STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525326	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Crest Health and Memory Care	2100 E Sixth St Merrill, WI 54452

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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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Based on interview and record review, the facility did not have policies in place to provide residents a written notice of transfer to include reason for transfer, Ombudsman contact information, and appeal rights. This has the potential to affect all 93 residents.This is evidenced by:On 06/03/26, Surveyor requested the facility's transfer notice policy. Surveyor reviewed the facility's policy and noted no protocol to provide residents a written transfer notice that states the reason for the transfer, Ombudsman contact information, and appeal rights.On 06/03/26 at 2:51 PM, Surveyor interviewed Director of Nursing (DON) B regarding written transfer notices. DON B stated being unaware that there was a requirement to provide a written notice of transfer to residents unless they were being discharged .

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 - Many	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not provide residents a written notice of transfer that includes reason for transfer, Ombudsman contact information, and appeal rights to 10 of 10 residents (R7, R17, R8, R14, R99, R6, R83, R3, R96, and R101) reviewed.R7 was transferred to the hospital on [DATE]. A written notice of transfer was not completed.R17 was transferred to the hospital on [DATE]. A written notice of transfer was not completed.R8 was transferred to the hospital on [DATE]. A written notice of transfer was not completed.R14 was transferred to the hospital on 2/21/26. A written notice of transfer was not completed.R99 was transferred to the hospital on [DATE] and 04/15/26. A written notice of transfer was not completed.R6 was transferred to the hospital on 2/25/26. A written notice of transfer was not completed.R83 was transferred to the hospital on 3/16/26. A written notice of transfer was not completed.R3 was transferred to the hospital on [DATE]. A written notice of transfer was not completed.R96 was transferred to the hospital on 5/27/26. A written notice of transfer was not completed.R101 was transferred to the hospital on 4/21/26. A written notice of transfer was not completed.This is evidenced by: Example 1 On 03/26/26, R7 was transferred to the local hospital R7's medical record did not have documentation of a written notice of transfer. On 06/03/26 at 2:51 PM, Surveyor interviewed Director of Nursing (DON) B regarding written transfer notices. DON B stated being unaware that there was a requirement to provide a written notice of transfer to residents unless they were discharged . Example 2 R17 was admitted to the facility on [DATE]. On 04/30/2026, R17 was transferred to the hospital. R17's medical record showed documentation of a signed bed hold notice, dated 04/30/2026. No documentation of a written notice of transfer was found. Example 3 R8 was admitted to the facility on [DATE]. R8 was transferred to the hospital on [DATE]. R8's medical record showed documentation of a signed bed hold notice, dated 01/12/2026. No documentation of a written notice of transfer was found. Example 4 R3 was admitted to the facility on [DATE]. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 04/03/2026, R3 was transferred to the hospital R3's medical record showed documentation of a signed bed hold notice, dated 04/03/2026. No documentation of a written notice of transfer was found. On 06/02/2026 at 1:45 PM, Surveyor interviewed DON B and asked what the facility's policy was for providing residents/legal representatives with a written notice of transfer. DON B stated the facility did not provide written notice of transfers, and DON B was not aware this was a requirement prior to any transfers/discharges of residents. DON B was not able to provide evidence that a written notice of transfer was provided to R3, R8, and R17. Example 5 R14 was admitted to the facility on [DATE], with diagnoses including hyponatremia (low sodium levels,) hypocalcemia (low calcium levels,) hypomagnesium (low magnesium levels,) high blood pressure, and edema. R14's Minimum Data Set (MDS) assessment, dated 9/12/25, was titled Discharge Return Anticipated. Record review identified R14 was transferred to the hospital on 9/12/25, due to being found on the floor unresponsive. R14's electronic medical record did not have documentation of a written notice of transfer. Example 6 R6 was admitted to the facility on [DATE], with diagnoses including age related osteoporosis, anemia, osteoarthritis of right knee, history of stroke, abnormalities of gait and mobility, essential tremors, hemiplegia (partial paralysis) affecting right dominant side, and history of fracture of right arm humerus. R6's MDS dated [DATE] was titled Discharge. Record review identified R6 was transferred to the hospital on 2/25/26 due to potential fracture of arm after a fall. R6's electronic medical record did not have documentation of a written notice of transfer. Example 7 R83 was admitted to the facility on [DATE], with diagnoses that include history of stroke, congestive heart failure, adult failure to thrive, hypernatremia (high level of sodium,) hypokalemia (low potassium levels,) and type 2 diabetes. R83's MDS dated [DATE], was titled Discharge. Record review identified R83 was transferred to the hospital on 3/16/26 due to elevated sodium level and elevated blood sugar. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/2/26, Surveyor reviewed R83's electronic medical record. No documentation of a written notice of transfer was found. Example 8 R96 was admitted to the facility on [DATE], with diagnoses including pressure ulcer of sacral region stage 4, colostomy, paraplegia, osteomyelitis, and spina bifida. R96's MDS assessment dated [DATE] was titled Discharge Return Anticipated. Record review identified R96 was transferred to the hospital on 5/7/26 due to elevated sed rate (lab result) and concerns of osteomyelitis. R96's electronic medical record did not have documentation of a written notice of transfer. On 6/3/26 at 12:29 PM, Surveyor interviewed Medical Records (MR) P regarding the transfer process and paperwork as she handed off a copy of the bed hold to Surveyor. MR P stated honestly, we didn't know we had to do a written transfer notice for the resident or next of kin. We know about transfer notices to the hospital but not for the family/resident. MR P stated DON B now has a process put into place already so we can start doing that. Example 9 R99 was admitted on [DATE] with a Brief Interview for Mental Status (BIMS) score of 04/15, which indicated R99 had severe cognitive impairment. Review of R99's Electronic Health Record (EHR) had an MDS assessment dated [DATE] and 04/15/26 and were both titled, Discharge Return Anticipated. Surveyor was unable to find a notice of transfer in R99's medical record. On 06/03/2026 at 12:49 PM, Surveyor asked DON B for notice of transfer form for both of these two hospitalizations. DON B informed Surveyor that process was not being done at the time. Example 10 R101 was admitted to the facility on [DATE] with diagnoses of congestive heart failure and dementia. On 4/21/26, R101 was admitted to the hospital. Facility's bed hold policy was signed on 4/22/26. The facility did provide evidence that the Ombudsman was notified of R101's discharge. The facility did not provide written notice of transfer to resident or resident's representative.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility did not store, prepare, distribute, and serve food in accordance with professional standards for food service safety. This has the potential to affect 93 of 93 residents.-Surveyor observed an opened bag of cauliflower and an open bag of chopped celery were not dated with an expiration date, an open date, or a use by date.-Surveyor observed several individual uncovered bowls of lettuce without a date identifying when they were prepared. -Surveyor observed several uncovered prepared desserts without a date identifying when they were prepared.Findings include:On 6/1/26 at approximately 9:00 AM, during initial tour of the kitchen with Dietary Supervisor (DS) N, Surveyor observed in the walk-in freezer an open package of chicken breasts out of the original box without a use by or expiration date. Surveyor observed an opened bag of cauliflower and an opened bag of chopped celery without dates on them. DS N verified the opened packages did not have dates on them.Surveyor observed in the snack cooler, several individual bowls of uncovered lettuce salads without a date identifying when they were prepared. Surveyor observed in the dessert cooler, several individual bowls of uncovered prepared desserts without a date identifying when they were prepared.On 6/1/26 at approximately 9:15 AM, Surveyor interviewed DS N and asked what the expectation is for labeling and dating food items. DS N indicated they would expect opened/prepared food to be labeled and dated and prepared foods to be covered to prevent contamination when being stored for later use.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections. This had the potential to affect all 93 residents (R.) -The facility's measures to prevent the growth of Legionella and other opportunistic waterborne pathogens in the building water systems are not being performed based on nationally accepted standards and in accordance with their Water Management Program and the facility does not demonstrate they have system in place to monitor the control measures as indicated. -The facility did not disinfect equipment used during wound cares for R3. Registered Nurse (RN) L did not prevent possible cross contamination between wounds for R3. This could result in delayed healing of R3's wounds leading to a decline in R3's wounds. -RN C did not perform hand hygiene during dressing change for R4's coccyx wound. This could result in delayed healing and infection leading to a decline in R4's wound. Findings include: The facility's policy titled, Water Management Program, dated 3/6/2023 states, Potable Water System Monitoring Frequency. Temperature Monitoring - Take temps at specific points - Daily. Legionella Testing – Test 3 locations – Quarterly. Example 1 Water flushing logs indicated housekeeping was providing water flushes to vacant rooms twice a week. The facility did not have documentation of temperature monitoring or Legionella testing. The facility documentation did not control measures to prevent bacteria in the facility's water system were being monitored as indicated in their Water Management Policy. On 6/3/26 at about 8:30 AM, Surveyor interviewed Maintenance Lead O, who stated they just started in the position and don't know anything about what was required for water monitoring or testing. On 6/3/26 at 8:40 AM, Surveyor interviewed Registered Nurse (RN) D, who stated they were not able to locate any of the previous testing for bacteria or temperatures. RN D believes it was being done prior to previous Maintenance Lead's resignation in March but not able to locate those records. On 6/02/26 at 1:42 PM, Surveyor interviewed NHA A, who reported the facility has a water management program developed but the department in charge of implementing, operating and documenting what is to be done, was not made clear and was not done in accordance with their Water Management Program. Example 2 R3 was admitted to the facility on [DATE] with diagnoses that include type 2 diabetes mellitus with diabetic neuropathy and displaced bimalleolar (ankles) fractures of both right and left lower legs. R3 has a Brief Interview of Mental Status (BIMS) score of 15/15, which indicates intact cognition. R3 has physician orders dated 05/22/2026 which include: Right medial ankle, left medial, and lateral (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	ankle: Apply Aquacel ag, apply bordered foam dressing. On 06/03/2026 at 11:57 AM, Surveyor observed RN L perform wound care to R3's right and left lower legs. Surveyor observed R3 had both medial (inside) and lateral (outside) surgical incisions to left ankle. During setting up wound care supplies, RN L removed a pair of bandage scissors from her uniform jacket pocket and laid them on R3's bedside table next to wound care supplies. Without first disinfecting the bandage scissors, RN L proceeded to cut to size clean dressings with the scissors. RN L opened a package of sterile saline wipe and cleansed the medial open incisional wound of left ankle. Using the same saline wipe, RN L then cleansed the lateral open incisional wound of left ankle. RN L placed the dressings cut using the undisinfected scissors onto both open wound care sites on left ankle. RN L place dressing cut with undisinfected scissors unto right ankle incisional wound. RN L removed gloves after wound care and assessed R3's left foot. RN L noted a new scabbed area below R3's anterior great toe. With bare finger, RN L palpated the left great toe wound, including scabbed area. On 06/03/2026 at 11:57 AM, during R3's wound care, RN L stated to Surveyor that due to lack of hand based alcohol rubs and wound care supplies in R3's room, RN L was aware of personal faults in being infection control compliant. Example 3 Resident (R) 4 was admitted to the facility on [DATE] with diagnoses of need for assistance with personal care and pressure ulcer of right buttock stage II. R4 had doctor's orders including a coccyx foam dressing change every other day and as needed, as well as applying Tegaderm to heels bilaterally every 3 days and as needed. On 06/02/2026 at 9:38 AM, Surveyor observed Registered Nurse (RN) C perform cares with R4. RN C assisted R4 with removing their wet shirt and put a dry gown on. RN C then removed R4's socks and the bandages on their heels. RN C then cleaned each heel with a betadine wipe. RN C removed the soiled gloves and put on clean gloves. RN C did not perform hand hygiene between glove changes. RN C put new foam dressings on R4's heels and signed and dated the dressings. RN C then untaped R4's briefs and pulled the front down and tucked it between R4's legs. RN C then wiped R4's front peri area. RN C rolled R4 onto their right side and pulled out the briefs which were soiled with BM and wiped R4's buttocks clean. RN C removed gloves and put on clean gloves without performing any hand hygiene. RN C removed R4's coccyx dressing and this area was wiped clean and soiled gloves removed, no hand hygiene performed. RN C put on clean gloves, placed a new dressing to R4's coccyx area, and began to put a clean brief on them. On 06/02/2026 at 10:02 AM, Surveyor informed RN C of the observations made of glove changes without performing hand hygiene. RN C informed Surveyor they normally have a small hand sanitizer with them and normally do perform hand hygiene with glove changes. But RN C did not have the sanitizer today. On 06/03/2026 at 3:44 PM, Surveyor informed Director of Nursing (DON) B of the observation made of glove changes without performing hand hygiene with cares provided to R4. DON B informed Surveyor RN C should have performed hand hygiene when removing gloves and when putting on clean gloves. On 06/04/2026 at 7:14 AM, Surveyor informed RN D (who is also the facility's infection preventionist) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	of the observation of cares with R4 and no hand hygiene performed with glove changes. RN D informed Surveyor that RN D will frequently quiz staff walking down the halls in the facility. RN D also indicated the facility's corporation took all of the hand sanitizer stations out of residents' rooms and it has changed the staff process, but it is not right.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate foot care. Based on observation, interview, and record review, the facility did not ensure diabetic foot care and treatment was provided, in accordance with professional standards of practice for 6 residents (R3, R4, R22, R56, R80, R83) of 6 diabetic residents reviewed for diabetic foot care in a sample of 20 residents.The facility did not:-Have physician orders for daily diabetic foot checks on R3, R4, R22, R56, R80, R83.-Have documentation in medical records that diabetic foot assessments and/or cares for R3, R4, R22, R80, and R83-Perform diabetic nail cares, specifically trimming toenails for R3. The facility's failure to provide diabetic foot care to residents could result in physical, mental and psychological harm to residents, including infection and poor hygiene. Findings include:The facility policy, titled Skin Integrity Foot Care, dated 08/07/2025, states, Facility to ensure residents receive proper treatment and care within professional standards of practice.to maintain mobility and good foot health.R3, R4, R22, R56, R80 and R83 were all admitted to the facility with diagnosis of Type 2 diabetes mellitus and diabetic peripheral neuropathy. Surveyor did not find physician orders for daily diabetic foot assessments/cares for R3, R4, R22, R56, R80 and R83. Surveyor did not find documentation of daily diabetic foot assessments during cares under certified nursing assistant (CNA) tasks for R3, R4, R22, R80 and R83. These residents had no nursing progress note documentation on assessments/cares during daily diabetic foot checks, including trimming of nails. On 06/03/2026 at 11:57 AM, Surveyor observed licensed Practical Nurse (LPN) L perform wound cares to R3's right and left lower legs. R3's toenails on both feet were not trimmed and stretched over top of nail bed extending underneath the toes. On 06/03/2026 at 11:57 AM, during wound cares, Surveyor asked R3 if nail cares were offered while at facility. R3 stated no one has ever trimmed his toenails and was not aware of toenails extending underneath toes because of diabetic neuropathy and lack of sensation to feet. On 06/03/2026 at 11:57 AM, Surveyor asked LPN L when diabetic foot cares were provided to R3. LPN L stated they had not noticed R3's toenails during wound cares prior. LPN L confirmed wound cares were provided to both of R3's feet, with toenails exposed, at a minimum of every 2 days, sometimes daily. LPN L stated nurses performed the wound cares and had visual access to R3's feet, including toenails. On 06/0302026 at 1:06 PM, Surveyor asked Director of Nursing (DON) B who performs diabetic foot cares for residents. DON B stated all nurses are expected to perform foot care, including nail trimming to diabetic residents. DON B stated CNAs inform nurses if new findings are noted during cares on diabetic residents. On 06/04/2026 at 7:25 AM, Surveyor asked Registered Nurse (RN) F, which staff perform diabetic foot cares for residents at the facility. RN F stated, I guess the nurses do? RN F informed Surveyor the facility had a podiatry nurse in the past, however no longer did. RN F could not recall if a particular staff nurse was currently designated to do diabetic foot assessments/cares at the facility.

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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 observation, interview and record review, the facility did not ensure residents received treatment and care in accordance with professional standards of practice and the residents' comprehensive plan of care for 2 of 20 residents (R7 and R1) reviewed.R7 has chronic lymphedema. R7's lymphedema was not being routinely assessed through measurements to monitor for worsening. R7 had a 2,000 ml daily fluid restriction that was not monitored daily.Facility did not document fluid intake every shift for R1 who is on fluid restrictions as ordered by physician which could result in fluid overload for R1.Facility did not perform and document daily weights and pulses as ordered by physician for R1 which could result in physical harm for R1.Facility did not notify physician for weights outside of parameters as ordered by physician for R1 which could result in physical harm for R1. This is evidenced by: Example 1 R7 was admitted to the facility on [DATE] with lymphedema and prothrombin deficiency (a blood clotting disorder). R7's most recent comprehensive Minimum Data Set (MDS) assessment, dated 04/10/26, noted a Brief Interview for Mental Status (BIMS) score of 15/15, indicating cognition is intact. Surveyor reviewed R7's care plan and no interventions to monitor R7's lymphedema with measurements were noted. R7's orders: -Fluid restriction of 2,000 ml total daily. -Monitor fluid intake every shift. Surveyor reviewed R7's intake record and noted the following dates exceeding 2,000 ml restriction: -January 2026: 01/01, 01/02, 01/03, 01/04, 01/07, 01/12, and 01/29. No documentation was entered for PM shift noting fluid intake on 01/16 and 01/30. -February 2026: 02/11, 02/17, 02/18, and 02/28. No documentation was entered for PM shift noting fluid intake on 02/16 and 02/28. -March 2026: 03/01. 03/06, and 03/19. No documentation was entered on at least one shift noting fluid intake on 03/08, 03/11, 03/12, and 03/29. -April 2026: 04/01, 04/06, 04/07, 04/09, 04/21, 04/28, and 04/29. No documentation was entered on at least one shift noting fluid intake on 04/05, 04/11, 04/12, and 04/27. -May 2026: 05/05, 05/08, 05/10, 05/14, 05/16, 05/17, and 05/24. No documentation was entered on at least one shift noting fluid intake on 05/06 and 05/31. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Of note: no documentation of additional assessments or notification of provider was noted on days when R7's intake exceeded 2,000 ml. Surveyor reviewed R7's weights between 01/01/26 – 03/25/26 and noted no significant increase in weight greater than 3 lbs. Surveyor reviewed R7's nursing assessments and noted R7 to have lymphedema swelling on R7's left upper extremity (LUE), left lower extremity (LLE), and right lower extremity (RLE). No nursing documentation of circumference measurements of these extremities were noted. Surveyor reviewed R7's Occupational Therapy (OT) notes. The following measurements were documented in total active girth (TAG): 12/23/25: RLE 245.4 cm. January 2026: no measurements documented. February 2026: no measurements documented. 03/18/26: RLE 251.1 cm 03/19/26: RLE 260.9 cm. 03/24/26: RLE 285.2 cm. -Of note: RLE increased 24 cm from 03/19/26 to 03/24/26. OT notes R7's right thigh area is hard to touch and larger than left leg. Nursing is monitoring for cellulitis, congestive heart failure, and blood clots. On 03/26/26, R7 was transferred to the hospital for evaluation for increased pain in right leg. Surveyor reviewed hospital notes, dated 03/26/26, and noted a CT was completed with findings of multiple hematomas in R7's right thigh. R7 was admitted to the hospital and discharged back to the facility on [DATE]. On 06/01/26 at 9:18 AM, Surveyor interviewed R7 regarding lymphedema assessments and treatment. R7 stated having chronic lymphedema that is treated by the facility's lymphatic therapist since admission. R7 stated that in March 2026, they noticed a sudden increase in pain in the right thigh but wasn't sure of the cause. Surveyor asked R7 if this was reported to nursing. R7 stated yes, but they did not report this right away. Surveyor asked R7 if nursing does assessments to measure the extremities affected by the lymphedema. R7 stated only therapy does this. Surveyor asked R7 how often measurements are completed by therapy. R7 stated not being sure but thinks it is typically monthly. On 06/03/26 at 8:06 AM, Surveyor interviewed Registered Nurse (RN) K regarding fluid restrictions and lymphedema assessments. Surveyor asked RN K how fluid restrictions are monitored. RN K stated nursing should review intake daily, total the amount and ensure any overages are documented in the resident's chart and reported to the provider. Surveyor asked RN K how nursing staff assesses lymphedema. RN K stated nursing assesses the skin for any changes. Surveyor asked RN K how (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nursing determines if the lymphedema is worsening or changing. RN K stated using weights. Surveyor asked RN K if nursing does any circumference measurements to monitor lymphedema as weight may not increase with worsening. RN K stated OT does the measurements. Surveyor asked RN K how often OT completes measurements. RN K stated they did not know. On 06/03/26 at 8:53 AM, Surveyor interviewed Director of Nursing (DON) B regarding fluid restriction monitoring. Surveyor asked DON B what the expectation is for nursing to monitor fluid restrictions. DON B stated nursing enters in the amounts and dietary typically reviews this. Surveyor asked DON B if there is any expectation for nursing to review daily to ensure intake does not exceed the physician order of a daily restriction. DON B stated no, not unless there is a concern or change in condition. Surveyor asked DON B how this current practice ensures a daily fluid restriction is monitored. DON B stated it doesn't and it would be most appropriate for nurses to tally and review the totals daily. On 06/03/26 at 2:03 PM, Surveyor interviewed DON B regarding R7's lymphedema assessments. Surveyor asked DON B how nursing staff assesses R7 lymphedema. DON B stated their charting system alerts nursing for specific concerns, like weight. Surveyor asked DON B how nursing staff know if R7's lymphedema is worsening. DON B stated nursing does daily skin assessments and will note if R7's wraps are tighter. Surveyor asked if this would be a reliable method to determine worsening of lymphedema. DON B was unable to answer. Surveyor asked DON B if nursing is expected to do any measurements of circumference to monitor lymphedema. DON B stated no, therapy completes this. Surveyor asked DON B how often therapy completes measurements. DON B stated they did not know. Surveyor reviewed OT's measurements with DON B between 03/18/26 – 03/25/26 and noted the 24 cm increase in R7's RLE. Surveyor also reviewed R7's weights during this timeframe with DON B noting no significant increase. Surveyor asked DON B if regular circumference measurements by nursing staff could have identified this significant change. DON B stated yes, measurements would be important in identifying worsening of lymphedema. On 06/04/26 at 7:51 AM, Surveyor interviewed Director of Therapy Services (DTS) M regarding R7's lymphedema assessments. Surveyor asked DTS M how often therapy assesses R7's lymphedema measurements. DTS M stated at least monthly. Surveyor asked DTS M if nursing also takes measurements. DTS M stated no. Surveyor reviewed R7's therapy notes with DTS M, specifically noting no measurements taken in January or February 2026 and the significant change 03/18/26 – 03/25/26. Surveyor asked DTS M if monthly assessments were appropriate given R7's complex medical history and how quickly the hematomas developed in R7's RLE affected with lymphedema. DTS M stated no, with all R7 has going on, this should be completed more often. Example 2 R1 was admitted to the facility on [DATE] with diagnoses including hypertensive heart disease, chronic kidney disease stage 4, and candidal endocarditis (rare and highly lethal fungal infection of the heart valves or inner lining) and chronic respiratory failure. R1 has a Brief Interview for Mental Status (BIMS) score of 15/15, which means cognitively intact. R1 makes own healthcare decisions. R1's care plan, dated 02/19/2026, which states, Has renal failure related to chronic kidney disease stage 4. Interventions include.monitor/document/report to MD (medical doctor) the following signs/symptoms.weight gain over 2 pounds a day.increased heart rate. R1's care plan, dated 02/11/2026, also states, At nutritional risk.Interventions include.Fluid restriction 2000 mls (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(milliliters). R1's medical record has physician orders, dated 02/25/2026, stating, Fluid restriction 2000 mls – dietary total 1,440mls – limit fluids with meals to 480mls, nursing total AM: 300mls, PM: 300ml. R1's medical record has physician orders, dated 02/18/2026, stating, Parameter/orders for resident with CHF (congestive heart failure): monitor for edema (swelling), fluid restriction of 2 liters, daily weights – update provider if 3-pound(lb.) weight gain/loss in 24 hours or 5-pound weight gain/loss in one week. One time a day. R1's medical record has physician orders, dated 02/11/2026 stating, Pulse parameters: if greater than 120 or less than 50.if remains abnormal.call MD. On 06/02/2026 at 7:08 AM, Surveyor observed a half full 20 oz (ounce) bottle of soda on R1's bedside table. The soda bottle did not have any dated markings on the bottle made by staff for monitoring fluid levels to measure R1's shift intake. R1 informed Surveyor their husband brings in sodas and snacks. R1 stated staff is aware family brings in extra fluids for R1. R1 confirmed awareness of being on fluid restrictions and stated they only drink limited amounts daily. R1 told Surveyor the bottle of soda was 3 days old. On 06/03/2026 at 8:03 AM, Surveyor observed a full 20 oz bottle of soda on R1's bedside table. The soda bottle did not have any dated markings on the bottle made by staff for monitoring fluid levels to measure R1's shift intake. R1 informed Surveyor their husband brought in the new bottle of soda last evening. Surveyor asked R1 if staff weighed them daily. R1 stated staff take weights only on the days they want to get out of bed. R1 stated some days the preference is to stay in bed, and no weight is done on those days, especially weekends. Surveyor asked R1 if staff checked their pulse daily and R1 stated, Yes. On 06/03/2026, record review of R1's task administration record (TAR) and/or medical chart for May 2026 found: -Daily weights are not documented for 14 out of 31 days, with a consecutive stretch of no weight documentation ranging up to a 6-day stretch. -Several nursing documentations of R1 remaining in bed for the day. There is no nursing documentation of weights not being obtained while R1 remained in bed. -No documentation of physician notification for: 05/08/2026 – one day 3 lb. weight gain; 05/25/2026 – 5 lb. weight loss (note: last weight done 05/22/2026); 05/28/2026 – one day 5-pound weight gain. -No nursing documentation of pulses on R1 for 15 out of 31 days. -No documentation of R1's fluid intake for one or two shifts for 6 out of 31 days. -CNA care plan indicates R1's fluid restriction status with dietary and nursing allowances noted. CNA care plan indicates daily weights for R1 are to be done. -R1's CNA and nursing care plans do not indicate family brings R1 bottles of soda with additional fluid measuring interventions for staff. -R1 does not have a risk/benefit education and/or consent for possible noncompliance of fluid restriction status. On 06/02/2026 at 11:08 AM, Surveyor asked CNA G and Licensed Practical Nurse (LPN) L where fluid intake for R1 is documented. CNA G stated in R1's chart. Surveyor asked LPN L how fluids are differentiated and totaled for monitoring purposes between dietary intake and medication allowance intake. LPN L stated nurses tell CNAs how much fluids were given to R1 during medication passes and CNAs add it to R1's totals when charting. LPN N stated it cannot be guaranteed this charting (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	method of fluid intake for R1 is consistent amongst all nursing staff. On 06/02/2026 at 12:04 PM, Surveyor asked CNA J how staff document a resident's fluid intake when on fluid restrictions. CNA J stated fluid consumed during meals and any extra fluids are documented under CNA tasks in a resident's chart. CNA J stated they check with the nurses on what they give for fluids during medication passes and add it to the totals when documenting. On 06/02/2026 at 12:15 PM, Surveyor asked Registered Nurse (RN) F how a resident's fluid intake is documented. RN F stated they personally document fluids under the CNA tasks in a resident's chart. On 06/03/2026 at 10:44 AM, Surveyor asked CNA E how staff weigh R1 on days R1 prefers to stay in bed. CNA E stated staff can use the Hoyer lift (mechanical device for lifting that has a built-in scale) and raise R1 to a hovering position over the bed and obtain weight. CNA E stated weights are documented under the vitals task in R1's chart. On 06/03/2026 at 8:54 AM, Surveyor asked Director of Nursing (DON) B how residents who are on fluid restrictions are monitored and fluid intakes are documented. DON B stated the dietician monitors fluid intakes during monthly reviews. DON B stated nurses should document their medication pass fluids under CNA tasks but agreed this was not consistent within the facility. DON B could not confirm how nursing assesses a resident's fluid intake status accurately, and the medication administration record (MAR) should have a numerical option for documentation. DON B stated documentation under CNA tasks is the only current location to record fluids. Surveyor asked DON B if a resident desired to stay in bed and if weights were to be obtained daily, how staff should perform this task. DON B stated weights are not obtained and if a resident chooses not to be weighed, then it should be documented within the resident's medical chart. DON B confirmed a resident's care plan should indicate a resident's option to refuse getting out of bed, be weighed, and/or if a family brings in extra fluids that staff need to monitor intake status. DON B confirmed no care plan interventions or risk/benefit educations for R1 were in place.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure falls were investigated thoroughly to determine root cause, implement new safety interventions, and ensure adequate supervision for 1 of 8 residents (R) reviewed (R72).On 11/22/25, R72 had an unwitnessed fall. Root cause determined to be care planned intervention not in place. Facility did not complete thorough investigation to determine cause of safety intervention not in place, complete staff interviews, or evaluate staff competency.On 12/23/25, R72 had an unwitnessed fall with a resulting injury. Root cause determined to be care planned intervention not in place. Facility's investigation did not determine cause of safety intervention not in place, complete interviews with staff, or evaluate staff competency.On 03/28/26, R72 had an unwitnessed fall using equipment assessed to be unsafe without supervision. Facility's investigation did not determine if adequate supervision was in place, complete interviews with staff, or evaluate staff competency.On 04/25/26, R72 had an unwitnessed fall using equipment assessed to be unsafe without supervision. Facility's investigation did not determine if adequate supervision was in place, complete interviews with staff, or evaluate staff competency.This is evidenced by:Facility's policy titled, Fall Management System, with an effective date of 08/01/25, states: Policy: This facility is committed to promoting resident autonomy by providing an environment that remains as free of accident hazards as possible. Each resident is assisted in attaining or maintaining their highest practicable level of function through providing the resident adequate supervision.to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications.R72 was admitted to the facility on [DATE] with unspecified dementia, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, and memory deficit following cerebral infarction.R72's most recent quarterly Minimum Data Set (MDS), dated [DATE], noted a Brief Interview for Mental Status (BIMS) score of 10/15, indicating moderate cognitive impairment. R72 was noted to have one fall without injury and two falls with injury (except major).Surveyor reviewed R72's medical record and noted on 02/13/23, R72's durable power of attorney for healthcare due to incapacitation was initiated.On 06/03/25, R72 was assessed for ability to safely use electric recliner. The assessment noted R72 was not able to operate the controls appropriately.R72's care plan, with an initiated date of 08/01/25, and a target date of 06/09/26, states: [R72] has potential for falls related to CVA with left hemiparesis, dementia, weakness, balance deficit, seizure disorder, medications received, recent history of falls, decreased safety awareness and will be free of injury through review date. Interventions include: Dependent with use of electric recliner. -unable to use safely independently (Date Initiated: 08/01/2025). Pool noodle to right side of bed-left side of bed against wall (Date Initiated: 04/20/2026).Surveyor reviewed R72's fall notes and investigations:On 11/04/25, R72 had an unwitnessed fall in room. Facility investigation determined root cause to be R72 positioning self too close to the edge of the bed. New safety intervention to use a pool noodle to help R72 navigate boundary of mattress. R72's care plan was updated.On 11/22/25, R72 had an unwitnessed fall in room. R72 was unable to state what happened. Facility investigation determined root cause to be that staff did not place pool noodle on the bed. Re-education was completed with staff on ensuring pool noodle was placed on the bed and to follow R72's plan of care. No additional safety interventions were implemented. No staff interviews were completed. No staff competency evaluations were completed.On 12/23/25, R72 had an unwitnessed fall resulting in an abrasion on R72's left eyebrow. R72 was unable to state what happened. Facility investigation determined that the pool noodle was not in place. Re-education was completed with staff on ensuring pool noodle was placed on the bed and to follow R72's plan of care. No additional safety interventions were implemented. No additional skin assessments were documented of R72's injury. No staff interviews were completed. No staff competency evaluations were completed.On (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	03/28/26, R72 had an unwitnessed fall in room, falling out of electric recliner. Facility investigation determined root cause to be R72 resting in recliner unsupervised. New safety intervention to move R72's recliner to day area for R72 to rest with supervision and encourage rest periods in bed. No documentation of reviewing adequate supervision was noted. No staff interviews were completed. No staff competency evaluations were completed.Of note: supervised use of electric recliner was initiated on 08/01/25.On 04/25/26, R72 had an unwitnessed fall. R72 was found lying on floor next to recliner. Facility's investigation determined root cause to be sleeping in recliner. New safety intervention to attempt to place in bed on first rounds if in recliner. No documentation of reviewing adequate supervision was noted. No staff interviews were completed. No staff competency evaluations were completed.On 06/03/26 at 2:30 PM, Surveyor interviewed Assistant Director of Nursing (ADON) I regarding R72's falls. Surveyor asked ADON I how the facility determines the root cause after a fall if a resident is unable to state what happened and it is not witnessed. ADON I stated interviews with staff would be completed, audit of care plan, and additional review of staff involved. Surveyor asked ADON I if a review of staff competency was completed after R72's fall. ADON I stated no. Surveyor asked ADON I if audits or reviews were completed to determined adequate supervision of R72 using electric recliner. ADON I stated no. ADON I stated a more thorough investigation of R72's falls should have been completed.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids 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 residents received care and services for administration of parenteral medications consistent with professional standards of nursing practice for 2 residents (R17, R96) of 2 residents receiving parenteral medications reviewed in a sample of 20 residents. ~ R17 did not have arm circumference measurements at insertion site documented to ensure the peripherally inserted central line (PICC) was patent and not infiltrating into surrounding tissue during intravenous medication administrations. ~RN did not measure the circumference of R96's arm to ensure IV fluids via PICC line were not infiltrating surrounding tissue and not into the blood stream. Example 1 R17 was admitted to the facility on [DATE] and has diagnoses including Charcot-Marie-Tooth Disease (an inherited genetic condition that damages the peripheral nerves), right foot osteomyelitis (infection within the bone) and right hip septic arthritis. R17 has a Brief Interview for Mental Status (BIMS) score of 15/15, which means cognitively intact. R17 has a legal representative for healthcare decision making but is cognitively aware of medical diagnoses and treatment. R17's care plan, dated 05/08/2026, with target date 08/19/2026, states, Resident with right hip septic arthritis and right foot osteomyelitis. Interventions. administer antibiotic as per MD (medical doctor) orders. R17 has physician orders, dated 05/22/2026: Daptomycin 600mg (milligrams) intravenously (IV) one time a day for osteomyelitis. R17 has physician orders, dated 05/09/2026: Measure circumference of upper arm above insertions site daily. On 06/01/2026 at 10:00 AM, Surveyor observed R17 had a PICC line in place right upper arm. R17's PICC had a dated transparent dressing in place. R17 stated was aware of PICC placement and IV medication administration through the PICC. On 06/02/2026 at 11:23 AM, Surveyor asked R17 if nurses measured arm circumference at PICC site daily. R17 stated pretty much every day. R17's treatment administration record (TAR) for May 2026, did not have numerical documentation of daily arm circumferences. Beginning of 05/09/2026, R17's TAR has check marks at AM SH time with nursing initials for documentation of measurement of R17's arm circumference. R17's medical chart does not have nursing documentation of arm circumference measurements for comparison monitoring. On 06/02/2026 at 2:45 PM, Surveyor asked the nurse who measured R17's arm circumference earlier that day, licensed practical nurse (LPN) H, what R17's arm circumference was and where it was documented. LPN H stated there was no place to document a numerical value on the TAR. Surveyor asked LPN H how it was determined there was no change in R17's arm circumference if there were no numerical values documented daily for comparison. LPN H stated there was no way to determine (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	changes in R17's arm circumference. Surveyor asked LPN H what R17's measurements were for the day, and LPN H stated, 3cm (centimeters). Surveyor asked LPN H if the measurement was accurate, and LPN H went to a medication cart, pulled out the paper measuring tape used for R17 and stated, I am wrong, it was 30cm, not 3cm. I don't know IV's well. LPN H stated if there were documented measurements for comparison, it would be easier to determine inaccurate measurements and possible infiltrations. On 06/03/2026 at 8:54 AM, Surveyor asked Director of Nursing (DON) B where nurses document arm circumference measurements on residents with PICCs. DON B stated on a resident's TAR. Surveyor asked DON B how nurses assess complications of a possible PICC infiltration without numerical measurements to know previous day's circumference on the TAR. DON B stated the facility's electronic medical record for the arm circumference documentation was not set up to enter numerical values; however, nursing can place a narrative note within the TAR. DON B confirmed there was no narrative charting and/or numerical values in R17's TAR of arm circumferences. Example 2 R96 was admitted to the facility on [DATE], with diagnoses including a stage 4 pressure ulcer of sacral region, colostomy, paraplegia, osteomyelitis, and spina bifida. R96's Care Plan, updated 5/28/26, states: Focus: Temporary: IV ATB (antibiotic) therapy with PICC (peripherally inserted central catheter) in place. Date initiated 5/28/26 Goal: Will not have any complications related to IV (intravenous) therapy through the review date. Interventions/Tasks: Monitor/document report to MD PRN (as needed) s/sx (signs and symptoms) of infiltration at the site: [E][NAME] at the insertion site, [T]aut or stretched skin, [B]lanching or coolness of the skin, [S]lowing or stopping of infusion, [L]eaking of I.V. fluid out of the insertion site. R96's physician orders include: Measure circumference of upper arm above insertion site daily. One time a day for PICC STANDING ORDER Measure circumference of upper arm above insertion site daily. 5/27/26 06:00. Surveyor reviewed R96's orders, MAR (medication treatment record) and TAR (treatment administration record). The order to measure circumference of arm was blank on the TAR since order started 5/27/26. On 6/2/26 at 8:28 AM, Surveyor observed Assistant Director of Nursing (ADON) Q hang R96's IV bag. ADON Q constituted (mixed) the IV, primed the tubing, set up the IV pump, and attached the IV to the PICC line using appropriate standards of care and infection control practices. ADON Q did not measure the circumference of R96's arm as ordered. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/4/26 at 7:38 AM, Surveyor interviewed ADON Q who stated they do not measure the circumference or change the dressing. ADON Q stated ADON Q schedules it to be completed usually on PMs, and the LPNs can do it. On 6/4/26 at 7:42 AM, Surveyor interviewed Licensed Practical Nurse (LPN) L who stated LPNs do not do anything with PICC lines. Surveyor clarified that Surveyor was referring to changing the dressing of the PICC line and not administering medication. LPN L stated no I wouldn't do that as I'm not trained on that. I can't, I am an LPN. On 06/4/26 at 7:44 AM, Surveyor interviewed ADON Q about when are LPNs trained on PICC line dressing changes and site assessment. ADON Q stated we do not do many IVs here. LPNS are not really trained, yeah some say they do it some say they don't. ADON Q stated ADON Q needs to talk with DON B about that. Surveyor asked for clarification what ADON Q stated in earlier interview about the order to be completed on the PM shift and the LPNs change the dressing and measure the arm circumference. ADON Q stated it was put on PMs because there is an RN also and they can help if the LPN does not do that. Surveyor asked if ADON Q could confirm that measuring order was scheduled for R96 on the PMs. ADON Q said no it is not but usually it is. 0n 6/4/26 at 8:08 AM, Surveyor interviewed DON B regarding the order to measure the upper arm circumference above the PICC line. DON B stated DON B believes R96 was one of the orders the template was updated for supplemental documentation in the TAR (treatment administration record.) DON B stated they can now document the measurements. DON B stated they will look for documentation of circumference sizes in progress notes and let Surveyor know. DON B stated the expectation is to follow the order. On 6/4/26 at 8:55 AM, DON B came back to Surveyor and stated we looked and looked and can't find any progress notes with measurements. DON B handed the June TAR to Surveyor and stated, this is the only measurement I can find. The MAR from June had a measurement from 6/3/26 only.