STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525314	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Mills Health Services	901 Mulberry St Lake Mills, WI 53551

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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 - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure the facility that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider or a discharge summary that includes a recapitulation of the resident's stay to ensure a safe and orderly discharge for 2 (R2, R4) or 2 residents.* R2 has no documented discharge summary included recapitulation of R2's stay in the facility in R2's medical record. There was not documentation that R2 was explained or educated on medications, follow up appointments, self-catheterization or therapies that R2 was to receive after discharge home. * R1 had no discharge documentation, including a recapitulation of R1's stay, sent with R1 when R1 was discharged on 6/11 to an assisted living facility until R1 was already discharged from the facility and residing at the assisted living facility.Findings include:The facility's policy titled, Transfer and discharge: Implemented: June 2017, Reviewed: July 15, 2022, documents:Anticipated Transfers or Discharges-initiated by the resident.A. Obtain physicians' orders for transfer or discharge instructions of precautions for ongoing care.B. A member of the interdisciplinary team completes relevant sections of the discharge summary. The nurse caring for the resident at the time of discharge is responsible for ensuring the Discharge Summary is complete and includes but is not limited to the following:i. A recap of the resident's stay that includes diagnosis, course of illness/treatment or therapy, and pertinent lab, radiology and consultation results.ii. A final summary of the resident's status.iii. Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over the counter). iv. A post discharge plan of care that is developed with the participation of the resident, and the resident's representative(s) which will assist the resident to adjust to his or her new living environment.C. Orientation for transfer or discharge must be provided and documented to ensure safe and orderly transfer or discharge from the facility, in a form and manner that the resident can understand. Depending on the circumstances, this orientation may be provided by various members of the interdisciplinary team. D. Assist with transportation arrangement to the new facility and any other arrangements as needed.E. The comprehensive, person-centered care plan shall contain the resident's goals for admission and desired outcomes and shall be in alignment with the discharge. F. Supporting documentation shall include evidence of the resident's or resident's representative's verbal or written notice of intent to leave the facility, a discharge plan, and documented discussions with the resident and/or resident representative.1.) R2 was admitted to the facility on [DATE] with diagnosis that include urinary tract infection, hydronephrosis (a condition where the kidney swells due to a buildup of urine, typically caused by a blockage or obstruction in the urinary tract), and acute kidney injury. R2's Discharge Minimum Daily Set (MDS) with an assessment reference date of 4/02/25 documents a Brief Interview for Mental Status score of 14, indicating R2 as being cognitively intact. Under section GG Functional abilities and goals it documents R2 as requiring set up or clean up assist (helper sets up of cleans up resident completes activity. with Chair/bed to chair transfer, toileting hygiene and shower and bathing.R2's non-pressure weekly tracker dated 3/29/25, at 2:05 PM documents R2 had a skin tear acquired on the right dorsal foot. Measured: Length1.5x Width 0.1. Tissue type: 75% epithelial and 100% granulation with light bloody drainage.R2's physician's order dated 03/31/25 documents (PT and OT) physical and occupational therapy 5 times a week for 4 weeks. R2's nursing note dated 4/2/25, at 4:35 PM, documents the current resident status is resident has discharged to home and skin is healed.On 6/26/25, at 11:27 AM Surveyor interviewed Nursing Home Administrator (NHA)-A about R2's discharge process. Surveyor asked if the facility documented all the education and discharge instructions for R2's discharge to home on 4/2/25. NHA-A informed Surveyor that it was documented that R2 was discharged home. Surveyor asked NHA-A if a recapitulation of R2's stay including any home health or PT and OT that R2 was to receive once R2 was home and was this information included in R2's discharge summary. NHA-A informed Surveyor that R2 was involved in R2's discharge. Surveyor asked NHA-A where that information was documented, because Surveyor noted a very basic summary stating that R2 was discharged home. NHA-A informed Surveyor that R2 was provided all information required when R2 was discharged . Surveyor asked NHA-A where that information was documented and could NHA-A provide the Surveyor with the documentation. NHA-A informed Surveyor that R2 declined PT, OT and Home Health services. Surveyor asked NHA-A if the Surveyor could see that documentation in R2's medical record. NHA-A informed Surveyor that R2's declination of service was not in the medical record, but that NHA-A sent out

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R1's IDT (interdisciplinary team) clinical review note dated 6/2/25, at 9:23 a.m. , written by Previous Nursing Home Administrator (NHA)-I documents Interdisciplinary team reviewed fall at morning meeting. Resident has cognition deficit and is impulsive. OT (occupational therapy) to work on safe toileting techniques. Resident also had a visit from ALF (Assistant Living Facility) this day. Care plan updated. R1's social service note dated 6/2/25, at 15:47 (3:47 p.m.), written by NHA-A, who was the previous social worker, documents Writer spoke with resident's AHCPOA (activated health care power of attorney) stated resident is agreeable at times and other times needs redirection regarding the importance of going to [Assisted Living Facility Name]. Writer placed call to [Assisted Living Facility Name] and left voicemail for DON (Director of Nursing) to discuss documents needed for a smooth transition.R1's physician orders dated 6/3/25 documents May discharge to [Name] Memory Care facility when bed is available on currently prescribed medications.R1's progress note dated 6/3/25, at 19:21 (7:21 p.m.), written by Registered Nurse (RN)-J under summary documents Resident pleasant and cooperative. Alert and Ox3 (orientated times three). No c/o (complaint of) pain. Therapeutic diet. Independent with meals. Possible d/c (discharge) tomorrow. Resident aware but stated, might not be tomorrow. Order is in place however.R1's social service note dated 6/10/25, at 9:23 a.m., written by NHA-A, who was the previous social worker, documents Writer spoke with resident's AHCPOA on 6/9 to issue NOMNC (Notice of Medicare Non-Coverage) with LCD (last covered date) of 6/11 and discharge of 6/12. Writer received an email from AHCPOA stated she was not able to access the document. Writer resent NOMNC for AHCPOA to sign. AHCPOA notified writer that she will have resident discharge to [Assisted Living Facility Name] on 6/11.R1's Recapitulation of Stay - Discharge Summary with an effective date of 6/10/25 Section A. discharge information was e-signed on 6/15/25 by Director of Nursing (DON)-B. Section B Social Services was e-signed on 6/10/25 by Nursing Home Administrator (NHA)-A, who was the former social worker, on 6/10/25. Section C Nursing and rehab Services was e-signed on 6/15/25 by DON-B. Section D Dietary Services & Section E Activity Summary was e-signed on 6/10/25 by NHA-A. Section F Physician Signature was signed on 6/19/25.R1's discharge note dated 6/11/25, at 13:00 (1:00 p.m.), written by Licensed Practical Nurse (LPN)-E documents Discharge Location: ALF. discharged With: Res (Resident) discharged with all personal belongings and personal W/C (wheelchair). Family here assisted res with belongings. Belongings: Medications: All medication returned to pharmacy. Skin check: Vitals: Additional Information: Res in good spirits, 0 c/o (complaint of) pain/discomfort. On 6/26/25, at 9:32 a.m., Surveyor spoke with Assisted Living Staff-K on the telephone. Surveyor asked Assisted Living Staff-K if the facility sent a discharge summary with R1 when she was transferred to their facility on 6/11/25. Assisted Living Staff-K replied no, I had to call and ask them to send it. Assisted Living Staff-K informed Surveyor they did send discharge orders which were their admitting orders.On 6/26/25, at 11:19 a.m., Surveyor informed LPN-E her discharge note does not include what paperwork was sent with R1 when she was discharged to the assisted living facility on 6/11/25 and inquired how would Surveyor know what paperwork was sent. LPN-E informed Surveyor she didn't have to send any paperwork as it was already taken care of. Surveyor asked LPN-E who would of sent the discharge summary. LPN-E replied [first name of Medical Records Coordinator (MRC)-L].On 6/26/25, at 11:28 a.m., Surveyor asked MRC-L if she is involved when a resident is discharged . MRC-L replied yes and explained when the Social Worker or Director of Nursing (DON) as her to do something. MRC-L explained she'll print off the orders and get the orders signed by the medical doctor. Surveyor asked MRC-L if she was involved with R1's discharge. MRC-L replied I was not, she went to another facility. I got the orders signed by the doctor.On 6/26/25, at 11:58 a.m., Surveyor asked DON-B what is the process when a resident is discharged to another facility. DON-B explained they get orders, some assisted living facilities want their medication, others don't want the medication, the Nurse Practitioner comes every Thursday and will sign the discharge. DON-B informed

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No additional information was provided.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure residents with non pressure wounds received treatment and care in accordance with professional standards of practice for 1 (R1) of 1 residents reviewed with a non-pressure wound.R1 was admitted with a right lower extremity wound on 5/14/25. On 5/21/25, R1's wound treatment was changed. The facility did not recognize the scheduled treatment, only the PRN (as needed) portion of the order was implemented. R1 was not provided with treatment to the right lower extremity wound from 5/21/25 to 5/27/25 when the wound was identified as being healed.Findings include:The facility's policy titled, Pressure Injuries and Non Pressure Injuries and reviewed/revised 7/20/22 under policy documents: For those residents admitted with, or who subsequently developed a pressure injury or impaired skin integrity, they will receive care, treatment, and services that seek to promote healing, prevent infection, and prevent further development of pressure injuries/impaired skin integrity. The following protocols should guide prevention and treatment efforts, unless specified by a physician otherwise. Examples of impaired skin integrity include, but are not limited to, pressure injuries, venous (stasis) ulcers, arterial (ischemic) ulcers, diabetic (neuropathic) ulcers, surgical wounds, skin tears, and rashes.R1's diagnoses includes lymphedema (tissue swelling often in an arm or leg), venous insufficiency, and non pressure chronic ulcer of other part of right lower leg.R1's admission assessment dated [DATE] documents under the skin integrity section includes documentation of skin issues to the right lower leg front.R1's physician order dated 5/14/25 documents Wound care to bilateral lower extremities: remove old dressing, wash wounds with soap and water rinse areas and pat dry. Apply 3 layer profore wrap from base of toes to base of knee q (every) Tuesday and Friday, every day shift every Tue (Tuesday), Fri (Friday). This treatment was discontinued on 5/21/25.R1's physician order with an order & start date of 5/21/25 documents Wash RLE (right lower extremity) with soap and water pat dry apply calcium alginate to small open area to R (right) lat (lateral) shin cover with a 2 x (by) 2 then wrap leg with ace wrap from mid foot to knee daily and prn as needed.Surveyor reviewed R1's May TAR (treatment administration record). Surveyor noted R1's treatment with an order date & start date of 5/21/25 was not scheduled for daily and was only scheduled for PRN. Surveyor noted from 5/21 to 5/31 there are no checks & initials indicating the treatment was provided PRN. R1's wound evaluation dated 5/27/25 by Wound Physician-G documents Lymphademic wound of the right leg (resolved on 5/27/25).On 6/30/25, at 9:27 a.m., Surveyor informed Director of Nursing (DON)-B R1 was admitted with a right lower leg wound. On 5/21/25 the physician changed R1's treatment to wash the right lower extremity with soap & water, pat dry, apply calcium alginate and cover with a two by two daily and as needed. Surveyor had reviewed R1's May 2025 treatment record, noted this order was in the prn orders but did not see the scheduled order. Surveyor informed DON-B daily treatment was not provided until the wound healed on 5/27/25. DON-B informed Surveyor she will look into this and get back to Surveyor. On 6/30/25, at 1:40 p.m., Surveyor asked DON-B if there is any information as to why R1's treatment ordered on 5/21/25 and scheduled daily was not provided. DON-B did not have any information to provide to Surveyor.No additional information was provided as to why the facility did not ensure R1 received treatment and care in accordance with professional standards of practice for R1's non-pressure related wound.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that residents with a pressure injury or at risk for pressure injuries received necessary treatment and services, consistent with professional standards of practice, to prevent the development of pressure injuries and to promote healing for 2 (R1 andR4) of 3 residents reviewed for pressure injuries. * R1 admitted to the facility on [DATE] with a hospital discharge summary that included treatment for R1’s right ischium. This treatment was not picked up by the facility. On 5/14/25, the facility documented a stage 2 pressure injury (PI) to R1’s right buttock. Wound Physician-G’s treatment recommendation for the right buttock was not completed by the facility. On 5/27/25, the right buttock PI was noted to have declined, and Wound Physician-G changed the treatment orders. These orders were not picked up by the facility, and the facility did not develop a PI care plan for R1. The facility also failed to implement physician’s treatment orders from 6/3/25 and 6/10/25. Facility also documented R1 as having a right trochanter (hip) PI and a right lower leg vascular wound. When R1 was discharged to an Assisted Living (AL) facility on 6/11/25, the AL noted R1 had a stage 2 open area on her right buttock and 2 open areas on the left gluteal fold. The areas were warm to touch and painful with no dressings or ointments, and resident had blood in her brief where the wounds had made contact. Resident was sent to the hospital for evaluation and determined to have a coccygeal abscess which was concerning for osteomyelitis and a left buttock abscess. The facility's failure to provide care and promote the healing of R1's pressure injury, the failure to develop R1's pressure injuries care plan, and the failure to implement physician ordered treatments created a finding of Immediate Jeopardy (IJ) that began on 5/27/25. Surveyor notified NHA (Nursing Home Administrator)-A, DON (Director of Nursing)-B, and [NAME] President (VP) of Success-C of the immediate jeopardy on 6/30/25 at 1:20 p.m. The immediate jeopardy was removed on 6/30/25. The deficient practice continues at a scope and severity of G related to the example involving R4 and as the facility continues to implement its action plan. * R4 developed 3 stage 2 pressure injuries in 15 days. The residents care plan was not changed until 6/26. The resident was at risk was not provided with an air mattress for pressure relief for 14 days. R4 then developed an unstageable pressure injury. Findings include: The facility's policy titled, Pressure Injuries and Non Pressure Injuries, and reviewed/revised 7/20/22 documents under policy: This center will complete a comprehensive assessment to identify risk factors for the development of pressure injuries and put in place measures intended to achieve the goal of prevention of pressure injuries in our residents. For those residents admitted with, or who subsequently developed a pressure injury or impaired skin integrity, they will receive care, treatment, and services that seek to promote healing, prevent infection, and prevent further development of pressure injuries/impaired skin integrity. The following protocols should guide prevention and treatment efforts, unless specified by a physician otherwise. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Policy Explanation and Compliance Guidelines documents: 1. Upon admission: a. A head-to-toe body evaluation will be completed on every resident upon admission/readmission and will be documented on the Admission/readmission Evaluation UDA (user defined assessment). If skin is compromised: i. If pressure Injury: Initiate the Pressure Injury Weekly Tracker UDA - one per wound . iii. Ensure primary care physician (PCP) is aware of wounds/location of wounds and current treatment orders. iv. Ensure appropriate treatment orders for each wound area, as needed. v. Ensure resident/responsible party is awaref wounds and current treatment plan. vi. Evaluate for pain related to wounds and develop management plan if pain related to wounds is present. c. Initiate the baseline plan of care related to current skin status and skin risk level. (The comprehensive care plan will be developed within seven days of the completion of the comprehensive assessment - see below for additional information related to the comprehensive care plan). The Care Plan section documents: A Comprehensive Skin Integrity Care Plan is based on resident history, review of Skin Assessment, Braden Scale Scoring, Nutritional Assessments, resident and family interviews, and staff observations. Consider the areas of risk, as well as overall risk assessment score of the Braden Scale. Communicate identified risk factors and interventions to direct care staff. 1.) R1 was admitted to the facility on [DATE] with diagnoses including hypothyroidism (condition where thyroid gland doesn't produce enough thyroid hormones to meet the body's needs), lymphedema (tissue swelling often in an arm or leg), venous insufficiency, dementia (loss of cognitive function that interferes with a person's daily life and activities), PVD (peripheral vascular disease) (circulatory condition which narrows blood vessels reducing blood flow to limbs), chronic kidney disease (characterized by progressive damage and loss of kidney function) stage 2 (mild), adult failure to thrive, and anxiety disorder. R1's hospital Discharge summary dated [DATE] under Discharge Procedure Orders for wound care instructions documents: Location: R (right) ischium. If necessary, give pain medicine 1 hour prior to starting wound care. Remove all old dressings. Actively wash wound with antibacterial soap (i.e. Dial soap) and water using a washcloth. Rinse completely and pat dry with clean wash cloth or towel. Apply foam border to open area. Dressing changes to be done every other day by floor nurses. We will plan to have [R1's name] follow up in the Burn and Wound Clinic (phone number [number] on 5/22 at 3pm at [Name] Clinic. Surveyor was unable to locate these hospital discharge treatment orders in R1’s record nor is there a progress note indicating R1's physician was notified of these orders. R1's admission evaluation dated 5/14/25 completed by Registered Nurse/Unit Manager (RN/UM)-D has a Braden assessment score of 13 which indicates moderate risk for pressure injuries. The skin integrity section documents: 31) Right buttock. Type documents: pressure, measurements are 0.5 x (times) 0.5 x 0.1. Stage is II (2). Surveyor noted this is not a comprehensive assessment as there is not a description of the wound bed, peri wound, drainage, etc. There are no treatment orders for R1's right buttocks pressure injury identified on the 5/14/25 admission evaluation. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's progress note dated 5/15/25, at 11:00 a.m., by APNP (Advanced Practice Nurse Practitioner)-H under history of present illness documents: [R1's name], female with past medical history of chronic lymphedema, hypothyroidism, CKD (chronic kidney disease) stage 2, anemia, cognitive impairment and hypertension. She was admitted for observation for adult failure to thrive. APNP-H's progress note does not address R1's right buttock pressure injury. Surveyor reviewed R1's care plans and noted the following care plans: Activities initiated 5/20/25, ADL (activities of daily living) self-care deficit initiated 5/14/25, Advanced Directives initiated 5/19/25, Potential for elopement initiated 5/14/25, Cognitive Loss initiated 5/19/25, Difficulty communicating initiated 5/14/25, Urinary incontinence initiated 5/14/25, Bowel incontinence initiated 5/14/25, Dental or oral cavity health initiated 5/14/25, Potential for discharge initiated 5/14/25, At risk for falls initiated 5/14/25, Cardiac disease initiated 5/14/25, Edema/excess fluid volume initiated 5/14/25, At risk for nutritional status initiated 5/14/25, Pain leg initiated 5/14/25, Actual (ulcers at bilateral shins) initiated 5/14/25, Actual (ulcers at bilateral shins initiated 5/20/25, and At risk for retraumatization initiated 5/19/25. Surveyor noted the facility did not develop and implement a comprehensive pressure injury care plan. R1's admission MDS (minimum data set) with an assessment reference date of 5/20/25 has a BIMS (brief interview for mental status) score of 4 which indicates severe cognitive impairment. R1 is assessed as refusing care one to three days. R1 is assessed for eating as independent, roll left and right is partial/moderate assistance, toileting hygiene, showering, chair/bed to chair transfer, and toileting transfer is assessed as substantial/maximal assistance. R1 is frequently incontinent of urine and continent of bowel. R1 is at risk for pressure injury development and is assessed as having one stage 2 pressure injury which was present upon admission. R1's Braden assessment dated [DATE] has a score of 18 which indicates at risk for PIs. R1's pressure CAA (care area assessment) dated 5/23/25 under analysis of findings for nature of the problem/condition documents: Pressure ulcers CAA triggered secondary to actual pressure ulcers. Contributing factors include ADL (activity daily living)/functional/mobility impairment, history of pressure ulcers, actual pressure ulcers, cognitive loss, and use of medications that can contribute to skin breakdown, incontinence, and pain. Risk factors include pain, development of PU (pressure ulcer)/skin condition, and fluid deficit risk. A licensed nurse assess the skin each week. It is also assessed by caregivers with each bath and each time the resident is dressed. The physician is to be notified of any abnormal findings and treatment orders are obtained. Caregivers assist with repositioning at least every two hours and as needed for comfort. Care plan will be initiated or reviewed to improve or maintain current ADL status and functional ability, maintain continence status, prevent pain, and decrease pressure ulcer/fluid deficit risk. Location of documentation see NN (nurses notes), Braden, TAR (treatment administration record), wound nurse documentation and measurements for the look back period. Under care plan considerations for describe impact of this problem/need on the resident and your rational for care plan decision has the exact same documentation as documented under the analysis of findings for nature of the problem/condition. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's pressure injury weekly tracker with an effective date of 5/20/25 completed by Director of Nursing (DON)-B documents for site 31) Right buttock, type is pressure, length 0.5, width 0.5, depth 0.1, and Stage is II (2). Tissue type is granulation tissue, granulation % (percentage) is 100. Drainage is none. Surveyor noted this comprehensive pressure injury assessment was 6 days after R1 was admitted to the facility. Surveyor noted a stage 2 pressure injury does not have granulation and this area should have been staged at a Stage 3. The assessment does not include a description of the wound bed. Wound Physician-G's initial wound evaluation and management summary dated 5/20/25 documents: Stage 2 pressure wound of the right buttocks with wound size (L x W x D) (length times width times depth) of 0.5 x 0. 5 x 0.1 cm (centimeters). There is no description of the wound bed. Under dressing treatment plan for primary dressing documents: Zinc ointment apply Q (every) shift (3x (times) day) and as needed: if saturated, soiled, or dislodged. There is no order for the Zinc ointment and the Zinc ointment is not on R1's May 2025 MAR (medication administration record) or TAR (treatment administration record). R1 was receiving physical and occupational therapy. On 5/27/25, therapy changed R1's status to ad lib for ambulation and getting self dressed. R1's pressure injury weekly tracker with an effective date of 5/27/25 completed by Registered Nurse/Unit Manager (RN/UM)-D documents for site: 31) Right buttock, type is pressure, length is 3, width 0.5, depth 0.1, and stage is blank. Tissue type is granulation tissue. Skin % is 50. Drainage is Serosanguinous and amount of drainage is light. Wound Physician-G's wound evaluation and management summary dated 5/27/25 documents: Stage 2 pressure wound of the right buttock, partial thickness with wound size (L x W x D) of 3 x 0.5 x 0.1 cm. Cluster wound documents open ulceration area of 0.75 cm. Exudate is light sero-sanguineous. There is not a description of the wound bed. Under dressing treatment plan for Primary Dressing(s) documents: Alginate honey-impregnated apply once daily and as needed: if saturated, soiled, or dislodged. Secondary Dressing(s) Gauze island w/bdr (with border) apply once daily and as needed: if saturated, soiled, or dislodged. There is no order for R1's right buttock pressure injury treatment and the treatment recommended by Wound Physician-G is not listed on the May 2025 MAR or TAR. Surveyor noted the facility has still not developed a comprehensive pressure injury care plan and the PI has declined. R1's pressure injury weekly tracker with an effective date of 6/3/25 completed by DON-B documents for site: 31) Right buttock, type is pressure, length is 2, width 0.6, depth 0.1 and stage is II (2). Tissue type is Granulation tissue and Granulation % is 100. Drainage is none. Summary of findings is Worsening. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Wound Physician-G's wound evaluation and management summary dated 6/3/25 documents: Stage 2 pressure wound of the right buttock, partial thickness with wound size (L x W x D) of 2 x 0.6 x 0.1 cm. Cluster wound documents open ulceration area of 0.60 cm. squared. Exudate is Moderate sero-sanguineous. There is not a description of the wound bed. Under dressing treatment plan for Primary Dressing(s) documents: Alginate honey-impregnated apply once daily and as needed: if saturated, soiled, or dislodged. Secondary Dressing(s) Gauze island w/bdr (with border) apply once daily and as needed: if saturated, soiled, or dislodged. There is no order for R1's right buttock pressure injury treatment and the treatment recommended by Wound Physician-G is not listed on the June 2025 TAR. Surveyor noted the facility has still not developed a comprehensive pressure injury care plan. Surveyor was unable to locate a pressure injury weekly tracker for the week of 6/8/25 to 6/14/25. Wound Physician-G's wound evaluation and management summary dated 6/10/25 documents Stage 2 pressure wound of the right buttock, partial thickness with wound size (L x W x D) of 1.5 x 0.6 x 0.1 cm. Cluster wound documents open ulceration area of 0.45 cm. squared. Exudate is light sero-sanguineous. There is not a description of the wound bed. Under dressing treatment plan for Primary Dressing(s) documents: Alginate honey-impregnated apply once daily and as needed: if saturated, soiled, or dislodged. Secondary Dressing(s) Gauze island w/bdr (with border) apply once daily and as needed: if saturated, soiled, or dislodged. There is no order for R1's right buttock pressure injury treatment and the treatment recommended by Wound Physician-G is not listed on the June 2025 TAR. Surveyor noted the facility has still not developed a comprehensive pressure injury care plan. R1's shower/bath body check dated 6/10/25 documents: refused said she's taking it at home tomorrow. R1's weekly skin review with an effective date of 6/11/25 under skin condition is checked for pressure injury and other. For specify other documents: vascular. For site documents 25) Right trochanter (hip) and description documents pressure. For site documents 41) right lower leg (front) and description documents vascular. R1's discharge note dated 6/11/25, at 13:00 (1:00 p.m.), written by Licensed Practical Nurse (LPN)-E documents Discharge Location: ALF (assisted living facility). discharged With: Res (Resident) discharged with all personal belongings and personal W/C (wheelchair). Family here assisted res with belongings. Belongings: Medications: All medication returned to pharmacy. Skin check: (blank) Vitals: (blank) Additional Information: Res in good spirits, 0 c/o (complaint of) pain/discomfort. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/26/25, at 9:32 a.m., Surveyor telephoned and spoke with Assisted Living Staff-K. Surveyor asked Assisted Living Staff-K if they could explain to Surveyor how R1 was when she arrived at their facility. Assisted Living Staff-K read Surveyor their note and informed Surveyor would send this note to Surveyor. Surveyor noted Assisted Living Staff-K's note dated 6/11/25 at 5:24 p.m. documents: [R1's name] arrived at [Assisted Living Facility Name] at approximately 2:15 transported by her family from Lake Mills Care Center. She was accompanied by her children, [Name], [Name], and another daughter. I went to assess [R1's first name] at approximately 2:45 and found her sitting in her lift chair in her apartment, talking with her children. She was pleasant, disoriented to time and place, with severe short term memory loss. We discussed her needs and what would be done by staff to help her, and she and her family stated understanding. Head to toe assessment revealed the following: [R1's first name] wears a wig, and has her own natural hair. She wears prescription glasses, and does not need hearing aids. She has upper and lower dentures that she states she rarely takes out. Her oral mucosa were moist. Her lungs were clear to auscultation in all fields both posteriorly and anteriorly. Heart auscultation revealed a systolic murmur and a slightly irregular rhythm, apical heart rate was 108. She had positive bowel sounds and was drinking an ensure prior to the exam. [R1's first name] bilateral lower legs were extremely edematous from toes to above the knee. Compression garments were in place. When they were removed, skin inspection revealed chronic skin changes, with increased redness on the dorsal aspect of both lower legs. On her right posterior lower leg, there was a bandage in place. [R1's first name] and her family did not know what it was covering. On her left lower leg, there were scattered clear blisters and a pinpoint area that was opened. [R1's first name] stated that her butt hurt, so her pants and undergarments were removed for skin inspection. She had a 1.5 x 1.5 cm stage 2 open area on her right buttock that was surrounded by unblanchable tissue with suspected deep tissue injury. She had two open areas on the left gluteal fold that was covered with whitish slough and were unstageable. They, too, were surrounded by suspected deep tissue injury. To the left of her coccyx there was an opening that appeared to tunnel into the subcutaneous tissue. The area around the opening was covered with white slough, and the tissue surrounding the area was hard, red, and warm to touch. The coccygeal area was also painful to touch. There were no dressings, ointments or creams apparent upon inspection, and there was blood in her brief where the wounds had made contact with it. [R1's first name] stated that the pain prevented her from sitting or lying comfortably. [R1's first name] daughters stated that the prior SNF (skilled nursing facility) had mentioned nothing about wounds on her buttocks or coccyx. They did state that she had a previous pressure injury while at Lake Mills, but that their understanding was that it was healed. These wounds were not present at my initial evaluation approximately 10 days ago when [R1's first name] was still at the skilled facility. Vitals at this time were T (temperature) 101.4 F (Fahrenheit) (forehead); BP (blood pressure) 115/59; Pulse 108, Respirations 24. Because of the elevated temperature and the condition of the wounds, I recommended that the family take [R1's first name] to Urgent Care for evaluation. They agreed and transported her at approximately 1530 (3:30 p.m.). Family was instructed to request wound and skin evaluation, urinalysis, and wound care orders. They know to get any antibiotics prescribed filled at [Pharmacy Name] so that they can be started as soon as possible. Staff is instructed to call me when/if [R1's first name] returns to the facility. Assisted Living Staff-K’s note dated 6/12/25 at 9:08 a.m. documents: [R1's first name] was admitted to [Name] Hospital in [Name] last evening via the urgent care center. [Name], Registered Nurse Case Management (RNCM) called with an update this morning. [R1's first name] coccygeal abscess that is concerning for osteomyelitis and a left buttock abscess. She is having imaging and blood cultures done, and her plan of care is being developed . (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/26/25, at 11:05 a.m., Surveyor interviewed Certified Nursing Assistant (CNA)-T, who worked the day shift on 6/10/25 and 6/11/25 and was assigned to R1 on 6/11/25,. CNA-T informed Surveyor R1 kind of wanted to do her own thing. Surveyor asked CNA-T on the day R1 was discharged (6/11/25) did she provide any cares for R1. CNA-T replied no, she kind of does her own things. Surveyor asked CNA-T if she ever saw R1's buttocks. CNA-T replied, I would put cream. Surveyor asked the last time she saw R1's buttocks. CNA-T wasn't able to tell Surveyor and informed Surveyor she did help R1 in and out of the bathroom. CNA-T informed Surveyor she would offer to change R1's shirt and wash her up but R1 would say no I'm fine I'll get it. Surveyor asked CNA-T on the day of discharge did she help with R1's discharge. CNA-T replied no and explained R1's family packed everything up. On 6/26/25, at 11:12 a.m., Surveyor interviewed CNA-S, who worked the day shift on 6/10/25, regarding R1. CNA-S informed Surveyor R1 liked to transfer herself a lot, but CNA-S would help her to bathroom and change R1 if she didn't already do it. CNA-S indicated she had to stop R1 from doing things herself and she was impulsive. Surveyor asked CNA-S if she saw R1's buttocks. CNA-S replied, I wiped her guess I didn't put my face up to see, had to be quick as didn't allow you to do much with her. Surveyor stated to CNA-S so you didn't look at her bottom. CNA-S replied no. CNA-S explained R1 would stand up and pull up her pants. Surveyor asked CNA-S if she washed R1 up in bed. CNA-S replied she wouldn't let me, sometimes let me help change her shirt. On 6/26/25, at 11:58 a.m., Surveyor asked DON-B what is the process for when a resident is admitted regarding a skin assessment. DON-B explained RN/UM-D or another RN does a head to toe assessment. Surveyor inquired about R1. DON-B informed Surveyor R1 refused to have the dressings on her legs removed. DON-B explained R1 was admitted on a Wednesday and they changed the dressing on Friday. Surveyor asked about R1 buttocks. DON-B replied, buttocks, I don't remember her butt. Surveyor informed DON-B the admission assessment on 5/14/25 does not have a description of the wound bed. RN/UM-D looked at R1's admission assessment and then stated to Surveyor didn't write a whole lot. Surveyor informed DON-B there wasn't a comprehensive assessment until 6 days later on 5/20/25. Surveyor asked if R1's pressure injury had 100% granulation tissue why was the pressure injury staged as a 2 not a stage 3. DON-B replied that's a good question and explained the pressure injury wasn't that deep. Surveyor asked DON-B why the wound doctor doesn't document the wound bed for R1's pressure injury. DON-B replied that's a good question, I usually write the wound bed. Surveyor informed DON-B on 5/27/25, the wound doctor documents cluster of wound. DON-B explained if there is more than one open area he will measure one greater area. Surveyor informed DON-B the pressure injury weekly tracker dated 5/27/25 has granulation tissue and 50% skin. DON-B informed Surveyor she was on vacation this week and stated that's weird. Surveyor informed DON-B the weekly skin review dated 6/11/25 by RN-F documents a trochanter (hip) pressure injury. DON-B informed Surveyor R1 didn't have anything on her hip and doesn't know where that came from. DON-B informed Surveyor she will have to speak with RN-F. Surveyor informed DON-B Surveyor could speak with RN-F. Surveyor informed DON-B Surveyor was unable to locate an order and didn't see any treatment for R1's right buttock pressure injury. DON-B informed Surveyor she thinks they were doing calazime cream. DON-B looked in R1's physician order and then stated you're right. DON-B explained Wound Physician-G sends his notes electronically, which goes in the resident's record and Wound Physician-G doesn't put orders in. Surveyor informed DON-B Wound Physician-G on 5/27/25 documents a treatment with alginate honey and gauze island border dressing which was never completed. DON-B informed Surveyor that the treatment was never transcribed and it's an area of opportunity. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/26/25, at 12:31 p.m., Surveyor telephoned RN-F. Surveyor asked RN-F how she completed R1's skin check. RN-F informed Surveyor she honestly can't remember and would have to look at the computer. RN-F informed Surveyor R1 had wraps on her legs. Surveyor asked about R1's buttocks. RN-F informed Surveyor she didn't think she had anything. Surveyor asked RN-F on 6/11/25 did she look at R1's buttocks. RN-F replied I honestly don't remember. RN-F informed Surveyor first name of DON-B was kind of telling her what Surveyor was looking at and maybe she got her mixed up. RN-F informed Surveyor she was coming to the facility for a 1:30 p.m. meeting. Surveyor asked RN-F to see Surveyor while at the facility. On 6/26/25, at 2:44 p.m., Surveyor met with RN-F regarding R1. RN-F informed Surveyor some nurses document buttocks and some ischium. RN-F informed Surveyor she slipped up and put hip. Surveyor inquired about the right lower leg. RN-F informed Surveyor that was her mistake and it was healed. Surveyor asked RN-F how she did R1's skin check. RN-F replied in the bathroom and had asked the CNAs when they were toileting her to let her know. Surveyor asked RN-F if she looked at R1's buttocks. RN-F replied yes, had her stand up, cleaned her and took a look. Surveyor asked RN-F if the time she charted was the time she did the skin check. RN-F informed Surveyor it may have been earlier and she couldn't say as she didn't know if they had two nurses or she was by herself. Surveyor asked RN-F if staff had to take R1 to the bathroom or could R1 go by herself. RN-F informed Surveyor R1 wasn't supposed to and thinks at the end R1 was a one assist. Surveyor asked RN-F when she was doing R1's skin check did she spread the cheeks of R1's buttocks. RN-F replied I did the best I could. On 6/26/25, at 2:52 p.m. Surveyor interviewed CNA-R, who worked the evening shift on 6/10/25, about R1. CNA-R informed Surveyor R1 could be demanding, she went from being friendly to mean and did a lot of the cares herself. CNA-R informed Surveyor R1 didn't want them to do anything, would put the call light on and would already be in the bathroom. Surveyor asked CNA-R if she saw R1's buttocks. CNA-R replied yes, during the mid-point when she was here, can't say at the end because she was more independent. CNA-R informed Surveyor her buttocks were red and they did offer cream. Surveyor asked CNA-R if she observed R1's buttocks on 6/10/25, the day before R1 was discharged . CNA-R replied no I don't think I did. On 6/26/25, at 3:21 p.m. Surveyor interviewed RN-J, who worked the evening shift on 6/10/25, about R1. Surveyor asked RN-J if she had to do any treatments for R1. RN-J replied no. Surveyor asked RN-J if she ever saw R1's buttocks. RN-J replied no. RN-J informed Surveyor when the CNAs are doing cares, if there are any concerns they will get the nurse and their shower sheets. On 6/30/25, at 7:50 a.m., Surveyor interviewed CNA-U regarding R1. CNA-U informed Surveyor R1 mostly hung out in her room and refused cares. Surveyor informed CNA-U she was on the schedule for the evening shift on 6/10/25, day shift on 6/11/25, and inquired if she did any cares for R1 during this time. CNA-U informed Surveyor not that she could recall. Surveyor asked CNA-U if she observed R1's buttocks. CNA-U replied no she really wouldn't let us help her. On 6/30/25, at 8:03 a.m., Surveyor interviewed CNA-V regarding R1. CNA-V informed Surveyor R1 self-transferred, had a couple falls, refused cares, and would sit on the bed with the walker. CNA-V informed Surveyor R1 really didn't let them do a whole lot. Surveyor asked CNA-V if she ever saw R1's buttocks. CNA-V replied no. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/30/25, at 8:09 a.m., Surveyor asked Physician-W if he knows why the wound doctor doesn't describe the wound bed. Physician-W informed Surveyor he has no idea and doesn't follow wounds. Surveyor asked if [Name of Wound company] follows all wounds at the facility. Physician-W replied yes. On 6/30/25, at 8:19 a.m., Surveyor interviewed CNA-Q, who worked the day shift on 6/10/25 and 6/11/25, about R1. CNA-Q informed Surveyor R1 was independent and could be rude. Surveyor asked CNA-Q if she assisted R1 with going to the bathroom. CNA-Q informed Surveyor if she caught R1 and R1 would take herself. CNA-Q informed Surveyor one time R1 called and she helped her but only one time. Surveyor asked CNA-Q if she saw R1's buttocks. CNA-Q replied no, she didn't like them to change her. CNA-Q informed Surveyor she doesn't have R1's assignment often and is usually assigned to other assignments. On 6/30/25, at 8:28 a.m., Surveyor asked RN/UM-D what she does when a resident is admitted . RN/UM-D explained she does a head to toe assessment under the admission evaluation and kick starts the care plan. Surveyor asked RN/UM-D if she remembers R1. RN/UM-D replied yes. Surveyor asked RN/UM-D why there wasn't a pressure injury care plan developed. RN/UM-D replied not sure, I'd have to look at that. RN/UM-D informed Surveyor R1 had lymphedema wounds and an area on her bottom. RN/UM-D informed Surveyor in the beginning R1 didn't want anyone to look at her, she was very shy. On 6/30/25, at 8:38 a.m., Surveyor spoke with Wound Physician-G on the telephone regarding R1. Surveyor inquired why he didn't describe the wound bed for R1's pressure injury. Wound Physician-G explained when he stages the pressure injury as a stage 2 the program locks him out of describing the wound bed to safeguard inappropriate documentation. Surveyor informed Wound Physician-G he was documenting R1's right buttock pressure injury as a stage 2 but the facility was documenting 100% granulation. Wound Physician-G informed Surveyor he didn't think there was granulation and R1 was admitted with the pressure ulcer, not acquired. Surveyor asked Wound Physician-G if he was aware facility staff were not doing any treatment for R1's right buttock pressure injury. Wound Physician-G replied no, he wasn't aware. Wound Physician-G informed Surveyor there are times the nurses take off the bandage before he comes and doesn't get worried if the bandage is off. Wound Physician-G informed Surveyor he can't physically put orders in PCC (pointclickcare). Surveyor asked Wound Physician-G if R1 had any other pressure injuries other than the right buttocks. Wound Physician-G informed Surveyor not that he was made aware of and doesn't do a skin sweep and it was just the butt cheek that they were seeing. Surveyor inquired about when Wound Physician-G clusters areas. Wound Physician-G informed Surveyor if the wounds are on the same anatomical location and required the same treatment he will cluster the wounds. Wound Physician-G informed Surveyor R1 had excoriation and it was his judgement call to cluster together. On 6/30/25, at 9:24 a.m., RN/UM-D stated to Surveyor it was me, don't know how I missed the pressure care plan. Surveyor asked RN/UM-D who reviews the hospital discharge summary. RN/UM-D informed Surveyor it depends, DON-B will put the orders in and someone will double check and if DON-B is not here she will and another nurse will double check. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/30/25, at 9:27 a.m., Surveyor asked DON-B if she has any information regarding the assessments documenting 100% granulation and R1's pressure injury being staged at a stage 2. DON-B informed Surveyor it may be her error and informed Surveyor the wound bed was nice beefy red. Surveyor informed DON-B there was not a pressure injury care plan for R1. DON-B informed Surveyor RN/UM-D just told her that. Surveyor asked DON-B when R1 was admitted did she review R1's hospital discharge summary. DON-B informed Surveyor she usually does the discharge summary and RN/UM-D does the physical assessment. Sur

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on record review and interview, the facility did not ensure 7 out of 8 staff members reviewed received behavioral health training to care for residents diagnosed with a mental, psychosocial, or other behavioral health conditions. Certified Nursing Assistant (CNA)-Q, CNA-R, CNA-T, CNA-V, Registered Nurse (RN)-Y, Licensed Practical Nurse (LPN)-E, and Housekeeping-Z, did not receive behavioral health training.This deficient practice has the potential to affect all 29 residents residing at the facility that have the potential to experience behavioral health issues. Findings include:On 7/3/25, Surveyor randomly selected 8 facility staff members for review. Surveyor reviewed the employee records of CNA-Q, CNA-R, CNA-T, CNA-V, CNA-X, Registered Nurse (RN)-Y, Licensed Practical Nurse (LPN)-E, and Housekeeping-Z. The facility was unable to provide documentation that CNA-Q, CNA-R, CNA-T, CNA-V, Registered Nurse (RN)-Y, Licensed Practical Nurse (LPN)-E, and Housekeeping-Z, received the required behavioral health training within the year based on hire date.CNA-Q Date of Hire: 1/1/23 (did not receive behavioral health training)CNA-R Date of Hire: 10/1/17 (did not receive behavioral health training)CNA-T Date of Hire: 10/1/17 (did not receive behavioral health training)CNA-V Date of Hire: 9/12/22 (did not receive behavioral health training)RN-Y Date of Hire: 8/3/22 (did not receive behavioral health training)LPN-E Date of Hire: 10/1/17 (did not receive behavioral health training)Housekeeping-Z: Date of Hire 8/2/22 (did not receive behavioral health training)Surveyor noted that when asking Nursing Home Administrator (NHA)-A for a policy on required annual in-service training, NHA-A stated, the facility did not have a policy on in-service training. On 7/3/25, at 12:15 AM, Surveyor interviewed NHA-A who stated, the Director of Nursing (DON) is responsible for assuring staff receive the required training and NHA-A completes a second review of the training. NHA-A stated, the facility uses software to provide in-service training. Surveyor notified NHA-A that 7 out of 8 selected staff have not received the behavioral health training. NHA-A stated that she would consult with team and get back to Surveyor if any additional information could be found.On 7/3/25, at 1:45 PM, Surveyor interviewed [NAME] President of Success-C who stated that all 8 of the staff members selected have training on caring for people with substance use disorder and feels this training should account for behavioral health training. Surveyor stated, even though residents with substance use disorders have behaviors that require staff training, this is only one component of behavioral training and staff need to have training on all behaviors that are associated with mental illness, psychosocial, or other behavioral health conditions and could not be counted as the completion of behavioral health training.On 7/3/25, at 3:00 PM, Surveyor notified NHA-A, DON-B and [NAME] President of Success-C of concern that 7 out of 8 staff members did not receive the behavioral health training and even though other trainings such as substance abuse, trauma informed care and dementia all include behaviors of residents, there needs to be a specific training related to behaviors of residents to encompass all resident illnesses or conditions. The facility team expressed understanding. No additional information was provided.