STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525332	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverview Health Services	428 N 6th St Tomahawk, WI 54487

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not ensure nursing staff had the appropriate competencies and skills sets to provide nursing and related services to ensure resident safety for 3 of 30 residents (R1, R4, and R8). Licensed Practical Nurses (LPNs) assessed R1 after a fall, without contacting a Registered Nurse (RN), the Director of Nursing (DON), or R1's provider prior to moving R1 for 5 of 8 falls. No documentation to support that the LPN contacted an RN prior to moving R8 after a fall.LPN did not report a change of condition in R4 to an RN.Per the Wisconsin LPNs Standard of Practice (N 6.04), -LPNs must work under the general supervision of an RN or direction of a provider. -LPNs provide basic nursing care, including collecting data and recording it. -LPNs must report changes in a patient's condition to the appropriate person. -LPNs must consult with a provider if they know a delegated act may harm a patient. The facility's policy titled, Fall Prevention and Management Guidelines, read in part.7. When any resident experiences a fall, the facility will: -Complete a post-fall assessment and review: 1) Physical assessment with vital signs. Example 1 R1 admitted to the facility on [DATE], after falling at home and laying on the ground for several days. R1's diagnoses included dementia. On 11/20/25, a Minimum Data Set (MDS) assessment confirmed R1 scored 04/15 during Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. R1's care plan included the following: -At risk for falls due to dementia, poor safety awareness, and history of falls. Interventions included bed in low position, 11/24/25. Fall mat on right side of bed, 11/24/25. Wide scoop mattress, 01/02/26. Bolster mattress, 01/25/26. On 01/26/26, Surveyor reviewed R1's falls. Surveyor noted R1 had eight falls since admission. Surveyor noted 5 of 8 fall assessments were completed by LPNs and did not include documentation (continued on next page)

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

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

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the LPN updated an RN, DON, or provider prior to moving R1, per the following: -11/17/25, LPN J, Resident found on the floor by floor CNA at approx. 0430. Resident apparently rolled out of the right side parallel to his bed. Resident was in the supine position with head pointed towards the wall and feet towards the bathroom door. No new injuries noted and no increase or unusual pain noted. Resident assessed for injuries. ROM x's 4, right and left hip flexed without pain or discomfort, no new bruising, no new abrasions, and no new skin tears. Resident assisted off of the floor with a mechanical lift and 2 floor CNA's. Neuro checks initiated per facility protocol and WNL's. Awaiting call back from [clinic]. -11/24/25, LPN J, At approx. 0240, resident found side laying on his right side to the right side of bed. Resident had apparently rolled out of bed and rolled onto the floor. Resident unable to articulate how or why resident rolled onto the floor. Resident does have an alternating air mattress. Intervention is to ensure resident is in the center of the bed. Resident assessed for new injuries. None apparent. ROM x's 4, right and left hip flexed without pain or discomfort, right andleft leg are equal and symmetrical, no new bruising, no new skin tears, no new abrasions, and no new scratches. Resident denies any unusual pain or discomfort. Resident stated that he was having usual aches and pains and requested medication. Hydrocodone/APAP 5/325mg administered at 0300. Neuro checks initiated and are WNL's. Call currently out to [clinic] to update. Resident is currently center of bed resting comfortably at this time. -11/25/25, LPN J, Writer could hear a faint call for help coming from the west hallway. Writer went to investigate and found resident right side laying to the right side of bed. Identical fall as previous. Resident assessed for injury and no new injuries noted. ROM x's 4, resident does complain of pain in right arm which is a chronic problem for this resident, no new scratches, no new bruises, no new abrasions. Right and left hip flexed without pain or discomfort. Neuro checks initiated and are WNL's. Hydrocodone/APAP 5/325mg administered for a pain rating of 5 out of the 1-10 pain scale. Call out to [clinic] and awaiting call back at this time. Resident is currently in bed resting at this time. 15 minute checks in place as an intervention to prevent further incidents. -01/02/26, LPN K, Res. Was calling out and staff found him laying on his back next to bed on the mat with head positioned elevated from the floor pointing to the direction of the head of the bed. Able to move all extremities without any changes in mobility. No c/o pain. No injury from this fall. VSS. Neuro's WNL. Res. Alert and talking loudly per his usual. He did state he slid off the side of the couch. We did explain to him he was in a bed, he did ask where he was and informed his of his location. He was quite calm with interaction as usually he is yelling. Assisted him back into bed and positioned him for comfort and safety. Placed call light and gave him instructions to place call light on if he needed assist. His level of comprehension is impaired. Informed administrator of res. Fall. [NP from clinic] was informed and will follow facility protocol for fall. Also called res. LG and left detailed message. -01/25/26, LPN J, Resident found on the floor with head against wall just below TV and legs extended towards the bed in room. Resident was on his back with gripper socks on both feet, tee shirt on, and soiled adult disposable brief. Resident stated, I had to go to the bathroom. Resident assessed for injuries, none apparent. ROM x's 4, right and left hip flexed without pain or discomfort, BLE are equal and symmetrical, no bruising, no skin tears, and no abrasions noted. Neuro checks initiated and are WNL's. On 01/27/2026 at 7:31 AM, Surveyor interviewed LPN L. LPN L stated LPNs cannot start intravenous (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(IV)s or administer IV medications but are able to assess. Surveyor asked LPN L if there is a difference between RN and LPN scope of practice. LPN L then stated, Oh yes, by assess I meant gather the data, VS, etc, then let RN know. Our DON is on call 24/7 so the LPN would call her if there was no RN in the building. If DON is not available or on PTO, there is a backup plan, such as an RN or DON from another building, or also contact provider prior to moving the resident. On 01/27/2026 at 7:37 AM, Surveyor interviewed Nursing Home Administrator (NHA) A. NHA A stated, The DON is on call 24/7, and the LPN would collect the information, call DON, and DON would take over the role or the judgement. NHA A reported understanding the Surveyor's concern of an LPN assessing a resident after a fall and moving the resident prior to contacting an RN, DON, or provider. Surveyor requested any additional information the facility may have to demonstrate compliance. On 01/27/26 at approximately 9:00 AM, Surveyor received a handwritten note from DON G, which read, We follow the WI Administrative Code N 6, Standards of Practice for RNs and LPNs. Example 2 R8 was admitted to facility on 11/03/25 with diagnosis of Parkinson's disease with dyskinesia fluctuation (difficulty in performing or controlling voluntary movements). R8's admission Minimum Data with target date of 11/09/25 and documented on 11/13/25 indicates:R8 has a BIMS of 7/15 (moderately impaired).R8 has a history of falls prior to admission and had one fall since admission to facility. On 01/04/26 at 10:24 AM, facility documented R8 tipped over in wheelchair and sustained a fall without injury and documented Resident [R8] appears to have slid down causing the chair to tip. No apparent injuries noted. Resident [R8] denied pain or discomfort. Resident [R8] denied hitting his head & was able to lift his bottom to get into the Hoyer sling. Resident [R8] unable to offer much information regarding fall but when asked if he hit his head he told the nurse No. Resident [R8] assisted back to his wheelchair via Hoyer & 2 staff members. No documentation to support the LPN contacted an RN prior to removing R8 off the floor to concur with findings from the fall. Example 3 R4 was admitted to facility on 08/08/2025, and has diagnoses of anxiety disorder, fracture of unspecified part of neck right femur, Parkinson's disease, dementia, unspecified severity, without behavioral disturbance. R4's Minimum Data Set (MDS) assessment, dated 08/08/2025, indicated that R4 has a Brief Interview for Mental Status (BIMS) score of 00/15, which means severe cognition impairment. R4 has an activated power of attorney for healthcare decision making. R4's care plan, dated 08/28/2025, with a target date of 03/25/2026, states in part: I have difficulty communicating related to: decline in cognitive status.Interventions include mirror residents facial expression/body language to communicate your understanding of emotion being expressed. Care plan states in part: I am at risk for complications due to musculoskeletal problems related to fracture right hip.Interventions include.at times I am non-compliant with hip abductor pillow. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 01/27/2026 at 9:02 AM, Surveyor interviewed R4's husband (legal representative) and asked if any concerns were identified during R4's residence at facility between dates 08/08/2025 and 10/13/2025. R4's husband stated R4 sustained a right hip fracture from a fall at home requiring a stay at the facility for rehabilitation. The discharge goal was for R4 to be able to return home. R4's husband stated it was discovered on 10/13/2025, during a previously scheduled routine follow up orthopedic visit, that R4 has a dislocated right hip. It is to be noted that R4 had two prior right hip dislocations following fracture surgery, both requiring immediate intervention. R4's husband arrived in the morning of the appointment on 10/13/2025 and found R4 sitting in the commons area crying. R4's husband spoke with a nurse - he could not recall name - who told him R4 would be evaluated at the orthopedic appointment later that day. R4's husband indicated how upset he was that no one from facility addressed R4's obvious discomfort from right hip dislocation and intervened sooner. During R4's hospital admission, husband decided against further surgical interventions and R4 returning to facility. Following a brief stay at another skilled nursing home, R4 was discharged to home on hospice. On 01/27/2026, record review of R4's medical record found the following: R4 was admitted to the facility following right hip arthroplasty for a hip fracture resulted from fall at home. R4's goal was to be able to return home to live On 09/01/2025 at 1:55 PM, R4 had suffered a fall at the facility resulting in a mildly displaced fracture across right femoral neck with shortening of the right femoral neck. A total hip arthroplast was done on 09/20/2025 for repair of fracture and R4 returned to facility on 09/25/2025. On 09/29/2025 and 10/08/2025, R4 was diagnosed by xray (radiographic imaging) to have recurring right hip/femoral head dislocations. R4 was treated with external reductions in the emergency department (ED) and returned to the facility. Record review of R4's medical record had several documented incidences of R4's noncompliance with maintaining proper right hip alignment and allowing placement of an abductor pillow because of R4's dementia. On 10/12/2025 at 8:48 PM, LPN I documented [R4] has some slight swelling noted tonight in right hip. No complaint of pain except when staff is placing abductor pillow in bed. There is no documentation found in R4's medical record of LPN I notifying a provider, RN or R4's legal representative of R4's change in condition. There is no further documentation by nursing staff in R4's medical record of further assessments or notifications surrounding right hip swelling and pain. On 10/13/2025 at 3:44 PM, DON B documented in R4's medical record R4's husband called facility to inform them an x-ray done at orthopedic's office revealed a right hip dislocation. R4 was admitted to the hospital with tentative surgery planned. R4 did not return to facility for readmission. On 01/17/2026 at 10:03 AM, Surveyor interviewed DON G and [NAME] President of Success (VPS) F about facility expectations for practicing LPNs' notification of a resident's change in condition. VPS F stated an LPN, after discovering a change in a resident's condition, is expected to notify an RN and/or provider immediately, regardless of time of day. DON G, who is the acting DON at facility while current DON out on sick leave, stated all nurses provide an oncoming/off going shift report on every resident. Shift changes happen at 6:00 AM, 2:00 PM, and 10:00 PM. DON G could not provide documentation of assessment or notification of R4's change in condition for 10/12/2025 8:41 PM to 10/13/2025 9:30 AM. DON G did not work at this facility (DON for partner facility), however was (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	aware of R4's history of dementia and recurring hip dislocations, indicating a need for close monitoring and notification of status changes.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure each resident has the right to a dignified existence, self-determination, and communication by ensuring the ability to communication interventions were in place for 1 of 4 residents (R8).Surveyor observed R8 sitting in lounge area without the jingle bell R8 uses to communicate with staff when R8 needs something.R8 was admitted to facility on 11/03/25 with diagnosis that include Parkinson's disease with dyskinesia fluctuation (difficulty in performing or controlling voluntary movements).R8's admission Minimum Data with target date of 11/09/25 and documented on 11/13/25 indicates:R8 has a BIMS of 7/15 (moderately impaired).R8 has no speech sometimes understood and sometimes understands.R8's care plan, I have difficulty communicating as evidenced by whispered/soft voice, initiated on 11/03/25.R8's ADL care plan intervention labeled and dated 11/07/25 Communication states: Uses jingle bell when not in bed.On 01/26/2026 at 9:18 AM, Surveyor observed R8 sitting in facility's TV lounge area with Life Enrichment ([NAME]) D and was unable to visualize the jingle bell.Surveyor approached and interviewed [NAME] D regarding the jingle bell. [NAME] D stated R8 had the jingle bell the day prior, but R8 does not have it now.On 01/26/2026 at 9:24 AM, Surveyor interviewed Certified Nursing Assistant (CNA) C regarding the jingle bell whereabouts. Surveyor observed the following: CNA C went to R8's room to search for the jingle bell and was unable to locate the jingle bell. CNA C came back out to lobby to talk to [NAME] D who told CNA C where it was located the day before in R8's room. CNA C went back to R8's room and found the jingle bell between several large containers of R8's snacks and brought it to R8.On 01/26/2026 at 11:21 AM, Surveyor observed [NAME] D respond to R8 ringing jingle bell at lunch table, and after R8 and [NAME] D had a conversation (of note, Surveyor was unable to hear), R8 placed jingle bell on dining table. On 01/26/2026 at 11:25 AM, Surveyor observed R8 fidgeting in chair at dining table and R8 picked up and rang the jingle bell. [NAME] D responded immediately to the ringing and talked with R8 who became relaxed.On 01/26/2026 at 12:43 PM, Surveyor interviewed CNA C and asked what the expectation is for R8's jingle bell. CNA C stated that whoever assists R8 out of room should make sure the jingle bell is in R8's possession. CNA C stated she was not aware who got R8 up this morning.Surveyor further asked CNA C if R8 uses the jingle bell. CNA C stated R8 does know how to use it appropriately. On 01/26/2026 at 1:00 PM, Surveyor interviewed [NAME] D regarding earlier observation of responding when R8 used the jingle bell during lunch. [NAME] D stated R8 was having a difficult time communicating due to diagnosis. [NAME] D stated R8's ability to communicate as the day goes on and believes it is due to medication administration. On 01/26/2026 at 1:19 PM, Surveyor reviewed Hospice binder and noted documentation dated 01/26/26 in the morning, that staff from Hospice gave R8 a shower and documented following task, that R8 was taken to common lounge. On 01/26/2026 at 4:04 PM, Surveyor informed NHA A regarding observation of R8 not having the jingle bell intervention in place per plan of care when out of room. NHA A was made aware a staff member from Hospice had completed R8's care that morning and brought R8 out to lounge. NHA A stated the expectation is for R8 to have his jingle bed when out of room by staff and Hospice agency. NHA A stated that the care Kardex is available behind door in resident rooms to refer to.On 01/27/2026 at 11:36 AM, Surveyor interviewed R8's Spouse M via phone, who stated R8 is supposed to have the bell when not in room and stated R8 does not always have it, and it is left in room. Spouse M stated R8 may not always remember to use the bell, but feels if R8 was able to visually see the bell, then R8 would utilize it more.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility did not notify a physician and/or RN about a significant change in a resident's physical status for 1 resident (R4) of 13 residents reviewed in a sample of 13.Documentation in R4's medical record by Licensed Practical Nurse (LPN) I indicated a change in R4's physical condition during an evening shift.LPN I did not notify a physician or a Registered Nurse (RN) for further guidance, resulting in R4's prolonged discomfort resulting from a dislocated hip.R4's medical record did not include further documentation of assessment by licensed staff following LPN I's initial documentation of a physical change in R4's status, resulting in delayed intervention for a dislocated hip. This is evidenced by: The facility policy, titled Change in Condition: When to report to the MD/NP/PA, adapted from AMDA Clinical Practice Guidelines 2003, states in part: Immediate notification.any symptom, sign or apparent discomfort that is: acute or sudden in onset, and a marked change in relation to usual symptoms and signs, or unrelieved by measures already prescribed.marked localized bruising, swelling, or pain over joint or bone, with or without recent fall.based on Wisconsin's Nurse Practice Act - Standards of Practice for registered nurses and licensed practical nurses, chapter N6.LPNs must be trained on: what constitutes a change in condition, including but not limited to:.pain changes or decline in function.Who to notify and when: notify RN immediately, MD/NP/PA R4 was admitted to facility on 08/08/2025 and has diagnoses of anxiety disorder, fracture of unspecified part of neck right femur, Parkinson's disease, dementia, unspecified severity, without behavioral disturbance. R4's Minimum Data Set (MDS) assessment, dated 08/08/2025, indicated that R4 has a Brief Interview for Mental Status (BIMS) score of 00 which means severe cognition impairment. RN has an activated power of attorney for healthcare decision making. R4's care plan, dated 08/28/2025, with a target date of 03/25/2026, states in part: I have difficulty communicating related to: decline in cognitive status.Interventions include mirror residents facial expression/body language to communicate your understanding of emotion being expressed. Care Plan states in part: I am at risk for complications due to musculoskeletal problems related to fracture right hip.Interventions include.at times I am non-compliant with hip abductor pillow. On 01/27/2026 at 9:02 AM, Surveyor interviewed R4's husband (legal representative) and asked if any concerns were identified during R4's residence at facility between dates 08/08/2025 and 10/13/2025. R4's husband stated R4 sustained a right hip fracture from a fall at home requiring a stay at the facility for rehabilitation. The discharge goal was for R4 to be able to return home. R4's husband stated it was discovered on 10/13/2025, during a previously scheduled routine follow up orthopedic visit, that R4 has a dislocated right hip. It is to be noted that R4 had two prior right hip dislocations following fracture surgery, both requiring immediate intervention. R4's husband arrived in the morning of the appointment on 10/13/2025 and found R4 sitting in the commons area crying. R4's husband spoke with a nurse - he could not recall name - who told him R4 would be evaluated at the orthopedic appointment later that day. R4's husband indicated how upset he was that no one from facility addressed R4's obvious discomfort from right hip dislocation and intervened sooner. During R4's hospital admission, husband decided against further surgical interventions and R4 returning to facility. Following a brief stay at another skilled nursing home, R4 was discharged to home on hospice. On 01/27/2026, record review of R4's medical record found the following:R4 was admitted to the facility following right hip arthroplasty for a hip fracture resulted from fall at home. R4's goal was to be able to return home to liveOn 09/01/2025 at 1:55PM, R4 suffered a fall at facility. No injuries noted and R4 was up and about her usual activity according to RN nursing documentation. R4's husband, clinic and director of nurses (DON) notified of incident.On 09/04/2025 an x-ray (radiographic image) of right hip done per request of physical therapy due to R4 having difficulty bearing weight on right leg. Xray indicated no findings of right hip/leg fractures or dislocations.On 09/19/2025, R4's husband requested a repeat x-ray of right hip be done due to R4 showing nonverbal cues of pain with hip after (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	09/01/2025 fall. It is documented by RN that R4 is an extensive assist of 2 with transfers. Xray revealed a mildly displaced fracture across right femoral neck with shortening of the right femoral neck. Nurse practitioner (NP) notified and requested R4 be transferred to emergency department (ED) for evaluation. R4 transferred to ED at 9:30 PM. R4's husband aware of transfer.On 09/20/2025, R4 had a right total hip arthroplasty done. R4 was readmitted to facility on 09/25/2025.On 09/29/2025, the NP rounding states, R4's right leg is slightly internally rotated and she is complaining of increased pain. Xray ordered by NP and done. Xray resulted as no acute fracture or dislocation identified. However, there is a superior dislocation of right femoral head across right hip joint. R4 was transferred to the ED for evaluation at 9:35 PM. R4's husband was aware of transfer to ED. On 09/20/2025 at 12:40 AM, R4 returned to facility after dislocation of neck of right femur was reduced. On 10/08/2025, R4's husband voiced concerns to an RN about R4 having some right hip swelling and internal rotation of right hip. R4's husband requested R4 be transferred to the ED for evaluation. R4's provider updated. ED informed facility RN on 10/08/2025 at 10:13 AM that R4's right hip was again dislocated and was able to be maneuvered back in place. ED MD informed RN it was recommended a follow up with orthopedic surgeon (after ED MD consulted with orthopedic MD) be made for R4. ED MD had been in contact with R4's husband.On 10/09/2025, R4's medical record states her husband set up an appointment for R4 to see orthopedics on 10/13/2025 at 9:45 AM.On 10/12/2025 at 8:48 PM, LPN I documented [R4] has some slight swelling noted tonight in right hip. No complaint of pain except when staff is placing abductor pillow in bed. There is no documentation found in R4's medical record of LPN I notifying a provider, RN or R4's legal representative of R4's change in condition. There is no further documentation by nursing staff in R4's medical record of further assessments or notifications surrounding right hip swelling and pain. On 10/13/2025 at 3:44 PM, DON documented in R4's medical record R4's husband called facility to inform them an x-ray done at orthopedics' office revealed a right hip dislocation. R4 was admitted to the hospital with tentative surgery planned. R4 did not return to facility for readmission. Record review of R4's medical record had several documented incidences of R4's noncompliance with maintaining proper right hip alignment and allowing placement of an abductor pillow because of R4's dementia. R4's care plan had no updates or interventions in place regarding recurring hip dislocations and alternatives for maintaining hip alignment when R4 was not able to comply. On 01/17/2026 at 10:03 AM, Surveyor interviewed DON G and [NAME] President of Success (VPS) F and asked what the facility's expectations are for practicing LPNs giving notification of a resident's change in condition. VPS F stated an LPN, after discovering a change in a resident's condition, is expected to notify an RN and/or provider immediately, regardless of time of day. DON G, who is the acting DON at facility while current DON out on sick leave, stated all nurses provide an oncoming/off going shift report on every resident. Shift changes happen at 6:00 AM, 2:00 PM, and 10:00 PM. DON G could not provide documentation of assessment or notification of R4's change in condition for 10/12/2025 8:41 PM to 10/13/2025 9:30 AM. DON G did not work at this facility (DON for partner facility), however was aware of R4's history of dementia and recurring hip dislocations, indicating a need for close monitoring and notification of status changes.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and interviews, the facility did not ensure residents/representatives received written or verbal consent of Bed Hold reserved payment at time of transfer and the notice of transfer prior to discharge or transfer did not include written specific reason the specific for transfer for 2 of 3 residents (R4 and R14). R4 was sent to the hospital via ambulance on 09/19/25 for a change in condition. R4's representative was provided with a Bed Hold Request form that did not contain the written specific reason for transfer and was dated 09/22/25 of receiving verbal consent.R14 was sent to hospital via ambulance on 12/27/2025 for a change in condition. R14's representative was provided with a Bed Hold Request form that did not contain the written specific reason for transfer and was dated 12/29/25 of verbal consentThe facility policy, titled Bed Hold Notice, dated 04/23/25, states: It is the policy of this facility to provide written information to the resident and/or the resident representative regarding bed hold practices both well in advance, and at the time of a transfer for hospitalization.The facility policy further states: In the event of an emergency transfer of a resident, the facility will provide written notice of the facility's bed-hold policies to the resident and/or the resident representative within 24 hours.R4 was sent to the hospital via ambulance on 09/19/25 for a change in condition. R4's representative was provided with a Bed Hold Request form that did not contain the written specific reason for transfer and was dated 09/22/25 of receiving verbal consent.R14 was sent to hospital via ambulance on 12/27/2025 for a change in condition. R14's representative was provided with a Bed Hold Request form that did not contain the written specific reason for transfer and was dated 12/29/25 of verbal consent.On 01/26/26 at 2:42 PM, Surveyor interviewed facility's Business Office Manager (BOM) E regarding process of providing bed hold information to a resident or resident representative who is being transferred/discharged . BOM E stated the information regarding bed hold and notice of transfer is completed as soon as BOM E is aware of transfer or discharge.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525332	A. Building B. Wing	01/27/2026

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not conduct a Level II Preadmission Screening and Resident Review (PASARR) for 1 of 4 residents reviewed (R33) within 30 days of admission to ensure individuals with a serious mental disorder received care and services in the most integrated setting possible. This is evidenced by:The facility policy, titled Resident Assessment - Coordination with PASARR Program, with a date implemented of 11/10/25, reads in part, The Level II resident review must be completed within 40 calendar days of admission.Surveyor reviewed R33's record and noted R33 was admitted on [DATE] with a diagnosis of major depressive order.R33's original order included Quetiapine Fumarate 25MG once daily and Duloxetine HCl 30 MG twice a day. R33's Quetiapine Fumarate was discontinued and on 1/26/26 R33's Duloxetine HCl was increased to 60MG in the morning and 30MG at bedtime.Surveyor noted on 11/6/25, a Level I PASRR screening noted R33 had a major mental disorder and has taken psychotropic medications to treat symptoms or behaviors of a major mental disorder, indicating a Level II PASRR should be completed. Screening indicated a short-term hospital discharge exemption, 30-day maximum.Surveyor reviewed R33's record and could not locate a Level II PASRR screening.On 1/27/2026 at 10:45 AM, Surveyor interviewed Social Services Director (SSD) H, who is responsible in part for the facility's PASRR screening process. SSD H confirmed a Level II PASRR was not completed for R33. SSD H reported R33 was not expected to stay beyond 30 days for care and a Level II PASRR should have been done in November 2025. SSD H acknowledged the facility does not have a system in place to ensure a PASRR II is completed for residents that stay past the 30-day window.

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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. Based on interview and record review, the facility did not ensure pain management was provided to residents, consistent with the comprehensive person-centered care plan, and the resident's goals and preferences for 1 resident (R4) of 2 residents reviewed for pain management in a sample of 13. Facility did not develop and implement a care plan on pain management for R4 with a known diagnosis of dementia. R4 may not normally recognize and verbalize when having pain resulting in a prolonged status of discomfort while experiencing a hip dislocation. This is evidenced by:The facility policy, titled Pain Management, last revised 08/09/2022, states in part: The interventions for pain management will be incorporated into the components of the comprehensive care plan, addressing conditions or situations that may be associated with pain or may be included as a specific pain management need or goal.Non-pharmacological interventions will include but are not limited to.cold compress, warm shower/bath, massage, turning and repositioning, cognitive/behavioral interventions such as music, diversions, relaxation techniques.R4 was admitted to facility on 08/08/2025 and has diagnoses of anxiety disorder, fracture of unspecified part of neck right femur, Parkinson's disease, dementia, unspecified severity, without behavioral disturbance. R4 was discharged from facility on 10/13/2025. R4's Minimum Data Set (MDS) assessment, dated 08/08/2025, indicated that R4 has a Brief Interview for Mental Status (BIMS) score of 00/15, which means severe cognitive impairment. R4 has an activated power of attorney (POA) for healthcare decision making. R4's care plan, dated 08/28/2025, with a target date of 03/25/2026, states in part: I have difficulty communicating related to decline in cognitive status.Interventions include mirror residents facial expression/body language to communicate your understanding of emotion being expressed. Care plan states in part: I am at risk for complications due to musculoskeletal problems related to fracture right hip.Interventions include.at times I am non-compliant with hip abductor pillow.On 01/27/2026 at 9:02 AM, Surveyor interviewed R4's husband (legal representative) and asked if any concerns were identified during R4's residence at facility between dates 08/08/2025 and 10/13/2025. R4's husband stated R4 sustained a right hip fracture from a fall at home requiring a stay at the facility for rehabilitation. The discharge goal was for R4 to be able to return home. R4's husband stated it was discovered on 10/13/2025, during a previously scheduled routine follow up orthopedic visit, that R4 had a dislocated right hip. It is to be noted that R4 had two prior right hip dislocations following fracture surgery, both requiring immediate intervention. R4's husband arrived in the morning of the appointment on 10/13/2025 and found R4 sitting in the commons area crying. R4's husband spoke with a nurse - he could not recall name - who told him R4 would be evaluated at the orthopedic appointment later that day. R4's husband indicated how upset he was that no one from facility addressed R4's obvious discomfort from right hip dislocation and intervened sooner. During R4's hospital admission, husband decided against further surgical interventions and R4 returning to facility. Following a brief stay at another skilled nursing home, R4 was discharged to home on hospice. On 01/27/2026, record review of R4's medical record found the following: On 09/01/2025 at 1:55 PM, R4 had suffered a fall at the facility resulting in a mildly displaced fracture across right femoral neck with shortening of the right femoral neck. A total hip arthroplasty was done on 09/20/2025 for repair of fracture and R4 returned to facility on 09/25/2025. On 09/29/2025 and 10/08/2025, R4 was diagnosed by x-ray (radiographic imaging) to have recurring right hip/femoral head dislocations. R4 was treated with external reductions in the emergency department (ED) and returned to the facility. On 10/12/2025 at 8:48 PM, LPN I documented [R4] has some slight selling noted tonight in right hip. No complaint of pain except when staff is placing abductor pillow in bed. There is no documentation found in R4's medical record of LPN I notifying a provider, an RN or R4's legal representative of R4's change in condition. There is no further documentation by nursing staff in R4's medical record of further assessments or notifications surrounding right hip swelling and pain. R4 received scheduled dose of Tylenol per (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility medication administration record (MAR) but no additional pain medications such as the hydrocodone/acetaminophen (Vicodin - a scheduled II narcotic for pain control) as ordered if needed for additional pain control. On 10/13/2025 at 3:44 PM, DON B documented in R4's medical record R4's husband called facility to inform them an x-ray done at orthopedic's office revealed a right hip dislocation. R4 was admitted to the hospital with tentative surgery planned. R4 did not return to facility for readmission. On 09/30/2025, physician ordered Tylenol oral tablet 325mg, give 650mg by mouth three times a day for pain related to difficulty in walking. R4's MAR consistently shows medication administration as ordered, along with pain level evaluation. On 09/25/2025, physician ordered Hydrocodone/acetaminophen 5/325mg (also known as Vicodin, a scheduled II narcotic used for pain control), one tablet by mouth every 6 hours as needed for post-surgical pain. Medication was administered to R4 once on 09/29/2025, once on 10/03/2025 (pain score of 2) and once on 10/08/2025 (pain score of 10). On 01/27/2026 at 10:03 AM, Surveyor interviewed Director of Nursing (DON) G on how nursing assesses for pain on residents who have dementia and cannot necessarily recognize or express pain in the conventional manner. DON G stated the facility uses the PAINAD (Pain Evaluation in Advanced Dementia) measuring tool. PAINAD uses observation of behaviors to measure pain levels in dementia residents. These observations include breathing; negative vocalizations such as moaning, calling out, crying; facial expressions such as grimacing, smiling; body language such as tenseness, pacing, fidgeting; and resident's ability to be consoled. R4's MAR indicated once daily PAINAD assessments on alternating shifts. Pain levels were documented prior to each Tylenol administration, ranging from level 0 to level 10. R4's medical record had several documented incidents by nursing and providers of R4's noncompliance with maintaining proper right hip alignment and allowing and/or keeping placement of an abductor pillow between legs. There are several daily skilled note entries by nursing indicating R4 had episodes of agitation and restlessness. No interventions for agitation and restlessness documented, which are behavioral indicators of possible pain according to the PAINAD measuring tool the facility uses for pain assessment. Record review of R4's medical record did not indicate development of a comprehensive care plan with interventions for R4's pain assessment and management including the observation of nonverbal indicators utilizing the PAINAD measuring tool. R4's care plan was not updated to include history of recurring right hip/femoral head fractures and right hip dislocations, and monitoring cues with interventions for detection of possible recurrences. R4's care plan does not include pharmaceutical interventions (beyond scheduled Tylenol) as ordered by physician for management of severe pain. R4's care plan did not include interventions to monitor agitation and restlessness type behaviors as possible exhibitions of discomfort being experienced by R4.