STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525327	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clement Manor Health Care Center	3939 S 92nd St Greenfield, WI 53228

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 1 (R59) of 1 sampled residents, received basic life support, including cardiopulmonary resuscitation (CPR), in a timely and effective manner. This deficient practice has the potential to affect 4 of 46 residents with full code status.*R59 was identified as a full code and staff did not immediately initiate CPR upon discovering R59 was pulseless and non-breathing.The facility's failure to provide basic life support for a resident with a full code status, created a finding of immediate jeopardy that began on [DATE]. Surveyor notified Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B of the immediate jeopardy on [DATE] at 11:36 AM. The immediate jeopardy was removed on [DATE]. However, the deficient practice continues at a scope/severity of E (potential for more than minimal harm/pattern) as the facility continues to implement its action plan.Findings include:The facility's policy and procedure titled CPR dated 6/2025 documents: RATIONALE: All residents have the right to be educated and informed about the risks and benefits of resuscitation and to have their wishes and desires upheld at all times while residing in the facility. (The facility) will support the legal and philosophical rights as well as the theological beliefs of residents to decide their specific course of care and treatment including the right to be resuscitated in the event of a cardio-pulmonary arrest.POLICY: (The facility) will honor all resident's requests for CPR/DNR with proper documentation and physician approval. Resident's preferences for change will be honored throughout the course of their stay at (the facility). If the resident declines to make a decision or sign the necessary paperwork, the resident will automatically be treated as a full code status. (The facility) offers Cardio-Pulmonary Resuscitation (CPR). Basic CPR (BLS) consists of chest compressions and rescue breathing performed by CPR certified personnel. Regardless of a resident's decision to elect CPR or decline any resuscitation options (DNR), in the event of choking or suspected choking, every resident will receive the Heimlich maneuver with emergency personnel (EMT) summoned in the maneuver is ineffective. Such could result in CPR being initiated. All licensed nurses will be certified in CPR.1.) R59 was admitted to the facility on [DATE] with diagnoses of acute hypoxemic respiratory failure due to acute on chronic heart failure with preserved ejection fraction, severe mitral valve regurgitation in the setting of volume overload, pulmonary hypertension, chronic kidney disease Stage IV/V requiring temporary dialysis, and anemia.R59's admission Minimum Data Set (MDS) assessment dated [DATE] documented that R59 was assessed to be cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 and did not have an activated Power of Attorney (POA). The MDS documents that R59 had elected to be a Full Code status on admission.R59's Advance Directives Care Plan initiated on [DATE] documented that R59 chose to be a full code or receive basic life support and CPR in case R59 went pulseless and non-breathing.R59's dashboard on the electronic medical record indicated R59 was a Full Code.On [DATE] at 2:49 AM, Registered Nurse (RN)-M documented a late entry for [DATE] at 6:00 PM. RN-M documented: R59 had returned from dialysis at 4:45 PM, vital signs were blood pressure 113/56, pulse 67, and blood sugar 143. R59 was awake and alert and feeling well. At 5:00 PM, the Certified Nursing Assistant (CNA) assisted R59 into the recliner for supper. RN-M (continued on next page)

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

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	documented R59 had eaten supper and at 6:00 PM a CNA had picked up R59's dinner tray. At 6:10 PM, a CNA walked by R59's room and observed R59 to be gray in color and not breathing. The CNA called to RN-M where RN-M found R59 breathless and pulseless, gray and cool to the touch. At 6:10 PM RN-M called 911 as R59 was a full code. RN-M called R59's family member and explained what was going on with R59 and confirmed R59 was a full code. RN-M documented chest compressions were started by RN-M and at 6:15 PM the Emergency Medical Technicians (EMTs) were at the bedside and took over life saving measures. R59 was taking a few breaths on their own when the EMTs left with R59.The OEM (Office of Emergency Management) Prehospital Care Report completed by the EMTs that responded to the 911 call documented the 911 call was received on [DATE] at 6:02 PM and the ambulance was dispatched at 6:04 PM arriving at R59's bedside at 6:07 PM. The narrative section of the form documented the ambulance was dispatched for a pulseless nonbreathing resident. Upon arrival on the scene, staff were performing CPR on R59. R59 was in a recliner. R59's face was pale, the core was warm to the touch, and R59 was unresponsive. Facility staff stated R59's last known well time was at approximately 5:50 PM when they cleaned up R59's dinner. Per facility staff, they had performed CPR for 3 minutes prior to EMT's arrival with no ventilations. R59 was confirmed to be in cardiac arrest and was placed on the floor for effective CPR. The EMTs documented R59 was shocked and regained a pulse prior to leaving for the hospital at 6:23 PM. Surveyor noted discrepancy in the times of events between RN-M's documentation and the EMT's documentation. The EMT's documentation was completed in real time while RN-M's documentation was written almost 7 hours after the event.On [DATE] at 3:01 PM, Surveyor requested from Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B all documentation for R59's code blue on [DATE] to include an incident report, any investigation of the event, a code flow sheet or checklist, progress notes, and hospital documentation from [DATE].On [DATE] at 8:00 AM, Surveyor received a copy of RN-M's progress note on [DATE] with the late entry for [DATE]. No other documents were provided.On [DATE] at 12:48 PM, Surveyor attempted to call RN-M. RN-M did not answer. A voicemail message was left to call Surveyor back and RN-M did not return the call.On [DATE] at 12:55 PM, Surveyor observed the crash (emergency) cart on the North Unit. The crash cart was 4 doors down from R59's room on the same hallway. There was a backboard on the bottom shelf of the cart, and the Emergency Cart Monthly Checks were completed for January, February, March, and [DATE]. January, February, and [DATE] had the same zip tag numbers while [DATE] zip tag numbers were different indicating the crash cart had been opened.In a telephone interview on [DATE] at 1:09 PM, Surveyor asked R59's family member what they could recall of the events on [DATE]. R59's family member stated R59 had texted them at 5:30 PM about what they hoped they were getting for dinner. R59's family member referred to the time stamp on their cell phone to recall and relay what time events happened. R59's family member stated at 6:04 PM, R59's family member got a phone call from RN-M telling them that R59 was gone. R59's family member stated they asked RN-M why they were not doing CPR or why paramedics weren't there. RN-M's response to R59's family member was, Oh, you want that? R59's family member stated R59 wanted life saving measures and had been asked that every time R59 went to the hospital or to the facility; the staff at the facility had explained the CPR process and yes, R59 had wanted it. R59's family member stated R59 had been at that facility in the past and wanted Full Code status then as well. R59's family member stated RN-M hung up the phone and called again at 6:21 PM stating the EMTs were taking R59 to the hospital and had left the facility.In an interview on [DATE] at 2:05 PM, Surveyor asked DON-B if there was any documentation from R59's code blue, such as a code flow sheet or any sort of summary of events. DON-B stated the interdisciplinary team had a debrief after the code, but nothing was documented because it was not a formal process. DON-B stated DON-B talks to all the staff involved to see what was done right or what needs to be improved. Surveyor asked DON-B what happens when there is a code. DON-B stated the code is paged overhead which goes to all the buildings on campus. DON-B stated the nurse, Licensed Practical Nurse (LPN)-N, from the CBRF (Community Based Residential Facility) responded to the page that (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	discussed at Quality Core quarterly until complete.The immediate jeopardy was removed on [DATE]. However, the deficient practice continues at a scope/severity of E (potential for more than minimal harm/pattern) as the facility continues to implement its action plan.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure residents received adequate supervision to prevent accidents for 2 (R9 and R23) of 4 residents reviewed for falls. *R9 experienced eleven falls since admission to the facility and R9's Falls plan of care was not revised after the falls to address the root causes of the fall. As a result of a fall, R9 sustained a right clavicle fracture and a left patella fracture. *R23 had a fall on 1/24/2026. The facility could not provide evidence that a post fall investigation was completed. R23's care plan was not updated post fall. Findings include: The facility policy and procedure titled Incidents – Reporting of Resident dated 5/2024 documents: PROCEDURE: . 5. An evaluation and analysis of the incident will occur in an attempt to identify the potential cause and to develop targeted interventions to reduce the potential for re-occurrence for incidents/accidents. 7. The unit RN/LPN will complete the [facility] Resident Accident/Incident Report form. 8. The original Resident Accident/Incident Report form will be kept with the report book until the physician and the resident representative have been notified. The report will then be given to the Nurse Manger for a completion check and then once signed by the MD, original given to DON and then Medical Director for review and signature. 9. The resident will be listed on the daily charting list for 72 hours and will also be listed on the 24 hour report board for the day of the incident. 10. The attending physician and the resident representative will be notified and it will be documented in the interdisciplinary notes. Documentation detailing the incident will be completed in the resident's medical record. 11. All incidents are thoroughly investigated and reviewed by the Interdisciplinary Team. 1.) R9 was admitted to the facility on [DATE] with diagnoses of dementia, emphysema, diabetes, and chronic kidney disease. R9's admission Minimum Data Set (MDS) assessment dated [DATE] documented that R9 was assessed to have severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 4. The MDS also documented that R9 had not had a fall since admission. R9's Falls Care Area Assessment (CAA) was not triggered for falls due to no falls documented as occurring. Record review documented R9 had a fall on 6/4/2025 at 9:30 PM which was not captured on R9's admission MDS. R9's Falls Care Plan was initiated on 6/3/2025 documented the following interventions: -Ensure that adaptive equipment, i.e. wheelchair, are within reach and in good repair. -Encourage and assist resident to wear non-skid footwear. -Remind resident to lock wheelchair brakes. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Encourage resident to wear and assist to apply eyeglasses while awake; keep eyeglasses clean and within reach. -Monitor resident for signs of fatigue when ambulating and encourage rest periods as needed. -Keep environment well-lit and clutter-free. -Keep call light within reach at all times. -Use gait belt for all transfers. -Keep bed in the low floor lock position. Make sure that the brakes are locked. -Ultra care low bed. On 6/5/2025 at 6:44 AM, in the progress notes, nursing documented R9 had a fall onto the knees next to the bed and R9 stated R9 was trying to get up and use the bathroom. R9 sustained a purple bruise to the right knee. The nurse documented on the Resident Accident/Incident Report that the fall occurred on 6/4/2025 at 9:30 PM and the new intervention was to have gripper socks on at bedtime. On 6/5/2025 at 3:00 PM, in the progress notes, the Interdisciplinary Team (IDT) documented R9's call light was within reach but not activated, R9 was last checked at 8:30 PM, and at the time of the fall, R9 was incontinent of urine. It was documented that the bed was locked and R9 did not have any footwear in place. The IDT documented gripper socks were to be utilized at bedtime. Surveyor noted R9's Falls Care Plan was not revised with this intervention and the intervention did not address R9's need to use the bathroom at the time of the fall. R9's Activities of Daily Living (ADL) Care Plan documented R9 was non-ambulatory. On 12/2/2025 at 4:00 AM in the progress notes, nursing documented: R9 was heard calling for help at 1:50 AM. R9 had last been seen at 1:00 AM sleeping in the recliner chair. When asked what R9 was doing, R9 stated R9 was getting up and slid out of the chair. R9's wheelchair rolled away as R9 did not have it locked. R9 reported pain to the right shoulder with decreased range of motion. An x-ray was taken of the right shoulder and showed arthritis with no fracture or dislocation. The nurse documented on the Resident Accident/Incident Report R9 should wear gripper socks when sleeping. R9's Falls Care Plan was revised on 12/2/2025 with the intervention: Fall on 12/2 NOC (night shift), Neuro check negative. POA aware of fall. XRAY to R (right) shoulder for decreased ROM (range of motion). Surveyor noted the intervention did not address the cause of the fall or prevent future falls and gripper socks were not added to the Care Plan. After the fall on 6/5/2025, the suggested intervention was to have R9 wear gripper socks at bedtime and Surveyor noted that the intervention was not added to R9's Falls Care Plan. On 12/6/2025 at 11:50 AM in the progress notes, nursing documented that R9 had extensive bruising to the right breast and chest measuring 34 cm x 35 cm. The bruise was deep purple/blue to the right breast extending up the right chest and around the right side towards the back. R9 stated R9 had fallen the other day and did not know the bruise was there. R9 had fallen on night shift on 12/2/2025 onto the right side of the body and an x-ray was ordered at that time. Bruising was to be expected. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 12/14/2025 at 2:00 PM in the progress notes, nursing documented R9 was noted to have a change in mentation with confusion. R9 fell the week before and was having increased confusion. R9 had been awake since 11:00 PM the night before and had not slept all night. R9 stated R9 is weak in the knees and was having difficulty standing. R9 stated the left knee was hurting. Upon assessment, R9's left knee was noted to have bruising to the inner knee, slightly swollen and tender, and warm to the touch. On 12/15/2025, the x-ray of the left knee was negative for fracture. On 12/19/2025 at 5:29 AM in the progress notes, nursing documented R9 was at the nurses' station area at 5:10 AM, up and ready for the day. At 5:15 AM, the nurse was called into R9s room where R9 was sitting on the floor in the bathroom. When asked what happened, R9 stated R9 was getting off the toilet. R9 was fully clothed with shoes on and nothing in the toilet. The nurse documented on the Resident Accident/Incident Report R9 should be encouraged to stay in the common area. R9's Falls Care Plan was revised on 12/19/2025 with the intervention: encourage resident to stay in common area. Surveyor noted the intervention did not address R9's statement of using the bathroom. On 12/19/2025 at 5:54 PM in the progress notes, nursing documented R9 had a fall at 3:30 PM in the doorway leading to the bathroom. R9 was noted to have a 1 cm x 1 cm purple area to the back of the head even after R9 denied R9 had hit their head. The nurse documented on the Resident Accident/Incident Report R9 should have Dycem placed in the chair. R9 was brought to the dining room at 4:30 PM when R9 reported to staff that R9 had a sharp pain to the chest along with shortness of breath and nausea. R9 was sent out 911 to rule out a concussion. R9 was admitted to the hospital on [DATE]. The admission history and physical documented R9 presented to the emergency department due to multiple falls at the facility, most recently about three times. There was a noted head injury with a complaint of a headache at the facility. R9 had a complaint of nausea and bruising to the left knee. R9 stated R9 was in a wheelchair and fell in the bathroom on the day of admission. R9 reported feeling dizzy when it happened. In the emergency room, R9 attempted to stand and became uncomfortable and tachycardic. R9s family did not feel comfortable at discharge and R9 was admitted for further evaluation and management. An x-ray of the left knee showed a comminuted plateau fracture (fracture of the left patella), and a CT scan of the head showed a mildly displaced fracture of the right clavicle. R9 was readmitted to the facility on [DATE] with a left knee immobilizer to be worn at all times, and no weight bearing to the left leg. No revisions were made to R9's Falls Care Plan after the fall on 12/19/2025 at 3:30 PM resulting in a hospitalization including the Dycem to the chair that was suggested by the floor nurse at that time. R9's Falls Care Plan was revised on 12/30/2025 with the interventions: -Physical Therapy to evaluate transfer status. -Fall on 12/29 PM , found on bilateral knees, [NAME] (roll out of bed). No injuries noted. Brace off at times of fall, incontinent. Intervention: bilateral floor mats placed on floor around bed and educate resident to call for staff assist. On 1/11/2026 at 5:22 AM in the progress notes, nursing documented on 1/10/2026 at 11:15 PM, R9 was on the floor lying on the right side with a purple bump starting and complained of right shoulder pain. R9 was sent to the hospital for evaluation and treatment. R9 was returned to the facility at 4:30 AM with no new injuries. The nurse documented on the Resident Accident/Incident Report R9 must be (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	in bed at night and not the recliner with mats. R9's Falls Care Plan was revised on 1/15/2026 with the intervention: Fall on 01/10/26: intervention: pt (patient) should be in bed with matts [sic] next to both sides of bed at hours of sleep. Surveyor noted R9 prefers to sleep in the recliner and this preference was not taken into consideration when determining interventions. Surveyor noted the Falls Care Plan was updated five days after the fall. R9's Falls Care Plan was revised on 2/4/2026 with the intervention, place call light on resident's shirt when in recliner, after R9 had a fall out of the recliner on 2/4/2026. On 2/5/2026 at 5:43 PM in the progress notes, nursing documented R9 was found sitting on the floor five minutes after the nurse had left the room. R9 attempted to self transfer from the wheelchair to the chair. R9 had taken their shoes off prior to the fall and only had socks on at the time of the fall. The nurse documented on the Resident Accident/Incident Report R9 should call for assistance. Surveyor noted R9 had increased confusion with dementia and reminding R9 to call for assistance would not be an appropriate intervention for R9. On 2/6/2026 at 1:28 PM in the progress notes, nursing documented R9 was found on their knees in the doorway of the room. R9 stated they were trying to escape. R9 was in isolation for positive COVID-19. R9 was last seen by the nurse around noon sitting in the recliner. R9 was toileted around 11:30 AM and was continent at the time of the fall. R9 had taken the gripper socks and leg brace off and was barefoot at the time of the fall. R9 remained restless and came out of the room frequently, redirection minimally effective. The call light was clipped to R9's shirt after assisting back into the wheelchair and R9 took it off and wheeled out of the room. The nurse documented on the Resident Accident/Incident Report R9 should be educated to call for assistance and be reminded to keep shoes on. Surveyor noted R9 had increased confusion with dementia and reminding R9 to call for assistance would not be an appropriate intervention for R9. The Falls Care Plan was not revised. R9's Falls Care Plan was revised on 2/6/2026 with the intervention, increase rounding to every 30 minutes while in isolation, after R9 had a second fall in the room on 2/6/2026 at 8:40 PM. On 2/7/2026 at 3:49 PM in the progress notes, nursing documented R9 was found on the floor at 9:50 AM. R9 was observed on many occasions transferring self from the wheelchair to the recliner. One-on-one was initiated. This intervention was not put in the Falls Care Plan and no other documentation showed R9 was on one-to-one supervision. The nurse documented on the Resident Accident/Incident Report R9 was continent at the time of the fall and should have floor mats to the bedside and frequent rounding. R9's Falls Care Plan was revised on 2/7/2026 with the intervention: offer toileting at shift change AM to PM shift. Surveyor noted this intervention did not address the root cause of the fall as R9 was continent at the time of the fall. On 2/8/2026 at 5:08 PM in the progress notes, nursing documented R9 was on the floor at 1:15 PM in front of the recliner. R9 had slid from the recliner onto the floor after R9 removed their shoes, socks, and TED stockings. The nurse documented on the Resident Accident/Incident Report R9 should have a soft touch call light and frequent rounding should be provided by staff. R9's Falls Care Plan was revised on 2/11/2026 with the interventions: -Encourage resident to call for assist. -Encourage resident to keep shoes on when out of bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Round on resident frequently. Surveyor noted these interventions were suggested after the falls on 2/5/2026, 2/6/2026, 2/7/2026 and 2/8/2026, three to six days after the falls occurred. On 2/23/2026 at 2:58 AM in the progress notes, nursing documented R9 had a fall on 2/22/2026 at 8:30 PM. A Certified Nursing Assistant saw R9 stand in front of the recliner, lose balance, and fall forward onto the floor hitting the left side of the forehead. R9 sustained a 2 cm x 2 cm raised area. The nurse documented on the Resident Accident/Incident Report R9 should wear gripper socks at night. R9's Falls Care Plan was revised on 2/23/2026 with the intervention: ensure gripper socks are on at bedtime. Surveyor noted this intervention should have been added to R9's Falls Care Plan on 6/5/2025. On 5/12/2026 at 10:15 AM, Surveyor observed R9 sitting in a wheelchair in R9's room. R9 was pushing the wheelchair with the feet, moving around the room. Two fall mats were noted to be folded up and leaning against the wall. R9 had minimal verbalization when asked questions. Surveyor asked R9's family member about R9's falls. R9's family member said R9 had not had a fall in a while but had a lot of falls in a short span of time a while back. In an interview on 5/13/2026 at 1:47 PM, Surveyor asked Certified Nursing Assistant (CNA)-T if R9 had any falls. CNA-T stated R9 had not had any falls recently. CNA-T stated when R9 is in bed they put fall mats on both sides and R9 needs more supervision when R9 was in the room because R9 kept trying to go to the bathroom, but that has been a while now. Surveyor asked CNA-T if R9 slept in bed at night or in the recliner. CNA-T stated R9 normally sleeps in the recliner, not the bed. In an interview on 5/13/2026 at 1:57 PM, Surveyor asked CNA-Q if R9 had any falls. CNA-Q stated R9 had not had any falls since CNA-Q had worked there. CNA-Q stated R9 has floor mats and uses a sit to stand lift for transfers. CNA-Q stated mostly they have to keep an eye on R9 to make sure R9 does not wander off. In an interview on 5/14/2026 at 9:37 AM, Surveyor asked Director of Nursing (DON)-B what the process was when a resident has a fall. DON-B stated falls have an incident report procedure where the nurse on the floor makes sure the resident is safe and not injured and then will call the family and provider to inform them of the fall. DON-B stated a report is started by the floor nurse and that will be given to the nurse manager; the nurse manager gets any further information needed from the staff involved or the family if they were in the room when the fall occurred. The fall is discussed with the IDT. DON-B stated the facility is working on the plan for falls by evaluating the incident report process and overhauling it by taking the paper reports away. Surveyor reviewed with DON-B each fall R9 had and the concerns with each fall with the Falls Care Plan not being revised with new interventions or appropriate interventions; gripper socks were not added to the care plan when they were first suggested after the fall on 6/4/2025 and fall mats were implemented when R9 typically sleeps in the recliner. DON-B stated DON-B would look to see if more information could be found for each fall. In an interview on 5/14/2026 at 12:48 PM, Surveyor asked Licensed Practical Nurse (LPN)-U what role does an LPN play when a resident has a fall. LPN-U stated the nurse will assess the resident and make sure they are safe, and then the nurse will call the doctor and the family to let them know about the fall. Surveyor asked LPN-U what documentation would be completed by the nurse. LPN-U stated the incident is documented in the medical record including neurological checks. LPN-U stated the nurse would add any interventions to the care plan to prevent another fall and then would report to the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	next shift what happened. In an interview on 5/14/2026 at 12:54 PM, DON-B stated no further information regarding care plan revisions for R9 could be found and care plan revisions will have to be addressed with staff through an in-service. DON-B stated the toileting intervention that was suggested for the fall on 2/7/2026 was already in R9's Continence Care Plan. Surveyor shared that R9 was continent at the time of the fall on 2/7/2026 so that was not an appropriate intervention revision as it did not address the cause of the fall. Surveyor shared with DON-B the concern interventions were not implemented prior to the 12/19/2025 falls resulting in hospitalization and fractures to the right clavicle and left patella. DON-B stated these concerns would be shared with Nursing Home Administrator (NHA)-A. No additional information was provided at that time. 2.) R23 was admitted to the facility on [DATE] with pertinent diagnoses that include dementia (a syndrome that can be caused by a number of diseases which over time destroy nerve cells and damage the brain, typically leading to deterioration in cognitive function (i.e. the ability to process thought) beyond what might be expected from the usual consequences of biological ageing), anxiety disorder (persistent, excessive fear or worry in situations that are not threatening), sleep disorder (a condition that consistently disrupts your natural sleep patterns, affecting the quality, timing, and amount of sleep you get), repeated falls and bilateral hearing loss (a condition where a person experiences reduced hearing ability in both ears). R23's Quarterly Medicare Minimum Data Set (MDS) with an assessment reference date of 2/12/2026 documents a Brief Interview for Mental Status score of 02 indicating severe cognitive impairment. The MDS documents that R23 was assessed as usually understanding others and is usually understood by others and documents no other behaviors were documented for R23. R23's [NAME] Fall Risk Tool assessment was completed on 2/12/26 with a score of 39. 36 and over, indicating that R23 is at significant risk of falls. R23's progress note dated 1/24/2026, written at 8:51pm, documents: Resident found on side of bed, no injury to head. Small 3 separate skin tears found on inner left arm. Resident does not recall why she fell or what she was trying to get. R23's Falls care plan documents: Susceptibility to hazards related to progression of Dementia, hx (history) falls, kyphosis, lack of coordination, and decreased safety awareness as evidenced by hx of falls. Pertinent recent interventions include: -Bed knee height of res (resident). Start: 09/29/2025 -Ensure bed alarm is plugged in at all times. Start: 12/05/2025 -Soft touch call light. Start: 12/05/2025 -Continue current safety measures. Start: 12/05/2025 Surveyor was unable to locate any documented interventions after 12/05/2025. Surveyor noted that R23's last fall was 1/24/26 after which no new interventions were added to R23's plan of care. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 05/13/2026, at 3:17 PM, during the end of day meeting with facility, Surveyor requested additional fall investigation information regarding R23's fall on 1/24/26. Per Nursing Home Administrator (NHA)-A, the fall report is missing. NHA-A informed Surveyor that NHA-A saw that the fall is logged in the tracker so NHA-A knows it was given to physician for signature. NHA-A thinks the physician may have taken R23's fall report. On 05/14/2026, at 9:22 AM, Surveyor followed up with Director of Nursing (DON)-B regarding R23's fall investigation and neurological checks from 1/24/26 and was told they are still working on finding the information. Due to missing documentation, Surveyor was unable to verify if fall interventions were in place prior to R23's fall on 1/24/26. Due to missing documentation, Surveyor was unable to verify what the root cause of R23's fall on 1/24/26. No additional information was provided regarding the missing completed fall investigation and neurological checks for R23's fall on 1/24/26.

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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, staff interview, and record review, the facility did not ensure food was stored, prepared, distributed, and served in accordance with professional standards for food safety. This practice had the potential to affect all 46 residents residing in the facility. *Equipment in the kitchen was not in clean, sanitary condition. Three prep stations had grease built-up on the front and back, legs of prep stations had dried food on them, crumbs in the crevices of the doors, splattered dried food on the front. The heater had red dried splattered food on it. The temp fryer had crumbs on the crevices on the back and the cords and plug ins are extremely caked with dried food and grease. The stove had dried food and grease on the front, crumbs in the crevices under the buttons. The convection oven and fryer had dried splattered food and grease. *A scoop was observed to be left in the ready to use flour bin. The lids to the ready use items flour and sea salt were dirty and sticky. *The wall behind the dish machine was splattered with dried food items and was dirty. *On /13/26, Laundry Aide (LA)-H was observed in the kitchen without a hairnet on. *The refrigerator on the north unit had a dried spilled substance under the drawers. Findings include: The Cleaning and Sanitation of Dining and Food Service Areas policy dated 2023 policy documents: Policy: . The food and nutrition services staff will maintain the cleanliness and sanitation of the dining and food service areas through compliance with a written, comprehensive cleaning schedule. Procedure: 1.The director of food and nutrition services will determine all cleaning and sanitation tasks needed for the department. 2.Tasks shall be designated to be the responsibility of specific positions in the department. 3.Staff will be trained in the frequency of cleaning, as necessary. 4.The methods and guidelines to be used and agents used for cleaning shall be developed for each task or piece of equipment to be cleaned. 5. A cleaning schedule will be posted for all cleaning tasks, and staff will initial the tasks as completed. 6.Staff will be held accountable for cleaning assignments. The Sample Cleaning Schedule documents: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Daily: Exterior of dishwashers and other appliances -Monthly: Clean behind and under major appliances Vacuum and dust back of appliances Drawers and shelves -Twice Per Month: Ovens Kitchen cabinets and drawers -Refer to Housekeeping/Maintenance: Walls Cleaning Instructions: Cabinets and Drawers Policy: Cabinets and drawers will be free of food particles and dirt. They should be cleaned at least twice a month and as needed when spills occur. Procedure: . 3. Clean cabinet and drawers with a clean cloth soaked in mild detergent and water. Cleaning Instructions: Deep Fat Fryer Boil Out Process: Policy: . Fryers will be deep cleaned and sanitized at least every three months. Procedure: . 13. Spray the exterior of the deep fryer and the counter with a degreasing solution, allowing it to sit for a few minutes to remove grease. Wipe it down with a non-abrasive cloth and degreasing cleaning solution. Cleaning Instructions: Ovens Policy: . Ovens will be cleaned as needed and according to the cleaning schedule (at least once every two weeks). Spills and food particles will be removed after each use. Procedure: . 10. Clean the outside of the oven including the shelf above the stove top and the oven handles. 11.Remove spills and food particles after each oven use as needed. On 5/12/2026, at 8:43 AM, Surveyor completed the initial tour of the kitchen. Surveyor observed the three prep stations had grease build-up on the front and back, legs of prep stations had dried food on them, crumbs in the crevices of the doors, splattered dried food on the front. The heater has red dried splattered food on it. The temp fryer has crumbs on the crevices on the back and the cords and plug ins are extremely caked with dried food and grease. The stove was observed to have dried food and grease on the front, crumbs in the crevices under the buttons. The convection oven and fryer had dried splattered food and grease. Surveyor observed the ready to use flour bin had a scoop in it and the lids of the ready to use flour and sea salt are dirty and sticky. On 5/13/2026, at 8:23 AM, Dining Services Manager (DSM)-G explained to Surveyor the deep fryer oil is cleaned out per the log posted. Surveyor notes the oil was last cleaned out on 5/4/26. DSM-G (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	explained the ovens should be cleaned two times a month, the fryer is cleaned one time a month or as needed. Surveyor and DSM-G tour of the kitchen together at this time. Surveyor pointed out the scoop in the ready to use flour and the dirty lids of the ready to use flour and sea salt. Head Chef (HC)-E, DSM-G, and Surveyor toured together the rest of the kitchen. Surveyor pointed out to HC-E and DSM-G the three prep stations had grease build-up on the front and back, legs of prep stations had dried food on them, crumbs in the crevices of the doors, splattered dried food on the front. The heater had red dried splattered food on it. The temp fryer has crumbs on the crevices on the back and the cords and plug ins are extremely caked with dried food and grease. The stove had dried food and grease on the front, crumbs in the crevices under the buttons. The convection oven and fryer had dried splattered food and grease. Both HC-E and DSM-G agreed the equipment was dirty and should have been cleaned. On 5/13/2026, at 8:37 AM, Surveyor observed the first refrigerator on the north unit had a large, dried spill under the two drawers. DMS-G entered the unit at this time and Surveyor pointed out the condition of the refrigerator. DSM-G stated it is the responsibility of the kitchen staff to keep the refrigerator clean. On 5/13/2026, at 9:19 AM, Surveyor shared the concern of the sanitation and cleanliness of the equipment and the scoop left in the ready to use flour with DMS-G. DSM-G agreed it is a concern and HC-E already has someone cleaning the equipment. DSM-G is unable to provide completed scheduled cleaning logs of the equipment to verify cleaning on a regular basis. On 5/13/2026, at 12:49 PM, Surveyor observed the wall behind the dish machine to be dirty with dried splattered food on the wall. At this time, Surveyor observed Laundry Aide (LA)-H walking into the kitchen with no hair net on. Surveyor observed Dining Services Supervisor (DSS)-F tell LA-H, you have to remember you need a hair covering when coming into the kitchen. On 5/13/2026, at 10:44 AM, Surveyor shared the concern of the sanitation and cleanliness of the kitchen equipment, refrigerator on the north unit, and LA-H in the kitchen without a hair covering on with Nursing Home Administrator (NHA)-A. At this time, no further information has been provided. 2.) The facility policy and procedure titled Food Service Preparation, Cooking & Meal Serving Policy dated 5/15/2026 documents: . 8. Meal Service Process -Meals may be served in dining rooms or resident rooms based on preference and care needs. -Meals must be served promptly and in an appealing manner. -Verify tray accuracy at point of service: resident name, diet order, restrictions -Use clean, sanitized utensils. -Avoid touching food-contact surfaces. -Use proper utensils for ice handling. On 5/12/2026 at 12:07 PM, Surveyor observed lunch service in the South Unit dining room. Surveyor observed Server-L plating the food to be given to the residents in that dining room and the room trays for the South Unit. The menu consisted of hamburgers and Polish sausages on buns. Surveyor (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	observed Server-L using gloved hands to open the warming cart, take lids off the metal bins in the steam table, and touch resident meal tickets. Surveyor observed Server-L reach into the bag of hamburger buns with a gloved hand and remove the bun from the bag. Server-L opened the hamburger bun with the gloved hands, set the bun halves on the plate, and used a spatula to get the hamburger patty from the steam table. Server-L pushed the hamburger patty off the spatula with the gloved hand onto the bottom half of the bun. Server-L put the top of the bun onto the hamburger patty with the gloved hands and cut the hamburger in half with the spatula. Server-L picked up both halves of the hamburger and set one half of the hamburger down on a plate and set the other half of the hamburger down on the server surface of the steam table. Server-L removed the gloves, blew their nose, and then washed their hands. Server-L pushed up their glasses and then put gloves on. Server-L opened the warming cart with gloved hands, grabbed a bun out of the bag, and opened it to put a hamburger patty on the bun. Server-L picked up the bun top and placed it on the hamburger patty. Server-L took out a hot dog bun from the bag opening the bun with gloved hands, put a Polish sausage into the bun, and placed it on a plate. Server-L used gloved hands multiple times to get buns out of the bags and open the buns. Server-L used a pair of tongs to get the hot dog bun out of the bag and then used gloved hands to pry open the bun to place a Polish sausage into the bun. Server-L was observed throughout the meal service to touch contaminated surfaces with the gloved hands between touching the ready to eat buns that were being served to the residents. Surveyor shared with Server-L the observation of Server-L touching all the buns with gloved hands after touching other contaminated surfaces and then using tongs to remove the buns from the bags at the end of the meal service. Surveyor asked Server-L if Server-L should have been using the tongs for the whole service. Server-L stated Server-L was not using the tongs at the beginning of the meal and then changed to using the tongs because Server-L remembered that tongs should have been used the whole time to get the buns out of the bag. Server-L stated Server-L was not sure if Server-L still needed to use the tongs once the buns were out of the bag or if they should have been used the whole time. On 5/12/2026 at 3:01 PM, Surveyor shared with Nursing Home Administrator (NHA)-A the observation of Server-L touching multiple contaminated surfaces with gloved hands and then touching the ready to eat buns during the plating of the lunch meal as well as setting half of a hamburger onto the contaminated server surface of the steam table. Surveyor shared the concern that the ready-to-eat food had been contaminated by Server-L's gloves. NHA-A agreed Server-L should not have been touching the food.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interview and record review the facility did not ensure a thorough investigation into a Covid outbreak was conducted. This had the potential to affect all 46 residents.The facility had a Covid outbreak on 2/7/26. The line list documents by 2/7/26, three residents were diagnosed with Covid. The facility did not conduct and document an investigation into this outbreak.Findings include:Surveyor reviewed the facility's Covid outbreak that began on 2/7/26. The outbreak line list documents on 2/15/26, R61 developed respiratory symptoms and tested positive for Covid. On 2/16/26, R39 developed respiratory symptoms and tested positive for Covid. On 2/17/26, R40 developed respiratory symptoms and tested positive for Covid. The facility did not document if any staff had any respiratory symptoms during that time period. The facility documented interventions put into place such as signage posted, communication to staff, emails to families and medical director notified, health department updated, contact tracing, PPE (Personal Protective Equipment) rounding and increased cleaning. The facility also conducted symptom monitoring for residents on the affected units. On 5/13/26 at 1:30 p.m., Surveyor interviewed Infection Control (IC) Registered Nurse (RN)-W. Infection Control (IC) RN-W stated she began her role in Infection Control in early January 2026. Surveyor reviewed with IC RN-W, the outbreak line list provided, and the list of interventions completed during the outbreak. Surveyor asked IC RN-W if a summary of an outbreak investigation was completed. Surveyor also asked if they conducted any tracking of staff who may have been ill during the outbreak period. IC RN-W stated she was unsure because she was fairly new and was still in training. On 5/13/26 at 2:04 p.m., Surveyor interviewed RN-V. RN-V had been helping IC RN-W with some of the infection control duties while IC RN-W was being trained. RN-V stated an outbreak investigation wasn't completed. On 5/13/26 at 3:25 p.m., during the daily exit meeting with Director of Nursing (DON)-B and Nursing Home Administrator (NHA)-A, Surveyor explained the concern an outbreak investigation was not completed for the Covid outbreak on 2/7/26.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. Based on interview and record review the facility did not ensure 6 (R60, R39, R1, R40, R37 and R33) of 6 residents reviewed for receiving antibiotics had indications for use of antibiotics.The facility uses McGeer's Criteria to determine indications of possible infections. R60, R39, R1, R40, R9, R37 and R33 did not have the necessary symptoms to indicate an infection. The facility's former Medical Director-K was informed these residents did not have indications of infection based on the facility's standard of practice and continued to prescribe antibiotics for those residents.Findings include:The facility's Antibiotic Reporting and Stewardship policy with reviewed date of 1/2025 documents: Complete infection tracking report manually or through tracking software. Tracking using McGeer Criterion will aid you in determining if the symptoms reveal a true infection or not.Note: remember that taking antibiotics excessively or unnecessarily for not true infections predisposes to other infections (i.e. MRSA (methicillin-resistant Staphylococcus aureus), C. Diff (Clostridioides difficile)). MD must be notified when the infection does not meet McGeer's criteria.Surveyor reviewed the facility's infection line list along with the infection rates. Surveyor discovered several residents that did not have an infection documented on the line list but were prescribed antibiotics.R60's McGeer's criteria form dated 3/26/26 documents R60 did not have symptoms that met the criteria for a urinary tract infection (UTI) and was prescribed antibiotics. R39's McGeer's criteria form dated 4/1/26 documents R39 did not have symptoms that met the criteria for a fungal skin infection and was prescribed an antifungal cream. R1's McGeer's criteria form dated 4/5/26 documents R1 did not have symptoms that met the criteria for pneumonia and was prescribed antibiotics. R40's McGeer's criteria form dated 4/17/26 documents R40 did not have symptoms that met the criteria for cellulitis and was prescribed antibiotics. R37's McGeer's criteria form dated 4/27/26 documents R37 did not have symptoms that met the criteria for a urinary tract infection (UTI) and was prescribed antibiotics. R33's McGeer's criteria form dated 4/6/26 documents R33 did not have symptoms that met the criteria for cellulitis and was prescribed antibiotics. On 5/13/26 at 1:30 p.m., Surveyor interviewed Infection Control Registered Nurse (RN)-W. Surveyor explained the concerns with residents not meeting criteria for an infection and being prescribed antibiotics. Infection Control RN-W stated she is still new, and RN-V was responsible for tracking infections during that time period. On 5/13/26 at 2:04 p.m., Surveyor interviewed RN-V. RN-V stated she had been responsible for infection control while Infection Control RN-W was being trained. RN-V stated the infections were being monitored and the residents that did not meet McGeer's criteria were kept on the line list and then indicated that it did not meet McGeer's criteria. Surveyor asked if the physician was educated that the residents' symptoms did not meet McGeer's criteria. RN-V stated the physician was former Medical Director-K. RN-V stated former Medical Director-K was educated and explained the facility's standard of practice regarding infections and former Medical Director-K insisted on prescribing antibiotics. RN-V stated former Medical Director-K has retired and the facility has a new Medical Director. RN-V stated things have improved regarding infection control with the new Medical Director.On 5/13/26 at 3:25 p.m., during the daily exit meeting with Director of Nursing (DON)-B and Nursing Home Administrator (NHA)-A, Surveyor explained the concern regarding residents being prescribed antibiotics and not meeting the facility's standard of practice of infections.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment were thoroughly investigated for 1 (regarding R33) of 3 allegations reviewed. *R33 reported concerns of misappropriation that were not investigated thoroughly, no like resident interviews were conducted. Findings include: The Facility Policy and Procedure titled Freedom from Abuse, Neglect, Exploitation, Misappropriation of Property last revised 3/2025, documents (in part): Policy: 1.Residents will not be subjected to abuse by anyone including, but not limited to, facility staff; other residents; consultants or volunteers; staff of other agencies; family members; legal guardians; friends; or other individuals. V. and VI. Investigation and Reporting: All incidents of mistreatment, suspected abuse, including resident to resident, neglect, exploitation, misappropriation and incidents of unknown etiology are investigated immediately (around the clock, and on any day of the week), utilizing the following format: ***Note: A thorough investigation may include: . Interviewing alleged victim(s) and witness(es) Interviewing accused individual(s) (including staff, visitors, resident's relatives, etc.) allegedly responsible for mistreatment, or suspected of causing an injury of unknown source Interviewing other residents to determine if they have been abused or mistreated Interviewing staff who worked the same shift as the accused to determine if they ever witnessed any mistreatment by the accused Interviewing staff who worked previous shifts to determine if they were aware of an injury. R33 was admitted to the facility on [DATE] with diagnosis that include Parkinson's disease and Type 2 diabetes. R33's admission Minimum Data Set (MDS) assessment dated [DATE] documents R33 is cognitively intact. On 5/12/26 at 10:05 AM, Surveyor interviewed R33. R33 informed Surveyor R33 was overwhelmed by a situation that recently happened. R33 informed Surveyor that fraudulent charges were made on R33's bank account. R33 stated it had been a nightmare. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed the facility reported incident (FRI) regarding R33's alleged misappropriation. R33's Misconduct incident report dated 4/13/26 documents, in part: On 4/13/26, the facility [Chief Operating Officer] COO-DD was notified by [R33's] bank of suspected fraudulent activity involving the credit card of [R33], who currently resides in the Health Center. The bank reported concerns regarding unauthorized transactions, indicating possible misappropriation of the resident's credit card. Additionally, [R33's] family contacted the facility to report the suspected fraud and expressed concern that the activity may involve a staff member. Law enforcement was notified. The facility summary of the investigation documented, in part: [COO-DD] received a phone call from [the bank] . reporting suspected misappropriation of [R33's] credit card. The bank identified multiple unauthorized transactions made . The name associated with the transaction was reported . and [facility] has no employee by that name . Both Social Workers were notified immediately and initiated an internal investigation . The [Police Department] was notified and an officer responded . to interview [R33] . On 5/13/26 at 10:24 AM, Surveyor interviewed COO-DD. COO-DD confirmed COO-DD spoke to R33's bank multiple times on 4/13/26. R33's bank staff informed COO-DD that R33's family suspected the fraudulent spending on R33's debit card could have been done by a staff member at the facility. The bank gave multiple names to COO-DD as possible people involved. COO-DD stated the names given to COO-DD were then taken to the facility Human Resources and Scheduling department. None of the names given to COO-DD by the bank were employed anywhere on the facility campus. COO-DD stated that the facility Social Workers were aware of the alleged misappropriation concern and were completing other parts of the investigation. The facility investigation included staff interviews from all staff that worked in the shifts prior to and during the alleged misappropriation. Surveyor noted there were no resident interviews included in the investigation. Surveyor noted facility staff did not interview other residents to see if any other resident had a credit card missing or missing money. Surveyor noted staff education to prevent misappropriation was not documented as completed after this allegation of misappropriation. On 5/13/26 at 8:32 AM, Surveyor interviewed Social Worker (SW)-EE stated R33's family called SW-EE on 4/13/26 to make SW-EE aware that multiple fraudulent charges were placed on R33's credit card and R33's family stated it could be a staff member at the facility. SW-EE stated SW-EE notified Campus Administrator (CA)-CC right away. SW-EE and Director of Social Work (DOSW)-FF started an investigation. SW-EE stated R33 did not have the credit card at the facility. According to R33's family, R33 had written the credit card number down on paper. SW-EE searched R33's room for the card number and did not find it. SW-EE stated R33 does do a lot of online shopping. The police were called and came to interview R33. Police also searched R33's room and did not find any written credit card number. The police informed SW-EE they believed it was more of a bank investigation. SW-EE stated the team completed a full investigation and were not convinced that it happened at the facility. Surveyor asked if any resident interviews were completed. SW-EE stated SW-EE typically completes 3 resident interviews, but SW-EE would have to look back and see. On 5/13/26 at 9:06 AM, Surveyor interviewed Director of Social Work (DOSW)-FF. DOSW-FF stated (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	SW-EE came and got DOSW-FF and they went to interview R33 together. DOSW-FF called the police immediately and they came to the facility. DOSW-FF stated the police made it sound like this was going to be handled between R33 and R33's bank. Police were thinking this was computerized fraud. DOSW-FF created a questionnaire document for any staff that were working at the facility during the specific time frame would fill out. The unit managers then were responsible for getting the staff statements. Surveyor asked if any resident interviews were completed. DOSW-FF stated DOSW-FF was not asked to complete any resident interviews and is typically directed by the Administrator if resident interviews are needed. DOSW-FF stated there were no other missing items reported at that time from other residents and no other resident has or uses a credit card like R33. On 5/13/26 at 9:22 AM, Surveyor interviewed Campus Administrator (CA)-CC who was responsible for submitting and investigating the allegation of misappropriation. CA-CC stated CA-CC was made aware of the allegation, and an investigation immediately began. Police were called. HR and Scheduling were involved to investigate any name given to the facility by R33's bank. CA-CC stated Social Workers were collecting statements from any staff that worked. Surveyor asked if any resident interviews were completed. CA-CC stated Social Work was handling that when gathering all the other information. Surveyor informed CA-CC of the concern other residents were not interviewed after an allegation of misappropriation. CA-CC understood the concern. On 5/13/26 at 3:16 PM, Surveyor informed Director of Nursing (DON)-B, Nursing Home Administrator (NHA)-A, CA-CC, and COO-DD of the concern that a thorough investigation was not completed into R33's allegation of misappropriation. The investigation did not include any resident interviews to identify the potential scope of the concern.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the Facility did not develop and implement a comprehensive person-centered care plan to meet a resident's medical, and psychosocial needs for 1 (R8) of 13 residents reviewed. R8 is hard of hearing, R8 does not have a comprehensive care plan that addresses being hard of hearing and strategies to assist R8. Findings include: The Facility Policy titled Care Plans, last revised 11/2017, documents (in part): PolicyThe plan of care will involve assessing the patient's/resident's needs, condition, impairment, disability or disease and planning appropriate care .Procedure .2. The interdisciplinary team will formulate the interdisciplinary total plan of care.Key Point:This includes: setting the goals for each problem based on the patient's/resident's assessed needs, abilities, readiness, preferences and length of stay which are realistic and measurable; deciding the interventions that will meet the stated goals; writing appropriate plan of care; and deciding when to review or evaluate each problem to see if goals are being achieved.3. Implementation of the plan of care should indicate appropriate instructions.Key Point:How instructions are communicatedWhen to carry out the different instructionsShows coordinating of all aspects of careReflects the actual giving of careShows the responsibility of the patient/resident, family and each discipline . R8 was admitted to the facility on [DATE] with diagnoses that include Parkinson's disease (a progressive brain disorder that occurs when nerve cells in the brain die or become impaired, losing the ability to produce a vital chemical called dopamine). R8's Quarterly Minimum Data Set (MDS) with an assessment reference date of 2/26/2026 indicated R8 had a Brief Interview for Mental Status score of 15 indicating R8 is cognitively intact; adequate hearing and R8 does not use hearing aids; R8 is understood and understands others. R8's communication care plan documents impaired communication - expressive related to [blank] as evidenced by [blank]. Surveyor noted there are no pertinent interventions included. Surveyor noted this care plan was not completed as some areas were left blank. Surveyor reviewed R8's electronic medical record (EMR) and was unable to locate a comprehensive care plan related to R8 being hard of hearing. Surveyor noted R8's 2/26/2026 MDS assessed R8 to have adequate hearing. R8's Activities assessment dated [DATE] documents hearing is moderate difficulty. In the notes section of the assessment, it is documented when staff speak louder at her eye level and at times repeat conversation R8 is able to interpret conversation. On 05/12/2026, at 10:04 AM, Surveyor interviewed R8. Surveyor was asked to move closer and speak up to be heard by R8. On 05/13/2026, at 8:50 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-X who stated yes, R8 is hard of hearing. CNA-X stated R8 being hard of hearing does not impede activities as staff know to speak up. On 05/13/2026, at 8:58 AM, Surveyor interviewed R8 and asked if being hard of hearing impacted activities and R8 said no. R8 stated they go to whatever they want and they do ok interpreting what is said. On 05/13/2026, at 9:00 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-Y regarding R8 being hard of hearing and was told CNAs know how to interact and there is no effect on R8's care or ability to tell staff their needs. Staff know to talk up and make sure R8 can see our lips. On 05/13/2026, at 12:47 PM, Surveyor interviewed Director of Nursing (DON)-B regarding a care plan for R8 being hard of hearing. DON-B replied will check. On 05/14/2026, at 9:22 AM, Surveyor followed up with DON-B regarding the hard of hearing care plan for R8 and asked who would start a care plan for a hard of hearing resident? DON-B replied, it should have started on admission, DON-B stated they did not find anything in the care plan. DON-B shared R8's Activity Assessment says R8 has a moderate hearing problem, and it is noted for staff to speak louder to R8. Surveyor stated it is a concern a care plan was not initiated for R8 being hard of hearing, so all staff are aware how best to assist R8. No additional information was provided regarding the lack of a comprehensive care plan that addresses R8 being hard of hearing.

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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 received care in accordance with professional standards of practice following a fall for 2 (R9 and R23) of 4 residents reviewed for falls. *R9 did not have documented neurological checks completed after unwitnessed falls or falls with a head injury. *R23 had a fall on 1/24/2026. The facility could not provide evidence neurological checks were completed post fall. Findings include: The facility policy and procedure titled Incidents – Reporting of Resident dated 5/2024 documents: PROCEDURE: . 4. A resident evaluation/data gathering will be done by the unit RN (Registered Nurse)/LPN (Licensed Practical Nurse). A neurological check is completed per policy if a resident hits their head or for an unwitnessed fall of a confused resident, or BIMS (Brief Interview of Mental Status) score (less than) <15. (found in the MDS under section C). The facility policy and procedure titled Neurological Evaluation Sheet dated 5/2024 documents: The RN or LPN will monitor the level of consciousness by evaluating three behavioral responses: eye opening, verbal response and motor response. Pupil reaction, limb response and vital signs are also assessed. The data area reviewed to recognize trends and a neurological condition which is improving, static or deteriorating. After a fall, neurological checks will be performed for all confused and disoriented resident or for residents who have hit their head using the Glasgow Coma Scale (GCS) and Neurological Assessment Record. The frequency of neurological checks will be as follows over 72 hours: Twice per shift for 24 hours and then once per shift for 48 hours. If a resident is alert and oriented x (times) 3 and has had an unwitnessed fall and denies hitting their head and with a BIMs of 13-15, neurological checks will be performed QS (every shift) for 24 hours. If a resident is alert and oriented x3 and has had an unwitnessed fall and has a visible head injury, neurological checks will be as follows over 72 hours: Twice per shift for 24 hours and then once per shift for 48 hours. When an unwitnessed fall occurs for a resident receiving an anticoagulant, except aspirin, the physician will be notified promptly even though there is no visible sign of injury. Any adverse changes in the resident's condition are an indication to increase the frequency of observations and notify the physician immediately. 1) R9 was admitted to the facility on [DATE] with diagnoses of dementia, emphysema, diabetes, and chronic kidney disease. R9's admission Minimum Data Set (MDS) assessment dated [DATE] documented R9 had severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 4 and had not had a fall since admission. The Falls Care Area Assessment (CAA) was not triggered for falls due to a fall not documented as occurring. Record review documented R9 had a fall on 6/4/2025 at 9:30 PM which was not captured on R9's admission MDS. On 6/5/2025 at 6:44 AM, in the progress notes, nursing documented R9 had a fall onto the knees next to the bed and R9 stated R9 was trying to get up and use the bathroom. R9 sustained a purple bruise to the right knee. The nurse documented R9's vital signs and that neurological checks were negative. The nurse documented on the Resident Accident/Incident Report that the fall occurred on 6/4/2025 at 9:30 PM. No other documentation of neurological checks was found. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/25/2025 at 8:27 PM, in the progress notes, nursing documented R9's POA (Power of Attorney) and physician were aware of R9's fall and post fall monitoring was in place. R9 got up to go to the bathroom from the recliner and got dizzy and fell. A bruise was developing on the forehead at the hairline. No documentation of neurological checks was found at the time of the fall or on the night shift following the fall. Progress notes on 9/26/2025, at 9:39 AM, through 9/28/2025, at 10:33 AM, documented neurological checks were within normal limits. On 12/2/2025 at 4:00 AM, in the progress notes, nursing documented R9 was heard calling for help at 1:50 AM. R9 had last been seen at 1:00 AM sleeping in the recliner chair. R9's neurological checks were negative. Progress notes on 12/2/2025 documented neurological checks were negative. No documentation of neurological checks was found on 12/3/2026. On 2/8/2026 at 5:08 PM, in the progress notes, nursing documented R9 was on the floor at 1:15 PM in front of the recliner. R9 had slid from the recliner onto the floor after R9 removed their shoes, socks, and TED stockings. No documentation of neurological checks after this unwitnessed fall was found. On 2/23/2026 at 2:58 AM, in the progress notes, nursing documented R9 had a fall on 2/22/2026 at 8:30 PM. A Certified Nursing Assistant saw R9 stand in front of the recliner, lose balance, and fall forward onto the floor hitting the left side of the forehead. R9 sustained a 2 cm (centimeter) x 2 cm raised area. Nursing documented the neurological check was negative. One progress note on 2/23/2026, at 10:12 AM, documented neurological checks were negative. No other neurological checks were documented. In an interview on 5/14/2026 at 9:37 AM, Surveyor reviewed with Director of Nursing (DON)-B each fall R9 had and the concern neurological checks were not being completed after unwitnessed falls. Surveyor shared with DON-B the fall packets provided to Surveyor did not all include the neurological check flow sheets. DON-B stated DON-B would look to see if more information could be found for each fall. In an interview on 5/14/2026 at 12:48 PM, Surveyor asked Licensed Practical Nurse (LPN)-U what role does an LPN play when a resident has a fall. LPN-U stated the nurse will assess the resident and make sure they are safe, and then the nurse will call the doctor and the family to let them know about the fall. Surveyor asked LPN-U what documentation would be completed by the nurse. LPN-U stated the incident is documented in the medical record including neurological checks. Surveyor asked LPN-U how often neurological checks were completed after a fall and when neurological checks were expected to be completed. LPN-U stated the neurological checks are completed on all unwitnessed falls for residents who have a low BIMS score or if the resident said they hit their head. LPN-U stated it is written on the neurological check flow sheet how often the checks were supposed to be done but did not know offhand how often. Surveyor reviewed the neurological check flow sheet and at the bottom of the form it documents for a resident with a BIMS score of 13-15 and able to tell you they did not hit their head, neurological checks should be completed every shift for 24 hours. The form did not document how often neurological checks should be completed for a resident that did hit their head or if their BIMS was less than 13. In an interview on 5/14/2026 at 12:54 PM, DON-B stated there is limited documentation for neurological checks in the progress notes and was not able to find any additional flow sheets for the various falls. DON-B understood Surveyor's concern for lack of documentation of neurological checks. DON-B stated these concerns would be shared with Nursing Home Administrator (NHA)-A. No further information was provided at that time. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.) R23 was admitted to the facility on [DATE] with pertinent diagnoses that include dementia (a syndrome that can be caused by a number of diseases which over time destroy nerve cells and damage the brain, typically leading to deterioration in cognitive function (i.e. the ability to process thought) beyond what might be expected from the usual consequences of biological ageing), anxiety disorder (persistent, excessive fear or worry in situations that are not threatening), sleep disorder (a condition that consistently disrupts your natural sleep patterns, affecting the quality, timing, and amount of sleep you get), repeated falls and bilateral hearing loss (a condition where a person experiences reduced hearing ability in both ears). R23's Quarterly Medicare Minimum Data Set (MDS) with an assessment reference date of 2/12/2026 documents a Brief Interview for Mental Status score of 02, indicating severe cognitive impairment for R23. The MDS documents R23 was assessed as usually understands others and is usually understood by others. R23's progress note dated 1/24/2026, written at 8:51pm, documents: Resident found on side of bed, no injury to head. Small 3 separate skin tears found on inner left arm . Resident does not recall why she fell or what she was trying to get . On 05/13/2026, at 8:04 AM, Surveyor was provided the progress notes related to R23's fall after requesting the investigation packet with neuro checks. On 05/13/2026, at 3:17 PM, Surveyor requested additional information including neurological checks regarding R23's fall. Per Nursing Home Administrator (NHA)-A the fall report is missing. NHA-A can see it is logged in the tracker so knows it was given to the physician for signature. NHA-A thinks the physician may have taken it. On 05/14/2026, at 9:22 AM, Surveyor followed up with Director of Nursing (DON)-B regarding R23's fall investigation and neurological checks from 1/24/26 and was told they are still working on finding the information. No additional information was provided regarding the missing neurological checks and fall investigation to determine if interventions were in place at the time of R23's fall and to identify the root cause of R23's fall.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure 1 (R2) of 3 residents reviewed maintains acceptable parameters of nutritional status, such as body weight or desirable body weight range and electrolyte balance. R2 was documented to have a significant weight gain on 4/30/26 and 5/12/26 with no documentation indicating R2's provider or Registered Dietician (RD) was notified. Findings include: The facility's policy titled Weights - Obtaining Resident, dated 3/8/1993, last reviewed 03/2026, documents the following:Nursing interventions for a weight gain may include:Discuss the weight variation with the resident and/or the family.Discuss the weight variation with the dietitian.Obtain parameters from the Physician/dietician if a weight gain is desirable.Notify the physician and family of the weight gain.Add to the 24-hour report until weight verification.Reweights and Physician Notification:For a fluctuation of 5 pounds (unless otherwise ordered by the provider), plus or minus, within one month, the resident will be reweighed the next morning per policy and the provider, and the family will be notified after the reweigh.The reweight will be done in the morning before breakfast.A nurse will verify the reweights.Reweights will be documented in the weight tracking tab in the EMR. R2 is an [AGE] year-old resident who was admitted to the facility on [DATE]. R2's diagnoses include hydronephrosis (swelling of one or both kidneys that occurs when urine cannot properly drain from the kidney down to the bladder), constipation (difficulty having a bowel movement) and Parkinson's Disease (a progressive neurological disorder that affects the nervous system and the parts of the body controlled by the nerves). R2's admission Minimum Data Set (MDS) completed on 3/27/26 documents R2 has bilateral lower extremity impairments. R2 is dependent on staff for toileting hygiene, showering self, rolling left to right and transfers. R2 is documented as having a weight loss that is not on a physician prescribed weight loss regimen. R2's Care Area Assessment (CAA) for nutritional status documents; continue to the care plan to maintain optimal nutritional and health status. R2's Dehydration/Fluid Maintenance CAA documents; proceed to the care plan to observe for dehydration. R2 was documented as having a Brief Interview for Mental Status (BIMS) score of 15, indicating that R2 is cognitively intact. R2's care plan documents:R2 is at risk for nutritional decline related to acute kidney injury, hydronephrosis, Parkinson's Disease, hypotension, chronic kidney disease, anemia, history of constipation and obstructive sleep apnea.Goal: R2 will consume greater than or equal to 50 to 75% of meals served.Interventions include:Provide a least restrictive diet.Honor food/ethic preferences.Offer a bedtime snack.Adaptive equipment as needed.Assist at meals as needed.Monitor for chewing/swallowing problems.Offer and encourage fluids with meals, medication pass and between meals.Monitor need for supplements.Goal: R2 will maintain weight within 5% of 150 pounds.Interventions include:Nutrition rounds with weekly weight x (times) 4 weeks, then per policy.Monitor intake. Significant weight lossGoal: R2 will consume adequate energy to maintain weight at 5% of 150 pounds.Interventions include:Encourage an average of 75% of meals.Nutrition rounds per policy.Notify the physician, family and RD (Registered Dietician)/DTR of significant change. Surveyor reviewed R2's EMR (Electronic Medical Record) which documents the following weights:3/21/26 146.2 lbs.3/26/26 144.4 lbs.4/2/26 145 lbs.4/9/26 145.4 lbs.4/16/26 140.9 lbs.4/23/26 139 lbs.4/30/26 154.2 lbs. (Surveyor notes this is a 10.94% weight gain in one week)5/7/26 151 lbs.5/12/26 182 lbs. (Surveyor notes this is a 20.53% weight gain in one week) On 5/14/26, at 10:18 AM, Surveyor notes a significant weight change on 4/30/26 and 5/12/26 with no documentation in R2's EMR indicating R2's provider or Registered Dietician (RD) was notified. Surveyor also notes R2's EMR does not document R2 was reweighed after significant weight gains on 4/20/26 and 5/12/26 to verify if the weights are accurate. On 5/13/26, at 2:03 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-T who stated facility staff use a shower chair or hoyer lift that is kept in the shower room to weigh residents. CNA-T stated the aide will get a weight on a resident on shower days or if the nurse asks the aide to get a weight. Weights are obtained with the (continued on next page)

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	525327	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident in the shower chair with no clothes on at the time of shower/weights. CNA-T stated they always weigh the resident with no clothes on. CNA-T stated the aide then tells the nurse the weight and the nurse will enter the weight in the computer. On 5/13/26, at 2:09 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-Z who stated the CNA will perform the weights with showers and then tell the nurse verbally the weight for the nurse to enter the weight in the computer. LPN-Z stated if the resident weighs less than 100 pounds and there is a weight gain or weight loss of 3 pounds difference, the nurse will get the resident reweighed the following day and place them on the 24-hour board. If the resident weighs more than 100 pounds and there is a weight gain or loss of 5 pounds difference, the nurse will get the resident reweighed the following day and place them on the 24-hour board. LPN-Z stated if the reweigh is out of parameters after the reweight, facility staff will notify the Medical Director (MD) and document in a progress note. ON 5/14/26, at 8:48 AM, Surveyor interviewed Registered Dietician (RD)-AA who stated she is the consulting RD for the facility and works remotely. RD-AA stated the facility has a diet technician who completes assessments and performs interviews which she will review and then make recommendations. RD-AA stated she will assess everyone initially upon admission and then annually, or if the resident has a significant change such as weight loss. RD-AA stated the facility's current diet technician is Admissions Coordinator-BB who is working temporary until the position is filled. Admissions Coordinator-BB will notify RD-AA of any weight changes. Surveyor asked RD-AA if she was aware of recent weight changes noted for R2 and RD-AA replied yes, she was aware. RD-AA stated R2 experienced some weight loss related to fluid balance changes throughout R2's hospital stay prior to R2's admission to the facility. RD-AA then reviewed R2's weight while speaking to Surveyor and then stated the weight obtained on 5/13/26 was definitely not right and then stated her last note dated 4/10/26, documents R2 was eating well, and RD-AA added an oral supplement. RD-AA stated she doesn't know how accurate R2's weights are. Surveyor asked RD-AA if she would expect facility staff to notify her of R2's weight gain documented on 4/30/26, and RD-AA responded, no she wouldn't expect the facility to contact her because it's a discrepancy. RD-AA then stated if it truly were an accurate weight, it wouldn't be a dietary concern and most likely would be a nursing concern. RD-AA stated weights have always been a challenge wherever she works and she questions the accuracy of R2's weights. RD-AA does not have documentation requesting a reweigh for R2. Surveyor notified RD-AA of concerns with R2 having significant weight changes on 4/30/26 and 5/12/26, with no documentation indicating RD-AA or R2's provider were notified. On 5/14/26, at 9:07 AM, Surveyor interviewed admission Coordinator-BB who stated she was filling in as the facility's diet tech until the facility is able to fill the diet tech position. admission Coordinator-BB stated RD-AA is the facility nutrition consultant and admission Coordinator-BB is trying to push the workload to RD-AA for RD-AA to take things over more. admission Coordinator-BB stated she will update RD-AA with new admissions, keep an eye on various items such as weight changes, residents that are new to hospice and food preferences. Surveyor asked admission Coordinator-BB how she is notified with a resident having any weight changes. admission Coordinator-BB stated she would look into the EMR (Electronic Medical Record) however, then stated it's different now because admission Coordinator-BB is not fully in the diet tech role. admission Coordinator-BB stated nurses will hand over a diet slip for admission Coordinator-BB to look further into the resident. admission Coordinator-BB stated the Nursing Home Administrator (NHA)-A had asked admission Coordinator-BB for an update on R2's weights earlier today and admission Coordinator-BB requested staff reweigh R2 today due to inaccurate weights. admission Coordinator-BB stated RD-AA is also aware. Surveyor notified admission Coordinator-BB of concerns with R2's weight fluctuations with no documentation noted in R2's EMR indicating R2's provider or RD-AA was notified. On 5/14/26, at 8:36 AM, Surveyor notified Director of Nursing (DON)-B of concerns with R2's weight fluctuations with no documentation noted in R2's EMR indicating R2's provider or RD-AA was notified. DON-B acknowledged these concerns.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review and staff interviews, the facility did not ensure that 1 (R7) out of 5 residents reviewed for unnecessary medications had their Pharmacist Drug regimen review/recommendations acted upon in a timely manner.R7's monthly pharmacy review recommendation was not acted upon.Evidenced by:Surveyor conducted a review of R7's monthly drug regimen reviews From January 2026- May 2026.On 1/19/26, the reviewing Pharmacist indicated there was an insignificant irregularity that was identified for R7 drug regimen. The recommendation documented, please verify frequency of vital checks. Appears that last BP (Blood Pressure) and pulse were done on 12/10/25, over one month now. On 5/14/26 at 2:00 PM, Surveyor was provided with a copy of the facility's response to the pharmacy recommendation. It was documented there was a gap in documents. Surveyor notes there is no evidence of when the facility responded to the recommendation and if this information was shared with the physician for recommendations/response. On 2/16/26, the reviewing Pharmacist documented there was an insignificant irregularity that was identified for R7's drug regimen. The recommendation documented Patient (R7) is on hospice, consider med (medication) list evaluation and discontinuing the following medications to decrease pill burden? Eliquis, Amiodarone, Ferrous Sulfate, Pantoprazole, probiotic.On 5/14/26 at 2:00 PM, Surveyor was provided with a copy of the facility's response to the pharmacy recommendation. There is no evidence of when the facility responded and if this information was shared with the physician for recommendations/response.On 3/16/26, the reviewing Pharmacist documented there was an insignificant irregularity that was identified for R7's drug regimen. The recommendation documented, please verify the entry for Senna 8.6 milligrams in Matrix. Pharmacy has an order for Senna S (with docusate) every day and as needed. This is being dispensed. Please update order to match what is being administered and update the frequency to every day as needed. On 5/14/26 at 2:00 PM, Surveyor was provided with a copy of the facility's response to the pharmacy recommendation. Surveyor notes there is no evidence of when the facility responded and if this information was shared with the physician for recommendations/response.On 4/17/ 26, the reviewing Pharmacist indicated there was an insignificant irregularity that was identified for R7's drug regimen. The recommendation documented SECOND REQUEST-Please verify the entry for Senna 8.6 milligrams in Matrix. Pharmacy has an order for Senna S (with docusate) every day and as needed. This is being dispensed. Please update order to match what is being administered and update the frequency to every day as needed. Additionally- SECOND REQUEST- Patient (R7) is on hospice, consider med list evaluation and discontinuing the following medications to decrease pill burden? Eliquis, Amiodarone, Ferrous Sulfate, Pantoprazole, probiotic.On 5/14/26 at 2:00 PM, Surveyor was provided with a copy of the facility's response to the pharmacy recommendation. A note was written by the nurse practitioner on 5/11/26 stating will address at next visit. Surveyor notes this response was over 1 month overdue from the 3/16/26 pharmacy recommendations and this was the second request for these recommendations to be acted upon. On 5/14/26 at 2:15 PM, Surveyor conducted an interview with Director of Nursing (DON) - B regarding the monthly pharmacy reviews. DON- B stated that once they receive the recommendations, the facility will forward onto the provider. DON- B could not provide any additional information as to why the above pharmacy recommendations had not been addressed in a timely manner.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review, the facility did not ensure the daily nursing staff posting contained all required information accurately. This deficient practice has the potential to affect all 46 Residents residing in the facility.The facility's nurse staff posting did not accurately reflect the correct number of staff members on each daily nurse staff schedule. Findings include:The facility's Daily Staffing Post effective January 2025 documents:Rationale: . To provide visibility and transparency, nursing staffing data will be posted daily.Policy:Daily nursing staffing numbers will be posted for all RN (Registered Nurses)-LPN (Licensed Practical Nurses)-CNA (Certified Nursing Assistants) hours per DHS 483.35 in a visible location. The posting will be updated at the beginning of each shift. All changes from the previous day will be reflected and kept on hand for a minimum of 18 months.Procedure:1. A copy of the nightly census count will be placed in the scheduler's mailbox daily.3. At the beginning of the day, the scheduler/designee will produce the staffing post for the current and following day. For Fridays, the posting will be displayed through Monday.4.Any changes to staffing such absences or late staff and pickups will be immediately adjusted and a new posting will be displayed. 5.Remove posting from prior day and make any adjustments that were written on the master schedule. 6.Maintain printed accessible records for a minimum of 18 months. On 5/12/26, at 2:34 PM, Surveyor observed the required nursing posting is posted for 5/12/26 and 5/13/26. Surveyor was informed by Information Systems Specialist (ISS)-C that Nursing Scheduler (NS)-D completes the nursing schedules and is responsible for the daily nursing postings. On 5/12/2026, at 3:32 PM, during the survey, Surveyor reviewed the nursing postings and the actual working schedules of RN, LPN, and CNAs for March 2026-May 2026. The following dates of actual working nursing schedules do not match the nursing postings provided by the facility for: March 2026: 1, 4, 5, 10, 14, 15, 16, 22, 23, 25, 26, 28, 29, 30, 31April 2026: 11, 13, 15, 17, 19, 20, 22, 23, 24, 29, May 2026: 1 and 2 Surveyor notes the nursing postings do not match the actual nursing schedules for the night shifts on the above listed days. On 5/13/2026, at 10:44 AM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A that the nursing postings do not match the actual nursing schedules for RN-LPN-CNAs for March-May 2nd. NHA-A stated NHA-A is aware of the concern because ISS-C brought it to NHA-A's attention yesterday after Surveyor was asking questions about the postings and understands the concern. On 5/13/2026, at 11:02 AM, Surveyor interviewed ISS-C. ISS-C stated ISS-C took over managing NS-D in 2021. ISS-C confirmed that NS-D posts two days of the nursing hours at one time. ISS-C stated NS-D is supposed to make any changes to the nursing hours postings by the end of the day and then the next morning the previous day nursing hour postings are removed, and the next day is posted. ISS-C stated there are no staff members assigned to make any changes to the nursing hour postings based on the actual nursing working schedule for night shift. ISS-C stated ISS-C re-educated NS-D about a year ago in regard to making sure the actual nursing working schedule matches the nursing hours posted for the day. ISS-C stated obviously I need to sit down with NS-D again. ISS-C stated, we are good at posting but not updating.