar insulin pen for R130 not dated when opened. *A Lantus Solostar insulin pen for R53. *A Humalog insulin kwikpen for R81 not dated when opened. Surveyor observed these 6 insulin pens were not separated in bags or other means and were just placed all together in the purple plastic basket. On [DATE], at 12:05 p.m., Surveyor asked LPN-Y if resident's insulin pens should be dated when open, labeled with a resident's name and separated. LPN-Y replied yes. Surveyor showed LPN-Y the insulin pens in the purple basket. On [DATE], at 12:54 p.m., Surveyor asked Director of Nursing (DON)-B if insulin pens should be dated when opened. DON-B replied yes. Surveyor then asked if the insulin pens should be separated. DON-B replied yes and explained each pen in an individual bag with the resident's name on it. Surveyor asked (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	DON-B if a pharmacy label should be removed. DON-B replied no that's how you know who's pen it is. On [DATE], at 12:55 p.m., Surveyor asked DON-B if eye drops should be dated when opened. DON-B replied they are supposed to be, yes. Surveyor informed DON-B of Surveyors observation in the front 2 South medication cart & 1 North back medication cart. On [DATE], at 12:36 PM, Surveyor observed medication cart on 2 North, and notes, 1 bottle of blood glucose test strips that was not labeled when opened. On [DATE], at 1:25 PM, Surveyor observed medication cart on 1 South and observed loose blood glucose test strips sitting in a medication cup with no expiration date or labeled when opened date. Surveyor also notes all Over the Counter (OTC) medications in the 1 South medication cart were not labeled with opened dates in the 1 South medication cart. Surveyor asked Registered Nurse (RN)-UU what was in the medication cup and RN-UU stated she ran out of blood glucose test strips earlier that day and had to borrow some from another cart because she ran out. Surveyor asked RN-UU how she knows when the test strips expire and RN-UU states there is an expiration date on the bottle. Surveyor then asked RN-UU if she will write anything on a bottle of blood glucose test strips when she gets a new bottle. RN-UU states, no she does not write on the bottle. Surveyor asked RN-UU how she knows when the blood glucose test strips expire, and RN-UU states there is a manufacturer expiration date on the blood glucose test strip bottle. RN-UU states her unit goes through test strips so quickly that they don't expire. RN-UU then stated sometimes we have 10 or more residents on the unit who are diabetics but right now we don't have that many diabetics. Surveyor notes, facility staff are unable to identify when test strips are opened or expired after open date. According to National Diabetic Supply, while sealed and unopened products [glucose test strips] are typically good until their expiration date, once opened, they have a limited usage period. Most brands recommend using them within 3 to 6 months after opening to ensure accurate results. https://nationaldiabeticsupply.com/best-practices-when-storing-glucose-test-strips/?srsltid=AfmBOoov0ttjAHsV On [DATE], at 1:47 PM, Surveyor interviewed Registered Nurse (RN)-NN and RN-LLL and asked if glucose test strips are labeled. RN-NN and RN-LLL stated, yes, staff are to label the glucose test strip bottle with an open date to determine expiration dates. On [DATE], at 8:39 AM, Surveyor requested a facility policy for glucose test strip storage. Director of Nursing (DON)-B states the facility does not have a policy regarding storage of glucose test strips. On [DATE], at 9:23 AM, Surveyor notified DON-B of concerns with the above findings. DON-B acknowledge these concerns. On [DATE], at 2:44 PM, the above findings were shared with Regional Director of Operations (RDO)-XX and Director of Operations (Director of Ops)-YY, and DON-B.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 for 6 (R80, R71, R45, R129, R11, & R90) of 6 Residents. *Appropriate hand hygiene was not observed during medication administration for R80 & R71. *Staff did not wear appropriate Personal Protective Equipment (PPE) when administering medication via a G (gastrostomy) tube to R80 & R45 who are on Enhanced Barrier Precautions (EBP). *The glucometer was not disinfected after R129's blood sugar was obtained. *Staff did not wear appropriate PPE during personal cares and tube feeding procedures for R11 who is on enhanced barrier precautions. *R90's Foley catheter drainage bag was observed on the floor and without any barrier to prevent contamination. Findings include: The facility's policy titled, Hand Hygiene and revised 03/27/2025 Under Guidelines 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. Under Explanation and Compliance Guidelines documents 1. Taff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. 2. Hand hygiene is indicated and will be performed under conditions listed in, but not limited to, the attached hand hygiene table. The Hand Hygiene Table includes Before preparing or handling medications The facility's policy titled, Enhanced Barrier Precautions and date reviewed/revised 01/05/2025 under Definitions documents Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves during high contact resident care activities. Under Explanation and Compliance Guidelines documents 4. High-contact resident care activities include a. Dressing. b. Bathing. c. Transferring. d. Providing hygiene. e. Changing linens. f. Changing briefs or assisting with toileting. g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC (peripherally inserted central catheter) lines, midline catheters. h. Wound care: any skin opening requiring a dressing. The facility's policy titled, Glucometer Disinfection and date reviewed/revised 11/11/2024 under guideline documents The purpose of this procedure is to provide guidelines for the disinfection of capillary-blood glucose sampling devices to prevent transmission of blood borne diseases to residents and employees. Under Policy Explanation and Compliance Guidelines documents 1. The facility will ensure blood glucometers will be cleaned and disinfected after each use and according to manufacturer's infections for multi-resident use. 3. The glucometers will be disinfected with a wipe pre-saturated with an EPA (environmental protection agency) registered healthcare disinfectant that is effective against HIV (human immunodeficiency virus), Hepatitis C and Hepatitis B virus. 4. Glucometers will be cleansed and disinfected after each use and according to manufacturer's (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters Edge Health and Rehabilitation Center	3415 N Sheridan Rd Kenosha, WI 53140

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	instructions regardless of whether they are intended for single resident or multiple resident use. 1.) On 9/23/25, at 8:49 a.m., Surveyor observed Licensed Practical Nurse (LPN)-KK inform R80 she was going to give him his medication. Surveyor observed there is an Enhanced Barrier Precaution sign on R80's door. At 8:51 a.m. Surveyor observed LPN-KK start to prepare R80's medication which consisted of Famotidine 20 mg (milligrams), Amantadine HCL 100 mg, Vitamin C 500 mg, Gabapentin 100 mg, Levetiracetam 1500 mg, Vitamin D3 400 IU (international unit), and Doxazosin Mesylate 2 mg. Surveyor observed LPN-KK did not perform any hand hygiene prior to preparing these medications. LPN-KK crushed Levetiracetam, placed gloves on, opened the Gabapentin capsules & poured the medication into a med cup. LPN-KK crushed the remainder of R80's medication individually pouring the medication in med cups. At 9:03 a.m. LPN-KK removed her gloves and placed another pair of gloves on. LPN-KK did not perform any hand hygiene. LPN-KK entered R80's room with the medication in individual medication cups and added water to each medication cup. Surveyor observed LPN-KK is only wearing gloves and is not wearing a gown. At 9:06 a.m. LPN-KK informed R80 she needs to check his blood pressure, placed R80's tube feeding on hold and obtained R80's blood pressure of 125/85. LPN-KK stirred each medication with a straw and at 9:09 a.m. LPN-KK checked placement of R80's G (gastrostomy) tube. At 9:11 a.m. LPN-KK flushed R80's G tube and then administered R80's medication individually flushing with water in between each medication. After administering R80's medication, LPN-KK placed a washcloth under R80's tube, pulled down R80's gown, covered R80 with bedding and stated to R80 ok [first name of R80] you have all your medication. At 9:24 a.m. LPN-KK rinsed out the syringe container, removed her gloves, wiped off the over bed table with a paper towel and then went to the medication cart. Surveyor observed LPN-KK did not perform hand hygiene after removing her gloves and was not wearing the appropriate PPE (personal protective equipment) for R80 who is on enhanced barrier precautions. 2.) On 9/23/25 at 9:37 a.m. Surveyor observed Licensed Practical Nurse-MM start to prepare R71's medication which consisted of Metoprolol Tartrate 12.5 mg (milligrams), Gabapentin 100 mg, Eliquis 5 mg, Furosemide 40 mg, Isosorbide Mononitrate 30 mg, Aspirin, 81 mg, Vitamin D3 5000 units, Hydrocodone Acetaminophen5-325 mg and Advair 250 mcg/50 mcg inhaler. Surveyor observed LPN-MM did not perform any hand hygiene prior to preparing R71's medication. 3.) On 9/23/25 at 11:57 a.m. Surveyor observed Registered Nurse (RN)-LL cleanse her hands and place gloves on. RN-LL placed a strip in the glucometers, cleansed R129's right ring finger with an alcohol pad, waved her hand over R129's finger to help dry the finger, poked R129's right ring finger, squeezed, and placed a drop of blood on the strip. RN-LL stated the blood sugar is 165. RN-LL removed her gloves and cleansed her hands. At 11:59 a.m. RN-LL disposed of the lancet in the sharps container and placed the glucometer on top of the medication cart. At 12:06 p.m. RN-LL administered R129's Novolin R insulin according to physician orders. At 12:07 p.m. Surveyor asked RN-LL if she has any other blood sugars. RN-LL explained to Surveyor she has two on the unit, R129 and R25. RN-LL gathered supplies to check R25's blood sugar. Surveyor asked RN-LL if she was going to check R25's blood sugar. RN-LL replied yes. Surveyor asked RN-LL if there is only one glucometer on each medication cart. RN-LL replied yes. Surveyor asked RN-LL when she disinfects the glucometer. RN-LL informed Surveyor she should probably have cleaned it before each patient. At 12:11p.m. RN-LL removed a wipe from the Micro-Kill two container and wrapped the glucometer with the wipe. At 12:12 p.m. RN-LL unwrapped the glucometer and placed a strip in the glucometer. Surveyor noted the disinfectant wipe was wrapped around the glucometer for only one minute. Surveyor noted the label on the wipe container documents disinfects hard nonporous surfaces in 2 minutes. RN-LL with gloves on cleansed R25's right index finger with an alcohol pad, waved to help dry R25's finger, poked R25's finger, squeezed the right index finger and placed a drop of blood on the strip. R25's blood sugar (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	UM-F replied yes. Surveyor asked when staff removes their gloves should they perform hand hygiene prior to placing on another pair of gloves. UM-F replied yes. On 9/24/25, at 9:12 a.m., Surveyor asked UM-F after a nurse checks a resident's blood sugar what should the nurse do with the glucometer. UM-F replied to use a wipe to clean them. Surveyor asked if the glucometer should be disinfected prior to checking the next blood sugar. UM-F replied yes. Surveyor asked UM-F if the nurse should follow the manufacturers recommendations on the wipe container. UM-F replied yes. Surveyor informed UM-F Surveyor as observed Micro Kill one and Micro Kill two on medication carts. Surveyor asked which wipe staff should be using to disinfect the glucometer. UM-F informed Surveyor they can use either wipe just as long as they are following the recommendations. On 9/24/25, at 9:18 a.m., Surveyor informed UM-F of the infection control concerns observed by Surveyor. 5.) The facility's policy and procedure titled Catheter Care dated 12/2/2024. The procedure explanation includes:2. Privacy bags will be available and catheter drainage bags will be covered at all times while in use. R90 was admitted to the facility on [DATE] for wound care and has a suprapubic bladder catheter. R90 is in Enhanced Barrier Precautions due to having wounds, colostomy and a suprapubic catheter. On 9/23/2025, at 8:13 AM, R90 bladder drainage bag was uncovered laying on the floor. On 9/24/2025, at 8:58 AM bladder drainage bag hanging on bed frame uncovered. On 09/24/2025, at 1:07 PM, Surveyor interviewed the Director of Nurses (DON) – B. The DON-B stated the Foley drainage bag should not be on the floor and should also be in a cover. On 9/24/2025, at 2:47 PM. At the facility exit meeting with the Nursing Home Administrator (NHA) -A and DON-B, Surveyor shared the drainage bag concerns. 6.) R11 was admitted to the facility on [DATE] with diagnoses of Autistic Disorder (affects how people interact with others, communicate, learn, and behave.), Repeated Falls, Unspecified Intellectual Disabilities (individual exhibits significant limitations in both intellectual functioning and adaptive behavior), Epilepsy (chronic neurological condition characterized by recurrent seizures, which are episodes of shaking and convulsions), Mood [Affective] Disorder (persistent and significant changes in mood, emotions, and behavior), Anxiety Disorder (excessive worry, fear, and nervousness that can interfere with daily life) and Gastrostomy(surgical procedure that creates an opening in the stomach through the abdominal wall to allow for feeding and medication administration directly into stomach). R11 currently has a legal guardian. R11's admission Minimum Data Set (MDS) completed 7/9/25 documents R11 demonstrates severely impaired cognitive skills for daily decision making and has short and long term memory deficits. R11's Patient Health Questionnaire (PHQ)-9 score is documented as 14 indicating R11 demonstrates moderate depressive symptoms. R11 demonstrates physical behaviors that significantly interferes with resident care, participation in activities, intrudes on privacy or activity of others, disrupts care of living environment. R11's MDS also documents that R11 demonstrates rejection of care and wandering daily. R11's has no range of motion impairment. R11 requires supervision for eating (at time of MDS, R11 was nothing by mouth (NPO), dependent for showers. R11's MDS requires (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	partial/moderate assistance for upper dressing and substantial/maximum for lower body dressing. R11 is independent for mobility and transfers. R11 currently receives bolus tube feedings four times a day for nutrition. R11's electronic medical record (EMR) contains a progress note written by Licensed Practical Nurse (LPN)-HHH on 9/21/25.R11 continues to have frequent loose stools. Nurse Practitioner updated, orders received to obtain stool specimen for possible C-diff, once specimen obtained can start Loperamide 2 mg every 8 hours PRN(as needed). Stool Specimen obtained. On 9/22/25, LPN-ZZ documented.Continues on contact precautions as stool sample for c-diff is pending. On 9/23/2025, at 11:39 AM, Surveyor observed R11 receiving bolus tube feeding. LPN-MM retrieved a bottle of tube feeding from R11's room, showed R11 the bottle, took gloves out of LPN-MM's pocket and put the gloves on. LPN-MM had Certified Nursing Assistant (CNA)-UUU assisting with the tube feeding. LPN-MM donned a gown from the cart located outside the room and with same gloves on, proceeded to start the process of R11 receiving tube feeding. CNA-UUU was also in the room with LPN-MM and was assisting to keep R11 calm and stable in the wheelchair. CNA-UUU placed hand on R11's arm and wheelchair. Surveyor observed R11 holding the tube for LPN-MM to inject the tube feeding by way of syringe. Surveyor observed when the procedure was complete, LPN-MM took off gown and gloves. CNA-UUU took off gloves. Neither LPN-MM nor CNA-UUU performed hand hygiene. Surveyor also observed that neither LPN-MM or CNA-UUU performed hand hygiene on R11 who was holding the tube the entire time, is pending for C-Diff and it is common for R11 to use the handrail and carts to pull self along the hallway while propelling the wheelchair. Surveyor notes the sign on the door states Enhanced Barrier Precautions (EBH) and other signs taped over that states to see nurse before entering room. Surveyor notes there is a cart outside R11's room containing personal protective equipment (PPE). On 9/23/2025, at 1:28 PM, Surveyor observed LPN-MMM in R11's room not wearing a gown, only wearing gloves. LPN-MM stated LPN-MM was changing R11's brief. Surveyor notes LPN-MM did perform hand hygiene after. On 9/24/2025, at 6:34 AM, Surveyor notes the contents of the cart outside of R11's room. The cart has hand sanitizer and two boxes of gloves on top, one box of gloves is empty. The first drawer has about twenty surgical masks. The middle drawer has two gowns in plastic and the bottom drawer has one gown in plastic. The sign on the door for is for EBP. The sign to stop and ask a nurse has been removed since yesterday. On 9/24/2025, at 6:51 AM, Surveyor observed R11 open up R11's door and came out to doorway. R11 is wearing a black shirt, shoes and brief which the is to be saturated with urine. Dementia Coordinator (DC)-M went into room and put gloves on. DC-M asked Unit Manager (UM)-F to bring towels and washcloths. DC-M did not put a gown on. DC-M then came out and got gloves and gown and provided cares for R11. Surveyor did not observe DC-M perform hand hygiene at any time. On 9/24/25, at at 10:01 AM, A Surveyor on the team interviewed UM-F who is also in the role of Infection Preventionist. The Surveyor asked UM-F about R11 being in isolation. UM-F stated, we have come to the nurse sign right now but R11 is in contact isolation. The nurse put the wrong one up there, but I have to fix it. Staff were going to try and get a sample but not sure they got one yet. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Sometimes residents will pull signs off the door. I just have to grab from downstairs. Surveyor has not observed any residents on the unit attempting to pull signs off the doors. Surveyor also notes a stool specimen was collected back on 9/21/25. On 9/24/2025, at 2:57 PM, Surveyor shared with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, Regional Director of Operations (RDO)-XX, and Director of Operations (DO)-YY the infection control concerns involving R11 and staff not wearing the appropriate PPE during cares and the tube feeding procedure. No further information has been provided by the facility at this time. On 9/25/2025, at 11:10 AM, Surveyor observed that the sign on R11's door now states contact precautions. On 9/25/2025, at 1:15 PM, Surveyor asked UM-F why there is a different sign on R11's door. UM-F stated there was a green sign on the door (for contact precautions), but it must have been taken down. Sometimes they pull the signs.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure staff did not engage in misappropriation of 1 (R9) of 1 resident's reviewed for misappropriation of property.*R9's cell phone was reported to be missing on 9/15/2025. Through investigation it was determined there was a misappropriation of property when housekeeper-PP took R9's personal cell phone on 8/21/2025 while R9 was hospitalized without R9's consent.Findings include:R9 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE]. R9 has diagnoses that include Chronic Respiratory Failure, Type 2 Diabetes Mellitus, Tracheostomy, and Encephalopathy. R9's admission Minimum Data Set (MDS) assessment dated [DATE] indicated R9 has moderately impaired cognition with a Brief Interview for Mental Status (BIMS) score of 12. R9 was confused and forgetful at times and had a guardian to assist in making healthcare decisions. On 9/15/2025, at 3:23 PM, the facility submitted an initial facility self-report to the State Agency acknowledging that R9's personal cell phone was missing. Surveyor reviewed the facility self-report and noted the facility concluded R9's phone was taken by housekeeper-PP around 8/21/2025 while R9 was admitted to the hospital.On 9/15/2025 R9's family member filed a grievance with social worker (SW)-D R9's personal cell phone was missing. SW-D looked in the laundry and residents' room with R9 and R9's family member permission. R9's family member was able access R9's phone records and noted R9's phone has been in use. Police were notified and an investigation was initiated.Police and R9's family member were able to determine R9's cell phone account was logged out and the [NAME] card removed on 8/21/2025. Review of phone records indicated the facility was called the morning of 9/15/2025. Nursing home administrator (NHA)-A was able to determine the phone call was made to the housekeeping director and the call came from housekeeper-PP. NHA-A reviewed facility surveillance and noted housekeeper-PP accessed R9's room on 8/21/2025, the same day R9's phone account was logged out of and [NAME] card taken out. NHA-A and police were unable to locate housekeeper-PP for interview.Findings of the facility self-report conclude R9's personal cell phone went missing while R9 was hospitalized between 8/6/2025 - 9/9/2025. R9's family reported R9's cell phone missing on 9/15/2025 and through investigation was determine housekeeper-PP went into R9's room on 8/21/2025. Through review of R9's phone records, R9's cell phone account was logged out and the [NAME] card taken out on 8/21/2025, and housekeeper-PP made a phone call on 9/15/2025 that came from the same phone number as R9's cell phone concluding that housekeeper-PP took R9's personal cell phone.On 9/29/2025, at 9:24 AM, Surveyor interviewed SW-D who stated R9's family would call R9 on the cell phone. When R9's family reported the cell phone missing on 9/15/2025 staff searched the laundry room and R9's room, then it was noted that R9's phone was still being used, and police were called, and an investigation began. SW-D stated R9's family filed a police report with the officer that came to the facility. Currently SW-D assists R9 with making phone calls to R9's family and arranging with R9's family for R9 to receive their phone calls. SW-D stated R9's family is working with police and the phone company to get R9 a new phone but is not sure of what the status is of that.On 9/29/2025, at 9:45 AM, Surveyor observed R9 lying in bed watching TV. R9 stated SW-D helps R9 call family and R9's family is working to get another cell phone for R9. R9 is happy to get the help from the facility to communicate with R9's family and getting a new cell phone.

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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** Based on observation, record review and interviews, the facility did not ensure 2 of 20 sampled residents' plan of care contained accurate information to implement interventions. * R90 was observed with an air mattress on their bed and a blue mat on their floor. R90 plan of car for a pressure injury did not include an air mattress. R90 plan of care for falls did not indicate when, and where, to use a blue mat. *R11 Guardian directed them to have pleasure feedings. This intervention was not documented on R11 comprehensive plan of cares. The facility's policy and procedure titled Care Plan Revisions Upon Status Change dated 5/12/2025. The purpose of this policy is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change. Findings include: 1.) R90 was admitted to the facility on [DATE] for wound care. On 9/22/2025, at 10:37 AM, Surveyor interviewed R90 in their bed. R90 was laying on their right side in bed. There was a mat on the left side of the bed. R90 stated they did not have any falls. R90 had an air mattress on their bed. R90 currently has a pressure injury on their right heel and sacrum. Surveyor reviewed the medical record. R90 had a fall from their bed on 7/25/25 with no injury. The fall documentation on 7/25/25 does not include a blue mat for an intervention. R90 has a stage 4 pressure injury on their sacrum. The wound assessment from Advanced Wound Care, dated 7/9/2025, documents the use of an air mattress to promote healing. On 9/23/2025, at 8:13 AM, Surveyor observed R90 in their bed. There was no blue mat on the floor. There was a folded blue mat leaning against the wall. There was an air mattress on the bed. On 09/24/2025, at 8:54 AM, Surveyor observed R90 in their bed eating breakfast. There was a blue mat on the left side of the bed. R90 body was facing the right side of the bed.R90 plan of care documents:*The resident is at risk for falls, accidents and incidents related to DeconditioningDate Initiated: 07/08/2025Created on: 06/14/2025An intervention dated on 6/14/25 includes a Floor Mat. There is not a direction on where, and when, to place the blue mat. There is not an assessment for the blue floor mat. *The resident has potential/actual impairment to skin integrity related to needs assist with cares. Pressure wounds to sacrum and heel.Date initiated: 6/12/25Created on: 6/12/25Intervention dated on 6/12/25 for a pressure reduction mattress. There is not a documented intervention for an air mattress to address R90 pressure injuries. On 9/25/2025, at 9:28 AM, Surveyor interviewed the Director of Nurses (DON) – B. The DON-B did not have information related to the air mattress. R90 does have an air mattress and did not know (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	why it was not on the plan of care for pressure injury. On 9/24/2025, at 9:32 AM, Surveyor interviewed the DON-B. The DON-B will review for additional information. On 9/24/2025, at 1:10 PM the DON-B spoke with Surveyor. The DON-B stated the blue mat is used for the side R90 leans to in bed. This is not documented on the plan of care, nor observed during observations. 2) R11 was admitted to the facility on [DATE] and has a legal guardian. R11 receives nutrition through a feeding tube, however the guardian has requested that R11 receive pleasure feedings of scrambled eggs two times a day. R11's Nutritional Evaluation completed 9/15/25 by Registered Dietitian (RD)-RRR documents R11 remains NPO due to ongoing aspiration risk and diagnosis Dysphagia, Oropharyngeal Phase. Tube feeding was increased (from 330cc 3 times a day to 360 cc three times a day) on 9/15/25 due to staff report that he has expressions around mealtime and appears as though R11 is hungry after R11's tube feedings. R11's Risk/Benefit Record Tool completed 9/17/25 by Social Worker Assistant (SWA)-D. The Risk/Benefit Record Tool documents that R11 will be receiving pleasure/small amounts of food two times daily. R11's current physician orders document regular diet mechanical soft-ground meat texture, thin consistency, can only have scrambled eggs for pleasure feeding with a start date 9/18/25. R11's comprehensive care plan has not been revised to include R11's pleasure feedings of scrambled eggs two times a day. Surveyor notes these targeted problems were not updated with the pleasure feedings of scrambled eggs two times a day. There is no documentation in R11's care plan that risks/benefits were reviewed with R11's representative and R11's representative requested the two pleasure feedings of scrambled eggs per day. R11's Kardex which instructs Certified Nursing Assistants (CNA) in the care of R11 as of 9/25/25 documents R11 is still NPO. On 9/25/2025, at 9:13 AM, Surveyor interviewed RD-RRR in regard to R11's comprehensive care plan. RD-RRR explained RD-RRR is at the facility two days a week, remote one day a week and always available. RD-RRR confirmed that R11's comprehensive care plan was not updated at the time pleasure feedings were added. RD-RRR informed Surveyor that RD-RRR updated R11's care plan indicating R11 can receive two pleasure feedings of scrambled eggs per day.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility did not ensure that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; and assistance with repositioning for 1 of 2 (R60) residents reviewed for ADL's (Activity of Daily Living).R60 was not provided assistance to reposition as she requested until Surveyor intervened and asked staff to assist the resident.Findings include:R60 was admitted to the facility on [DATE] and has diagnoses that include chronic kidney disease stage 3, chronic obstructive pulmonary disease, morbid obesity, asthma, dysphagia, anxiety disorder, major depressive disorder, hypertension, gout, gastroesophageal reflux disease and hereditary and idiopathic neuropathy.R60's BIMS (Brief Interview for Mental Status Score) dated 7/28/25 documents a score of 15, indicating no cognitive impairment.R60's admission MDS (Minimum Data Set) dated 8/3/25 documents: Functional Limitation in Range of Motion lower extremity (hip, knee, ankle, foot) - impairment on both sides.Roll left and right: The ability to roll from lying on back to left and right side and return to lying on back on the bed - partial/moderate assistance. R60's Admission/readmission/routine Head to Toe Evaluation dated 7/28/25 documents: Fall Risk evaluation - High risk.R60's Physical Therapy Discharge summary dated [DATE] documents: Bed mobility roll left and right = Substantial/maximal assistance.On 9/22/25 at 11:55 AM, Surveyor observed R60 lying in bed on her back, wearing a gown. R60 told Surveyor she wanted to get boosted up in bed, But the aid said she can't help me because she don't want to hurt her back. Surveyor offered to find someone to assist R60. R60 stated, Yes, but she won't because she don't want to hurt her back. Surveyor put R60's call light on and within a minute Certified Nursing Assistant (CNA)-FF entered the room and turned off the call light. Surveyor told CNA-FF that R60 would like to be repositioned and boosted up in bed. R60 stated to CNA-FF Tell her what you tell me, you can't because you don't want to hurt your back. CNA-FF stated, I can't by myself, I have to get someone to help me and left the room. On 9/22/25 at 12:15 PM, Surveyor noted R60 remained in the same position on her back and noted R60 had slid down more near the middle of the bed. Surveyor asked if anyone had been in to reposition her yet. R60 stated, No. I told you, she won't because she don't want to hurt her back. Surveyor observed a different CNA in the dining area where 3 residents were seated eating lunch. Surveyor observed CNA-FF enter another resident's room.On 9/22/25 at 12:25 PM, Surveyor observed no staff had been in R60's room to reposition/boost her up in bed as requested. Surveyor observed CNA-FF passing lunch trays to resident rooms. Surveyor reminded CNA-FF that R60 had asked to be boosted in bed and asked if she has been in her room to reposition her. CNA-FF stated, No, the other aid had to stay in the dining room, so I was alone out here. Surveyor asked CNA-FF if she asked anyone else for assistance, such as the nurse, to help her reposition R60. CNA-FF stated, No, now I'm passing trays. It had been 30 minutes since Surveyor and R60 requested assistance.On 9/22/25 at 12:33 PM, Surveyor entered R60's room, noting she had not been repositioned or boosted in bed. R60 had received her meal tray. Surveyor asked R60 if she was having lunch. R60 was tearful and replied (with voice cracking), My back hurts, I need to be boosted. I can't eat now, I'm not hungry, my back hurts. On 9/22/25 at 12:35 PM, Surveyor approached Licensed Practical Nurse (LPN)-Y who was standing at the medication cart at the nurse's station. Surveyor advised LPN-Y that R60 is uncomfortable, tearful and asked to be repositioned 40 minutes ago. Surveyor asked LPN-Y if he would help the CNA reposition the resident. LPN-Y stated, Absolutely, I'll go down there right now. Surveyor observed LPN-Y and another staff member enter R60's room. On 9/22/25 at 1:10 PM, Surveyor observed R60 positioned more upright in bed, with pillows on each side. When asked how she was feeling, R60 stated, Better, thank you. Surveyor asked her if now that she was boosted in bed, is she going to have lunch. R60 stated, No, I'm not hungry now, just forget it. Surveyor noted the CNA Point of Care documentation enter on 9/22/25 at 1:00 p.m. indicated R60 consumed 75% of her meal, when in fact the resident did not eat lunch.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure its procedures for indicating a residents' code status was followed for 1 (R11) of 20 residents sampled.R11 did not have a current physician order for R11's code status.Findings Include:The facility's policy and procedure Communication of Code Status revised 4/1/25 documents: .Explanation and Compliance Guidelines:2. When an order is written pertaining to a resident's presence or absence of an Advanced Directive, the directions will be clearly documented in designated sections of the medical record. 3. The nurse who notates the physician order is responsible for documenting the directions in all relevant sections of the medical record.4. The designated sections of the medical record are: physician orders obtained per election form and uploaded signed election form.R11 was admitted to the facility on [DATE] and has a legal guardian. On 9/22/2025, at 12:55 PM Surveyor completed a record review and notes that on 7/7/25, R11's guardian signed for R11 to be full code status. Surveyor noted on R11's current physician orders, there is no order for full code status.On 9/23/2025, at 1:53 PM, Surveyor received a copy of R11's current physician orders and confirmed R11's full code status is not documented in R11's current physician orders On 9/23/2025, at 1:55 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-MM. LPN-MM stated that the nurses have basic information for each resident on the unit which includes the code status of each resident. R11's code status documents full code. LPN-MM stated that LPN-MM would also double check in the resident's electronic medical record (EMR). Both Surveyor and LPN-MM pulled up R11's EMR and LPN-MM confirmed that R11 does not have a current code status listed.On 9/23/2025, at 10:14 AM, Surveyor interviewed Social Worker Assistant (SWA)-D in regard to code status. SWA-D stated that SWA-D had nothing to do with obtaining code status or maintaining the code status in a resident's EMR. SWA-D will verify in the care conference of what the code status is. Surveyor notes that R11 has not had a care conference.On 9/24/2025, at 2:57 PM, Surveyor shared with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, Regional Director of Operations (RDO)-XX, and Director of Operations (DO)-YY the concern that R11's current physician orders to not have an order for R11's full code status. NHA-A stated the expectation is that there should be a physician order for code status for each Resident.On 9/25/2025, at 8:12 AM, NHA-A informed Surveyor that the facility conducted an audit of every Resident to verify there was a physician order for code status.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility did not ensure 1 (R49) of 1 resident receiving oxygen had the prescribed oxygen setting. On 9/22/25 and 9/23/25, Surveyor observed R49 with a nasal cannula and oxygen flowing at 4 liters per minute. The physician orders document oxygen 2 liters per minute. Findings include: R49 was admitted to the facility on [DATE] with diagnoses of anxiety, chronic obstructive pulmonary disease (COPD) and hypertension. The oxygen therapy care plan with initiation date of 1/31/25 and revision date of 7/1/25 documents R49 receives oxygen via nasal cannula at 2 liters per minute. The physician orders dated 7/16/25 documents R49 received oxygen via nasal cannula at 2 liters per minute. On 9/22/25 at 9:54 a.m. Surveyor observed R49 in bed with a nasal cannula in her nose with the oxygen concentration indicating 4 liters of oxygen flowing. On 9/23/25 at 7:40 a.m. Surveyor observed R49 in bed with a nasal cannula in her nose with the oxygen concentration indicating 4 liters of oxygen flowing.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility did not ensure 1 (R3) of 1 resident reviewed for Dialysis received Dialysis care in accordance with professional standards of practice.*R3 did not have a MD (Medical Doctor) order for dialysis and for monitoring R57's Arterio-Venous (AV) Fistula for bruit (the regular, whooshing sound made by blood flowing through a dialysis fistula or graft) or thrill (the vibration felt over an arteriovenous fistula or graft) from 5/21/25 through 9/24/25.Findings include:The facility policy with a last reviewed date of 12/02/24 and titled, Hemodialysis documents, in part: This facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences to meet the special medical nursing, mental and psychosocial needs of residents receiving hemodialysis. The facility will ensure that the physician's orders for dialysis include: The type of access for dialysis (e.g. graft, arteriovenous shunt, external dialysis catheter) and location; The dialysis schedule; The nephrologist name and phone number; Transportation arrangements to and from the dialysis facility; Any medication administration or withholding of specific medications prior to dialysis treatments; Any fluid restriction if ordered by the physician. The nurse will ensure that the dialysis access site (e.g. AV shunt or graft) is checked before and after dialysis treatments and every shift for patency by auscultating for a bruit and palpating for a thrill. If absent, the nurse will immediately notify the attending physician, dialysis facility and/or nephrologist.R3 was admitted to the facility on [DATE] with diagnosis that include stroke affecting right dominant side and chronic kidney disease with dependence on renal dialysis.R3's Annual Minimum Data Set (MDS) assessment dated [DATE] documents R3 is cognitively intact. R3 receives dialysis.R3's dialysis care plan initiated on 5/4/22 documents the following pertinent interventions: My AV fistula is located on my left arm. Assess resident's dialysis port/shunt for [signs and symptoms] of bleeding [every] shift and when I return from dialysis. Assess resident's shunt for positive bruit and thrill [every] shift and after dialysis. Notify change or absence of thrill immediately to Dialysis Unit.On 5/20/25, R3 had a change of condition and admitted to the hospital with a diagnosis of pneumonia. R3 was admitted back to the facility on 5/26/25.Surveyor reviewed R3's MD orders and noted the facility did not have MD orders for the type of access for dialysis and location, the dialysis schedule, the nephrologist's name and phone number, the assessment for bruit and thrill every shift, and the care and assessment orders for before and after dialysis. On 9/24/2025 at 12:56 PM, Surveyor interviewed Registered Nurse (RN)-OO. Surveyor asked what MD orders are in place for residents who are on dialysis. RN-OO stated they would have MD orders for what type of access the resident has, orders for what days dialysis is completed and where it is completed, orders for weights before and after dialysis, orders for checking vital signs before and after dialysis, and orders to check the bruit and thrill every shift and before and after dialysis. Surveyor asked where the documentation for these orders is placed. RN-OO stated that the facility has a dialysis binder for each resident to aid in communication with the dialysis center. In the binder, the nurse will document the weight and vital signs before and after dialysis, any medication given or held or any other pertinent information. RN-OO stated that the documentation for weights, vital signs and assessing for the bruit and thrill each shift is also in the Treatment Administration Record (TAR). Surveyor reviewed R3's TAR and noted that R3 had dialysis orders and care orders of R3's AV site prior to R3's hospitalization on 5/20/25. After R3 returned to the facility on 5/26/25, facility staff did not enter R3's dialysis orders or care orders of R3's AV site.On 9/24/2025 at 12:56 PM, Surveyor interviewed RN-OO. Surveyor asked who enters orders when a resident is readmitted back to the facility after a hospitalization. RN-OO stated that the admitting nurse enters the orders. RN-OO stated that if a resident is gone from the facility greater than 24 hours, the resident's MD orders are discontinued. When the resident returns, it is like a new admission, and all MD orders need to be entered.On 9/24/2025 at 1:12 PM, Surveyor interviewed (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director of Nursing (DON)-B. Surveyor asked what MD orders should be in place for residents receiving dialysis. DON-B stated the resident should have orders to check the bruit and thrill every shift, orders that no blood pressure should be taken on the limb of the AV fistula/shunt, and orders identifying dialysis days. Surveyor shared the concerns that R3 does not have dialysis orders and does not have an order or documentation that R3's AV fistula is being monitored. DON-B indicated that after R3's admission to the hospital in May, R3's dialysis MD orders were not reentered into R3's electronic medical record.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure that irregularities noted by the pharmacist during the Medication Regimen Review (MRR) were sent to the attending physician to include at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified for 2 of 5 (R11 and R60) residents reviewed for unnecessary medications. R11's pharmacy MRR recommendations for July and September 2025 were not acted upon by the facility or physician. R60's pharmacy MRR recommendations for August 2025 were not acted upon by the facility or physician. Findings include: 1.) R60 admitted to the facility on [DATE] and has diagnoses that include chronic kidney disease stage 3, chronic obstructive pulmonary disease, morbid obesity, asthma, dysphagia, anxiety disorder, major depressive disorder, hypertension, gout, gastroesophageal reflux disease and hereditary and idiopathic neuropathy. The facility policy titled “Addressing Medication Regimen Review Irregularities (Pharmacist Recommendations) dated 11/11/24 documents (in part) … …It is the policy of this facility to provide a Medication Regimen Review for each resident in order to identify irregularities and respond to those irregularities in a timely manner to prevent the occurrence of an adverse drug event. 4. The pharmacist must report any irregularities to the attending physician, the facility's medical director and director of nursing, and the reports must be acted upon. b. Any irregularities noted by the pharmacist during this review must be documented on a separate, written report which may be in paper or electronic form. d. The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. Surveyor review of R60's MAR (Medication Administration Record) documented an order for Alprazolam Oral Tablet 0.25 MG (milligrams) give 1 tablet by mouth every 8 hours as needed for anxiety - start date 8/12/25. Facility progress note dated 8/22/25 at 12:58 PM, documented: Pharmacist reviewed/recommendation made/see separate report. The Pharmacy “Note to Attending Physician/Prescriber” printed 8/24/25 documents: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Current order: Alprazolam PRN OD (ordered) 8/12/25 without stop date. Resident with 10x (times) use since started. CMS F758 phase 2 implementation requires PRN psychotropic orders to be written for no more than 14 days. If PRN psychotropic orders are deemed necessary beyond this time, clinical rationale and a specific duration need to be provided by the prescriber. Recommendation: Please discontinue or provide rationale for continued PRN Alprazolam use for facility documentation. Surveyor noted options to check the following: Discontinue PRN Alprazolam Continue PRN Alprazolam as the benefits outweigh the risks. Reassess in (line blank) months. Surveyor noted neither recommendation/option was checked. Physician/Prescriber Response: Resident continues to take Alprazolam PRN daily. Schedule Alprazolam daily. Signed by NP (Nurse Practitioner) 9/23/25. Surveyor noted the physician response to the pharmacy recommendations on 8/22/25 was dated 9/23/25, after Surveyor asked for information. On 9/25/25 at 2:50 PM, Surveyor asked Director of Nursing (DON)-B what the process is and who is responsible for following up on pharmacy recommendations. DON-B reported the pharmacy sends her an email and then she notifies the NP or doctor. Surveyor advised DON-B of concern there was no follow up on R60's pharmacy recommendations from 8/22/25. 2.) R11 was admitted to the facility on [DATE] with diagnoses of Autistic Disorder (affects how people interact with others, communicate, learn, and behave.), Repeated Falls, Unspecified Intellectual Disabilities (individual exhibits significant limitations in both intellectual functioning and adaptive behavior), Epilepsy (chronic neurological condition characterized by recurrent seizures, which are episodes of shaking and convulsions), Mood [Affective] Disorder (persistent and significant changes in mood, emotions, and behavior), Anxiety Disorder (excessive worry, fear, and nervousness that can interfere with daily life) and Gastrostomy (surgical procedure that creates an opening in the stomach through the abdominal wall to allow for feeding and medication administration directly into stomach). R11 currently has a legal guardian. R11's admission Minimum Data Set (MDS) completed 7/9/25 documents R11 demonstrates severely impaired cognitive skills for daily decision making and has short and long term memory deficits. R11's Patient Health Questionnaire (PHQ)-9 score is documented as 14 indicating R11 demonstrates moderate depressive symptoms. R11 demonstrates physical behaviors that significantly interferes with resident care, participation in activities, intrudes on privacy or activity of others, disrupts care of living environment. R11's MDS also documents that R11 demonstrates rejection of care and wandering daily. R11's has no range of motion impairment. R11 requires supervision for eating (at time of MDS, R11 was nothing by mouth (NPO), dependent for showers. R11's MDS requires partial/moderate assistance for upper dressing and substantial/maximum for lower body dressing. R11 is independent for mobility and transfers. Surveyor reviewed R11's current physician orders and R11's pharmacy reviews. R11's facility progress note written by Consultant Pharmacist (CP)-NNN on 7/17/25, at 2:02 PM, (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented: …”Pharmacist reviewed/recommendation made/see separate report.”… 1.The Pharmacy “Note to Attending Physician/Prescriber” printed 7/18/25 and documented by CP-NNN: Lorazepam as needed(PRN) + Temazepam PRN since admit 7/3/25 Current order: CMS F758 phase 2 implementation requires PRN psychotropic orders to be written for no more than 14 days. If PRN psychotropic orders are deemed necessary beyond this time, clinical rationale and a specific duration need to be provided by the prescriber. Recommendation: Please discontinue or provide rationale for continued PRN Lorazepam + Temazepam use for facility documentation. Surveyor noted options to check the following: -Discontinue PRN Lorazepam -Continue PRN Lorazepam as the benefits outweigh the risks. Reassess in (line blank) months. AND -Discontinue PRN Temazepam -Continue PRN Temazepam as the benefits outweigh the risks. Reassess in (line blank) months. Surveyor noted neither recommendation/option was checked for both. A handwritten note with no signature on the form documents:…”8/5 Lorazepam changed to scheduled No change to Temazepam”… 2.The Pharmacy “Note to Attending Physician/Prescriber” printed 7/18/25 and documented by CP-NNN: Current Order: Duplicate Olanzapine 15 mg QHS agitation + high dose Quetiapine 400 mg 3 times a day Autism with behavior and agitation(manufacturer max dose=800 mg/day). CMS requires review of antipsychotics for Gradual Dose Reduction(GDR) within 2 weeks of admission. Antipsychotics are high risk list medications due to increased mortality from stroke, metabolic disorders and falls from sedation, movement disorders and orthostatic hypotension. Resident also on Buspar 30 mg twice daily anxiety + Lorazepam 1 mg q4h PRN agitation + Amitriptyline 50 mg qhs sleep + Temazepam 30 mg qhs PRN sleep 7/3/25. Also, on Depakote 625 mg three times daily + Oxcarbazepine 600mg twice daily for seizures which may also be helpful for mood and behaviors. Recommendation: Please consider a trial dose reduction to assess continued need for treatment and check one of the following: -Medication to be continued as ordered. Discontinuation of therapy likely will be harmful to resident (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and/or others, or it will interfere significantly with the provision of care for others. -Reduce the current order to Quetiapine 400 mg three times daily due to max per manufacturer and continued 15 mg qhs. Surveyor noted neither recommendation/option was checked for both. A handwritten note with no signature on the form documents:…”Olanzapine addressed on 7/18 Rept Quetiapine continued as is”… R11's facility progress note dated 9/25/25, at 1:37 PM, documented: …”Pharmacist reviewed/recommendation made/see separate report.”… 3.The Pharmacy “Note to Attending Physician/Prescriber” printed 9/25/25 and documented by CP-NNN: Current Order: Please clarify the following order from admission 9/12/25 for potential transcription error and potential risk for falls 1.Valproate 250 mg/5ml-give 5ml peg tube three times daily for seizure 625 mg three times daily. Please note 7.5v ml=375 mg not 625 mg. Resident was on 625 mg three times daily prior to readmit and discharge summary 9/12 notes 625am/625noon/625evening -Please notify prescriber resident was taking 5 mg(250 mg) 9/12 and then 7.5(375 mg) 9/20. Does of 625 mg=12.5 ml. 2.Lorazepam 1 mg q4h scheduled 00,4,8,12,16,20. Resident was on PRN prior 8/5/25. Scheduled 6 times a day may be viewed as chemical restraint since lowest possible dose not used. Please consider change back to PRN. 3.Olanzapine 30 mg qhs. Resident on 15 mg twice daily(increased from 15 mg qhs 7/18/25 prior readmit. -Should order be divided and given 15 mg twice daily or cx 30 mg qhs. 4.Temazepam 30 mg qhs insomnia 9/12/25. Resident on PRN prior admit. Discharge summary 9/12/25 notes PRN. Temazepam with 0 use prior admit to hospital and now scheduled. -Please clarify Temazepam order and if it should be PRN or scheduled. Surveyor noted neither recommendation/option was checked for the three. A handwritten note with no signature on the form documents:…”reviewed with MD 9/28/25 via phone.”… On 9/28/25, at 10:45 AM, Nursing Home Administrator (NHA)-A documented:…”Writer reviewed resident's medication since admission with MD. Amlodipine should remain discontinued due to blood pressures obtained at facility with some hypotensive results noted. Temazepam should remain scheduled instead of PRN to assist him with sleeping at night. Valproic acid was increased to (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the 625 mg level with follow-up for possible drug level check in a few weeks. Seroquel returned to 400 mg three times daily due to noted increases in expressions. On 9/25/25, at 2:50 PM, Surveyors interviewed Director of Nursing (DON)-B in regard to what the process is and who is responsible for following up on pharmacy recommendations. DON-B reported the pharmacy sends DON-B an email and then DON-B notifies the Nurse Practitioner or Physician. On 9/29/2025, at 2:44 PM, Surveyor shared with DON-B, Regional Director of Operations (RDO)-XX, and Director of Operations (DO)-YY the concern that R11's pharmacy reports were not being acknowledged by the physician with the recommendations as well as to discontinue or keep the medication orders the same. No further information has been provided by the facility at this time.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review the Facility did not ensure there was a medication error rate below 5 percent. There were 2 medication errors in 25 opportunities which resulted in a medication error rate of 8%. Two medication errors were identified for R71.R71 Pantoprazole Sodium 20 mg was not available to be administered and after receiving Advair inhaler, LPN-MM did not have R71 rinse & spit. Findings include:The facility's policy titled, Oral Inhalations and dated 01/23 under procedures documents 15. For steroid inhalers, provide resident with cup of water and instruct him/her to rinse mouth and spit water back into cup.On 9/23/25, at 9:37 a.m. Surveyor observed Licensed Practical Nurse (LPN)-MM prepare R71's medication which consisted of Metoprolol Tartrate 12.5 mg (milligrams), Gabapentin 100 mg, Eliquis 5 mg, Furosemide 40 mg, Isosorbide Monitrate 30 mg, Aspirin 81 mg, Vitamin D3 25 mcg (micrograms), Hydrocodone-Acetaminophen 5-325 mg and Fluticasone Propionate & Salmeterol 250mcg/50 mcg (Advair) inhaler.On 9/23/25, at 9:42 a.m., LPN-MM informed Surveyor R71 is out of Pantoprazole Sodium 20 mg. LPN-MM stated she ordered the medication in the computer and will call the pharmacy at the end of her shift.On 9/23/25, at 9:47 a.m. Surveyor verified the number of pills in the medication cup with LPN-MM. On 9/23/25, at 9:50 a.m., LPN-MM placed gloves on and entered R71's room. R71's wife informed LPN-MM R71 is not feeling well. LPN-MM informed Surveyor the NP was here earlier and was going to check with Nurse Practitioner (NP)-K as NP-K informed her R71 has cellulitis, was placed on an antibiotic but not that R71 was out of it. On 9/23/25, at 10:03 a.m., LPN-MM spoke with NP-K who accompanied LPN-MM to R71's room. NP-K informed LPN-MM to give R71 Eliquis and Advair.On 9/23/25, at 10:13 a.m. LPN-MM administered R71 Eliquis 5 mg whole with water. After administering R71's PO (by mouth) medication, LPN-MM administered R71's Fluticasone Propionate & Salmeterol 250 mcg/50 mcg (Advair) inhaler. Surveyor observed on the inhaler is a blue label which states rinse mouth after each use. LPN-MM did not offer to have R71 rinse & spit after.This observation resulted in two medication errors for R71 as Pantoprazole Sodium 20 mg was not available to be administered and LPN-MM did not offer to have R71 rinse & spit after receiving Advair inhaler.R71's physician orders include with an order date of 12/9/24 documents Advair Diskus Inhalation Aerosol Powder Breath Activated 250-50 MCG/ACT (micrograms/actuation) (Fluticasone-Salmeterol) 1 puff inhale orally two times a day for Rinse mouth with water and spit after each use related to Chronic Obstructive Pulmonary Disease, Unspecified (J44.9). On 9/25/25, at 12:06 p.m., Surveyor asked LPN-Y after giving a resident Advair, should the nurse have the resident rinse and spit. LPN-Y replied yes. On 9/25/25, at 12:51 p.m., Surveyor asked Director of Nursing (DON)-B after a resident receives Advair should staff offer to have the resident rinse and spit. DON-B replied yes. Surveyor asked DON-B when a resident's medication is reordered so the resident doesn't run out of any of their medication. DON-B replied when there are about five doses left. Surveyor informed DON-B after R71 received Advair LPN-MM did not have R71 rinse and spit. Surveyor had noted a blue label on the Advair inhaler which indicates to rinse & spit after use. Surveyor also informed DON-B R71's Pantoprazole Sodium 20 mg was not available. Surveyor informed DON-B this resulted in two medication errors.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure therapy services were provided in a timely manner for 2 (R11 and R50) of 2 residents reviewed for therapy services. *R11 has a MD order to start therapy services initiated on 9/11/25. R11 did not have a therapy evaluation until 9/22/25. *R50 was admitted to the facility on [DATE]. On 6/20/25, R50's MD documented that R50 should have a Physical (PT) and Occupational therapy (OT) evaluation and treatment. R50 was not evaluated and treated by PT and OT until 7/11/25. Findings include: The facility policy with a reviewed/revised date of 11/12/24 and titled, “Therapy Evaluation”, documents, in part: The licensed Therapist will perform an initial resident evaluation upon physician referral and re-evaluation where indicated . The rehabilitation department will be notified when a physician order is written for therapy evaluation and treatment. The licensed therapist will perform a chart review and initiate the evaluation. The initial evaluation will include, but is not limited to, the following: Resident name, date of birth , and health insurance or ID number. Diagnosis (treatment diagnosis and medical diagnosis). Past medical history. Prior level of function. Current functional level, including illness severity or complexity, as well as cognitive status. Rehabilitation potential/severity. Short- and long-term goals and time frames for completion. Treatment plan of care to accomplish goals. Resident's social support network and discharge plan. Initial evaluation will be completed as per facility policy. Evaluations will be documented, signed by licensed therapist, printed/uploaded, and placed in the resident's chart. Completed evaluation will be signed by the physician. *R50 was admitted to the facility on [DATE] with diagnoses that include Chronic respiratory failure with tracheostomy (a tube inserted into an airway to facilitate breathing), Quadriplegia (loss of motor function in all four limbs), Epilepsy (seizure disorder), Gastrostomy (feeding tube inserted into stomach to provide nutrition and medications), Stroke with hemiplegia (one sided weakness) and Metabolic encephalopathy (impaired brain function due to a systemic problem). R50's admission Minimum Data Set (MDS) assessment dated [DATE] documents R50 is severely cognitively impaired. R50 is dependent for all cares, toileting and mobility. R50's MD order initiated on 6/16/25 documents: PT/OT/ [speech therapy]/ [respiratory therapy] to evaluation and treat as indicated. R50's admission History and Physical (H&P) completed by Medical Director (MD)-J and dated 6/20/25 documents, in part… The medical problems that were addressed today: Brain tumor glioblastoma [status post] chemotherapy, radiation and craniectomy. G-tube dependent, trach dependent, nonverbal, quadriplegic, bedridden: PT OT to eval and treat… Surveyor reviewed R50's PT and OT evaluation and visit notes and noted that R50 started PT and OT on 7/11/25. Surveyor noted R50 did not start PT/OT for over 3 weeks after admission. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/29/25 at 2:57 PM, Surveyor interviewed MD-J. Surveyor asked if MD-J wanted R50 to participate in PT and OT after admission as documented in MD-J‘s H&P. MD-J stated absolutely. Surveyor informed MD-J that R50 did not start PT/OT until over 3 weeks of admission. Surveyor asked if R50 should have been evaluated sooner. MD-J stated R50 absolutely should have started closer to admission. MD-J stated that R50 is a critical and complicated medical case and would benefit from therapies at least weekly after admission. R50's Physician progress note dated 6/26/25 at 11:03 AM, documents, in part: … Continue to monitor for any increase in tone. Continue PT to improve strength, balance and coordination related to hemiplegia and deficits in proprioception… Surveyor noted R50's provider thought R50 was in PT when R50's progress note was written on 6/26/25. Surveyor noted R50 was not participating in PT/OT services on 6/26/25. On 9/29/25, Surveyor was given a one-page paper document form, “Screening tool” dated 6/17/25. R50's name is on the paper form. The following is documented on the form, in part: Purpose-Admit. Wheelchair, Mobility, [Activities of daily living], Bathing, Feeding, Toileting: Dependent. Diet: Tube fed… Recommendations: No eval. Comments: Baseline… On 9/29/25 at 10:20 AM, Surveyor interviewed Therapy Director (TD)-VV. TD-VV stated that TD-VV started this position on September 8th. Surveyor asked about the R50's paper document screening tool. TD-VV stated that this form was from the last therapy director. TD-VV stated that TD-VV had not seen this form and was searching for any documentation about R50's therapy evaluation on admission. TD-VV asked Surveyor for a copy of the form. Surveyor asked if this form is typically used. TD-VV stated that evaluations and screening should be entered into the computer and is not a paper document. Surveyor asked how long it takes for a newly admitted resident to be seen by therapy. TD-VV stated that typically a resident who was just admitted and has a MD order or consult for therapy will be evaluated within 3 days of admission. Surveyor showed TD-VV R50's admission H&P and MD order. Surveyor asked why R50 did not start treatment therapies until 7/11/25. TD-VV stated that R50 should have had a full evaluation closer to admission. Surveyor asked if the paper documentation is a full evaluation. TD-VV stated no and indicated that R50 should have had a more thorough evaluation than what is listed on the paper form. Surveyor asked if there was a change that R50 experienced that led to R50 being evaluated on 7/11/25 instead of closer to admission. TD-VV stated that TD-VV was not aware and did not know if anything changed but TD-VV knows that R50 should have been more thoroughly evaluated sooner. On 10/1/25 at 1:45, Surveyor informed Nursing Home Administrator (NHA)-A of the concern that R50 was admitted on [DATE]. R50 had a MD order, and documentation in R50's admission H&P that R50 should be evaluated and treated by PT and OT. R50 did not start receiving therapy services until 7/11/25. 2.) R11 was admitted to the facility on [DATE] with diagnoses of Autistic Disorder (affects how people interact with others, communicate, learn, and behave.), Repeated Falls, Unspecified Intellectual Disabilities (individual exhibits significant limitations in both intellectual functioning and adaptive behavior), Epilepsy (chronic neurological condition characterized by recurrent seizures, which are episodes of shaking and convulsions), Mood [Affective] Disorder (persistent and significant changes in mood, emotions, and behavior), Anxiety Disorder (excessive worry, fear, and nervousness that can interfere with daily life) and Gastrostomy (surgical procedure that creates an opening in the stomach through the abdominal wall to allow for feeding and medication administration (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	directly into stomach). R11 currently has a legal guardian. R11's admission Minimum Data Set (MDS) completed 7/9/25 documents R11 demonstrates severely impaired cognitive skills for daily decision making and has short and long term memory deficits. R11's Patient Health Questionnaire (PHQ)-9 score is documented as 14 indicating R11 demonstrates moderate depressive symptoms. R11 demonstrates physical behaviors that significantly interferes with resident care, participation in activities, intrudes on privacy or activity of others, disrupts care of living environment. R11's MDS also documents that R11 demonstrates rejection of care and wandering daily. R11's has no range of motion impairment. R11 requires supervision for eating (at time of MDS, R11 was nothing by mouth (NPO), dependent for showers. R11's MDS requires partial/moderate assistance for upper dressing and substantial/maximum for lower body dressing. R11 is independent for mobility and transfers. R11's current physician orders document: PT(physical therapy)/OT (occupational therapy)/ST (speech therapy)/RT (respiratory therapy) to evaluate and treat as indicated with an order date of 9/11/25. Speech Therapist (ST)-PPP documented a screen was completed on 9/11/25. ST-PPP documents due to severity of disability and recommended nothing by mouth (NPO), no treatment indicated at this time. An unsigned therapy screen completed 9/22/25 documents R11 would not benefit from skilled therapy services as R11 is currently at baseline with functional mobility. R11 has demonstrated aggressive behaviors, limiting R11's participation and proving unsafe for therapy. Surveyor notes that therapy disciplines did not attempt to screen R11 again for rehabilitation services and relied only on previous documentation of therapy disciplines. On 9/24/2025, at 12:48 PM, Surveyor interviewed Rehabilitation Director (Therapy Director)-VV. Therapy Director-VV stated a screen and/or evaluation should be completed within three days of a physician order. Therapy Director-VV stated the screen should be completed first and then the continued evaluations. Therapy Director-VV stated that R11 has been at baseline and nursing reports no changes. On 9/24/2025, at 2:57 PM, Surveyor shared with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, Regional Director of Operations (RDO)-XX, and Director of Operations (DO)-YY the concern that R11 was readmitted to the facility on [DATE] and current physician orders document a PT, ST, and OT evaluation was ordered on 9/11/25. A screen was not completed until 9/22/25, 11 days later for OT and PT, and a ST screen was completed on 9/11/25. Surveyor shared that OT, PT, and ST screens were completed based on documentation only and not actually physically re-assessing after re-admission to the facility after a lengthy hospitalization. Surveyor shared given the number of falls R11 continues to have, it is concerning that OT and PT have not been involved with new interventions to prevent R11 from falling. No further information has been provided by the facility at this time as to why there was a delay in completing therapy screens. On 9/29/2025, at 10:25 AM, Therapy Director-VV stated that typically there should not be a delay. Therapy Director-VV does not know who ordered therapy services on 9/11/25.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure 1 (R12) of 5 residents were offered/administered the pneumonia vaccine and/or influenza vaccine. R12 was admitted to the facility on [DATE] and was not offered or administered the influenza vaccine.Findings include:The facility's policy titled Influenza Vaccination, dated 5/29/24 documents the following:It is the guideline of this facility to minimize the risk of acquiring, transmitting or experiencing complications from influenza by offering our resident's, staff members, and volunteer workers annual immunization against influenza.The facility's policy titled Pneumococcal Vaccine, dated 12/3/24, last reviewed 1/30/25, documents the following:It is our policy to offer residents and staff immunization against pneumococcal disease in accordance with current Center for Disease Control (CDC) guidelines and recommendations:Each resident will be assessed for pneumococcal immunization upon admission. Self-report of immunization shall be accepted. Any additional efforts to obtain information shall be documented, including efforts to determine date of immunization or type of vaccine received.Each resident will be offered a pneumococcal immunization unless it is medically contraindicated, or the resident has already been immunized.R12 was admitted to the facility on [DATE]. R12 is [AGE] years old. R12's diagnoses include chronic respiratory failure (the lungs are unable to adequately exchange oxygen and carbon dioxide), congestive heart failure (a condition where the heart muscle is weakened and cannot pump blood effectively), and chronic kidney disease (a condition where the kidneys are unable to filter waste products and excess fluid from the blood). Surveyor reviewed R12's EMR and was unable to locate whether R12 was offered, received, or declined the influenza immunization.On 9/24/25, at 10:01 AM, Surveyor interviewed Unit Manager (UM)-F who states she will review immunization records for all new and current residents. IP-QQQ states she will offer influenza and pneumococcal immunizations to residents and review with their Power of Attorneys (POA) if their POA is activated. Surveyor asked UM-F who is responsible for verifying the influenza and pneumococcal immunizations are up to date and UM-F states she handles consents, and UM-F and floor staff administer the vaccinations. UM-F states education is provided verbally to the resident or Activated Power of Attorney (APOA) if they decline and document in the immunization tab in the EMR. Surveyor notified UM-F of concerns R12's EMR does not contain any documentation as to whether R12 was offered, received, or declined the influenza vaccine. UM-F stated R12 declined to provide R12's social security number (SSN) for staff to look up the immunization record in the Wisconsin Immunization Record (WIR). UM-F states R12 refused immunizations but will look into it.On 9/24/25, at 11:15 AM, UM-F provided Surveyor handwritten documentation regarding immunizations.Surveyor notes the following handwritten documentation:COVID-19 baseline testing consent form with R12's name handwritten on top of the consent form indicating on 4/25/25, R12 declined to provide SSN to look up record and conversation of immunizations. On 4/28/25, R12 declined immunization conversation. On 6/9/25, R12 declined immunization conversation. Surveyor notes this form for R12 is for COVID-19 and does not document influenza vaccines.Surveyor asked UM-F why this was not included in R12's EMR. UM-F states she was not in the IP role at the time and the previous IP documented this in the computer. Surveyor also asked if there were any recent attempts made to offer R12 their vaccines, and UM-F states no further offers for vaccines have been made to R12 other than what is documented.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure medical records contained documentation related to COVID-19 immunizations for 3 (R9, R11, R12) of 5 residents reviewed for immunizations.R9's Electronic Medical Record (EMR) does not contain any documentation as to whether R9 was offered, received, or declined the COVID-19 immunization.R11's EMR does not contain any documentation as to whether R11 was offered, received, or declined the COVID-19 immunization.R12's EMR does not contain any documentation as to whether R12 was offered, received, or declined the COVID-19 immunization.Findings include:The facility's policy titled COVID-19 Vaccination, dated 10/31/24, last reviewed 1/30/25, documents the following:It is the policy of this facility to minimize the risk of acquiring, transmitting or experiencing complications from COVID-19 by educating and offering our residents and staff the COVID-19 vaccine.1.) R9 was admitted to the facility on [DATE]. R9 is [AGE] years old and has a Guardian. R9's diagnoses include tracheostomy (an incision in the windpipe to relieve an obstruction to breathing), encephalopathy (a medical condition that affects the brain's function), laryngeal hypoplasia (a condition where the larynx/voice box is underdeveloped) , aneurysm of artery (a bulge in the wall of an artery, caused by a weakening of the vessel wall), and Type 2 Diabetes, (condition where the body does not use insulin effectively). Surveyor reviewed R9's EMR and was unable to locate whether R9 was offered, received, or declined the COVID-19 immunizations in 2023, 2024, or 2025. Surveyor notes R9 received the COVID 19 Moderna Booster on 5/3/2022.2.) R11 was admitted to the facility on [DATE]. R11 is [AGE] years old and has a Guardian. R11's diagnoses include autistic disorder (a condition related to brain development), epilepsy (a neurological disorder characterized by recurrent, unprovoked seizures), dementia (a decline in cognitive abilities, such as memory, thinking, and problem solving), dysphagia (difficulty swallowing), and gastrostomy (a tube placed in the stomach to administer food, medications, and fluids). Surveyor reviewed R11's EMR and was unable to locate whether R11 was offered, received, or declined the COVID-19 immunizations.3.) R12 was admitted to the facility on [DATE]. R12 is [AGE] years old. R12's diagnoses include chronic respiratory failure (the lungs are unable to adequately exchange oxygen and carbon dioxide), congestive heart failure (a condition where the heart muscle is weakened and cannot pump blood effectively), and chronic kidney disease (a condition where the kidneys are unable to filter waste products and excess fluid from the blood). Surveyor reviewed R12's EMR and was unable to locate whether R12 was offered, received, or declined the COVID-19 immunizations.On 9/24/25, at 10:01 AM, Surveyor interviewed Unit Manager (UM)-F who states she will review immunization records for all new and current residents. UM-F states she will offer COVID 19 immunizations to residents and review with their Power of Attorneys (POA) if their POA is activated. Surveyor asked UM-F who is responsible for verifying COVID-19 immunizations are up to date and UM-F states she handles consents, and UM-F and floor staff administer the COVID 19 vaccinations. UM-F states education is provided verbally to the resident or Activated Power of Attorney (APOA) if they decline and document in the immunization tab in the EMR. Surveyor notified UM-F of concerns with R9, R11, and R12's EMR does not contain any documentation as to whether R9, R11, and R12 were offered, received, or declined the COVID-19 immunization. UM-F stated R12 declined to provide R12's social security number (SSN) for staff to look up the immunization record in the Wisconsin Immunization Record (WIR). UM-F states R12 refused the COVID-19 immunization but will look into it. UM-F states R9 goes in and out of the hospital which is why R9 was not offered the COVID-19 immunization.On 9/24/25, at 11:15 AM, UM-F provided Surveyor handwritten documentation regarding COVID-19 immunizations.Surveyor notes the following handwritten documentation:R9's personal immunization history form with VM (voicemail) on 8/1/25 (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and 8/5/25. No further documentation is noted and Surveyor notes this is not in R9's EMR. Surveyor notes R9's personal immunization history documentation indicates COVID-19 vaccine is recommended now.R11's personal immunization history form with VM on 7/7/25, 7/8/25, 7/10/25, 7/15/25, 8/20/25, and 8/25/25. No further documentation is noted and Surveyor notes this is not in R11's EMR. Surveyor notes R11's personal immunization history documentation indicates COVID-19 vaccine is recommended now.COVID-19 baseline testing consent form with R12's name handwritten on top of the consent form indicating on 4/25/25, R12 declined to provide SSN to look up record and conversation of COVID-19 vaccine. On 4/28/25, R12 declined immunization conversation. On 6/9/25, R12 declined immunization conversation.Surveyor asked UM-F why this was not included in R9, R11, and R12's EMR. UM-F states she was not in the IP role at the time and the previous IP documented this in the computer. Surveyor also asked if there were any recent attempts made to R9, R11, and R12 for their COVID-19 vaccine, and UM-F states no further offers for COVID-19 vaccines have been made to R9, R11, and R12 other than what is documented.On 9/29/25, at 9:23 AM, Surveyor notified Director of Nursing (DON)-B of concerns with R9, R11, and R12's EMR does not contain any documentation that the COVID-19 vaccine was offered, received, or declined. DON-B acknowledged these concerns.