STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525333	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Watertown Health Care Center	121 Hospital Dr. Watertown, WI 53098

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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 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, staff and resident interview, and record review, the facility did not ensure 2 residents (R) (R9 and R13) of 23 sampled residents were treated with dignity and respect that promoted maintenance or enhancement of quality of life. R9 was observed being assisted by staff in the hallway and to an activity. R9's entire back and side were exposed.R13 was observed sitting in the common area wearing only a t-shirt and an incontinence brief.Findings include:The facility's Resident Rights Policy, dated, 1/5/26, states in part; .Resident Rights.The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility.the resident has a right to be treated with respect and dignity.1. R9 was admitted to the facility on [DATE] with diagnoses including heart failure, muscle weakness, obesity, anxiety, major depressive disorder, and multiple sclerosis (a chronic autoimmune disease of the central nervous system).R9's current care plan stated R9 needed extensive assist of one with bed mobility, assist of one with upper body, and extensive assist of one for lower body dressing.On 5/12/26 at approximately 12:00 PM, Surveyor interviewed R9 who indicated R9 enjoyed doing activities at the facility. R9 indicated R9 needed staff assistance with cares due to having MS (multiple sclerosis).On 5/12/26 at 2:20 PM, Surveyor observed R9 being assisted down the hallway and participating in activities with staff and peers. Surveyor observed R9 in a gown with R9's entire back and side exposed.On 5/12/26 at 3:00 PM, Registered Nurse (RN)-F indicated staff should assist R9 in covering R9's back and side. RN-F indicated R9 prefers to wear a gown and a shirt or something on the top half. RN-F indicated R9 should be covered while in common areas and needs staff assistance to do so. On 5/12/26 at 3:20 PM, Licensed Practical Nurse (LPN)-L indicated R9 prefers to wear a gown. LPN-L indicated LPN-L just observed R9's back exposed and typically R9 wears a shirt or something on the top half. LPN-L indicated R9's back and side should be covered when R9 is in common areas and participating in activities.2. R13 was admitted to the facility on [DATE] with diagnoses including age-related physical debility, major depressive disorder, restlessness and agitation, anxiety disorder, mild cognitive impairment, and dementia.R13's current care plan stated R13 needs maximal assistance of one person .On 5/13/26 at approximately 9:25 AM, Surveyor observed R13 sitting in the common area talking to a peer. R13 was wearing a t-shirt and an incontinence brief. R13's brief and entire bottom half were exposed. Surveyor observed multiple staff walk past while R13 was visiting in the common area. Certified Nursing Assistant (CNA)-J got a blanket and covered R13. CNA-J indicated R13 may choose not to wear pants. When Surveyor asked if R13's bottom half should be covered while R13 is in common areas to maintain R13's dignity, CNA-J did not respond.On 5/13/26 at 1:15 PM, Nursing Home Administrator (NHA)-A indicated residents should be dressed appropriately while in common areas of the facility for their dignity. NHA-A indicated R9's back and side should be covered while in activities and when R9 is out of R9's bedroom. NHA-A indicated R13 declines to wear pants at times which should be care planned. NHA-A indicated R13 can have a blanket to cover R13's bottom half. When Surveyor asked if R13 can have a longer shirt, dress, or robe, NHA A expressed understanding of the above concern.

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not ensure 2 residents (R) (R11 and R12) of 23 sampled who need assistance with activities of daily living (ADLs) received the necessary care and services.R11 was observed to have whiskers on the chin and chin area. R11 stated R11 did not like having whiskers and preferred to be shaved. R12 was observed to have a bowel movement while laying in bed. Despite reporting the bowel movement to staff, R12 was not assisted for 35 minutes.Findings include:The facility's Activities of Daily Living (ADLs), Supporting policy, dated 4/2025, states in part; .Residents who are unable to carry out activities of daily living independently receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene .Appropriate care and services are provided for residents who are unable to carry out ADLs independently, with the consent of the resident, and in accordance with the plan of care, including appropriate support and assistance with: a. hygiene (bathing, dressing, grooming, and oral care); .c. elimination (toileting) .1. R11 was admitted to the facility on [DATE] and had diagnoses including kidney disease, history of falling, muscle wasting, dementia, cognitive communication deficit, and anxiety disorder.R11's current care plan stated: .dressing/personal hygiene.maximal assist of one.On 5/12/26 at approximately 2:00 PM, Surveyor observed R11 to have whiskers on R11's chin and chin area.On 5/12/26 at 2:45 PM, Registered Nurse (RN)-F indicated R11 shouldn't have whiskers on R11's chin and chin area. RN-F indicated staff should assist residents with shaving on their shower days and as needed. RN-F indicated R11 had never refused cares for RN-F. RN-F indicated R11 wanted to be clean shaven and not have whiskers on R11's chin.2. R12 was admitted to the facility on [DATE] and had diagnoses including heart failure, depression, bipolar disorder, irritable bowel syndrome, and pressure ulcer of sacral region.R12's current care plan stated: .personal hygiene/toilet assist of one.On 5/12/26 at 3:45 PM, Surveyor observed R12 in bed. R12 stated R12 was not doing well. Surveyor noted R12's call light was on. R12 stated the call light had been on for an hour. R12 state prior to that, staff came in, shut the call light off, and told R12 they and another staff would be back to assist R12, however, no one had returned. R12 stated R12 had a bowel movement, needed help, and had been laying like that for hours. Surveyor informed Certified Nursing Assistant (CNA)-G that R12 had a bowel movement and needed assistance. Surveyor observed R12's call light on from 3:45 PM to 4:20 PM. At 4:15 PM, Surveyor asked CNA G if CNA-G reported that R12 needed assistance. CNA-G indicated CNA-G had reported it to staff who were working on R12's hallway after Surveyor informed CNA-G. At 4:20 PM, CNA-H answered R12's call light. When CNA-H exited R12's room, Surveyor asked if R12 had a bowel movement. CNA-H indicated R12 had a bowel movement and needed assistance. CNA-H indicated no one had told CNA-H that R12 needed assistance. Surveyor asked CNA-I if CNA-I was the other staff working on the hallway. CNA-I indicated yes. CNA-I indicated no one had reported to CNA-I that R12 needed assistance or had a bowel movement. CNA-H and CNA-I indicated staff should answer call lights within 5 to 10 minutes and/or as soon as they can.On 5/13/26 at 1:15 PM, Nursing Home Administrator (NHA)-A indicated staff should assist residents with shaving during shower days and as needed. NHA-A also indicated staff should have assisted R12 timely. NHA-A expressed understanding of the above concerns.

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F 0684 Level of Harm - 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 staff interview and record review, the facility did not ensure care and treatment in accordance with professional standards of practice for 4 residents (R) (R4, R5, R16, and R8) of 4 sampled residents. R4 was admitted to the facility with a surgical wound to the sternum that increased in size and became infected. Registered Nurse (RN) assessments were not completed timely and staff did not document changes in the wound or notify the physician of the changes. (This example is being cited at a level G (actual harm/isolated.) R5 went 4 days without a documented bowel movement (BM). The physician was not notified and R5 was not provided with prescribed as needed (PRN) medication. Staff did not consistently document whether or not R5 had a BM. In addition, R5's Treatment Administration Record (TAR) for colostomy care and surgical wound care was not thoroughly completed. R5's weekly skin checks were also not completed. R16 went multiple days without a documented BM. The physician was not notified and R16 was not provided with prescribed PRN medication. In addition, staff did not consistently document whether or not R16 had a BM. R8's Medication Administration Record (MAR) indicated multiple prescribed treatments, medications, and monitoring were not completed on 2/27/26, 3/12/26, 3/15/26, and 3/17/26 . Findings include: The facility's Wound Care policy, revised 10/2010, states in part: .The following information should be recorded in the resident's medical record: 1. The type of wound care given. 2. The date and time the wound care was given. 3. The position in which the resident was placed. 4. The name and title of the individual performing the wound care. 5. Any change in the resident's condition. 6. All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound. 7. How the resident tolerated the procedure. 8. Any problems or complaints made by the resident related to the procedure. 1. R4 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus, chronic kidney disease, anxiety disorder, depression, and was status post (s/p) coronary artery bypass grafting (CABG) (a procedure that creates a new path for blood to go around a blocked or partially blocked artery in the heart) (dated 3/14/26). R4's most recent Minimum Data Set (MDS) assessment, dated 5/7/26, indicated R4 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. R4's admission assessment, dated 4/8/26, stated in part: .Surgical wound to sternum 3 centimeters (cm) x 2 cm .Exudate: light, seropurulent (a mixture of purulent (pus) and serous, usually watery, yellow, green, tan, or brown) . Facility wound assessment documentation indicated the following: 4/14/26: Completed by an Licensed Practical Nurse (LPN). The assessment did not address R4's surgical wound to the sternum. The assessment only addressed R4's abdominal incisions. 4/21/26: Completed by an LPN. The assessment did not address R4's surgical wound to the sternum. The assessment only addressed R4's abdominal incisions. 4/28/26: Completed by Assistant Director of Nursing (ADON)-C. The assessment for R4's sternal wound indicated: 3.8 cm x 3.4 cm x 2.3 cm, tunneling, purulent drainage, odor, 75% slough (non-viable, dead tissue in a wound, typically yellow or white, that can impede healing and harbor bacteria). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	5/5/26: Completed by ADON-C. The assessment for R4's sternal wound indicated: 3.9 cm x 3.5 cm x 2.3 cm, tunneling, purulent drainage, odor, 75% slough. Nurse Practitioner (NP) notes indicated the following: 4/16/26: .Physical examination: Inspection of the midline surgical wound shows stable condition with some drainage, no erythema (superficial reddening of the skin, usually in patches, as a result of injury or irritation causing dilatation of the blood capillaries) .Assessment and Plan: Post-CABG Surgical Wound with Possible Infection: (R4) has a stable midline chest wound from CABG surgery complicated by drainage but no overt signs of cellulitis. Plan includes continuation of wound care with cleansing using Dakin's solution and application of skin protectant and iodoform gauze per wound care nurse. A course of antibiotics will be initiated pending lab results . 4/17/26: (R4) reported the wound dressing falls off frequently, leading to exposure and drainage .Physical Exam Results: .Wound on the chest with notable drainage; dressing frequently falls off .Assessment: 1. Chest wound post-CABG: Wound shows significant drainage and the dressing has difficulty staying in place, increasing the risk of infection .Plan: For the chest wound, a picture will be sent to the wound care physician for expert evaluation and recommendation regarding the initiation of antibiotics. The care staff will be notified to ensure the wound dressing is properly applied and maintained to prevent further dressing displacement . 5/5/26: (R4) reported a new open wound area on the upper part of R4's chest incision with some purulent drainage. The original lower chest wound remains open but is being managed with packing .Plan: A wound culture sample has been obtained for the new upper incision wound, with results pending. Empiric antibiotics will be considered based on culture results; staff to monitor wound closely and change dressings as needed to manage drainage. The cardiothoracic surgeon will follow the wound directly. (R4) has an upcoming clinic visit in two days . 5/6/26: (R4) presents for a follow-up visit for acute care management of MRSA-infected chest wounds following recent CABG surgery .(R4) was informed about a MRSA infection discovered from wound cultures obtained during prior visit .Plan: Begin oral antibiotic treatment with Bactrim Double Strength (DS) twice daily for 10 days based on culture and sensitivity results to address MRSA wound infection .Chronic care management includes monitoring of post-CABG wound healing with an emphasis on infection control . Documentation from Provider (PR)-U indicated the following: 4/20/26: After Visit Summary: The following issues were addressed: post-operative state: S/P CABG x 2; and dehiscence of operative wound . 4/28/26: Report of consultation.Report Requested Regarding: Sternal wound .Findings: Wound was debrided. (R4) needs better wound care, wet gauze (with) puracyn or sterile saline/water, then pack and cover (with) dry gauze and tape. Change every day. (R4) should shower every day or at least every other day .(It is important to note this order was noted by facility staff on 5/1/26.) 5/5/26: Report of Consultation .Findings: Upper sternal wound with tunneling and undermining - cleanse once a day, spray with puracyn, wet to dry dressing, if possible soak in gauze and pack. Continue Bactrim, wound care referral .(Surveyor requested documentation regarding R4's wound care referral and documentation from the wound care physician's visits, however, it was not provided.) (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 5/12/26 at 2:25 PM, Surveyor interviewed ADON-C who stated ADON-C first saw R4's wounds approximately 2 weeks after R4 was admitted . When Surveyor asked if R4's wounds should have been assessed by an RN prior to 4/28/26, ADON-C stated ADON-C would have to look. (Surveyor requested ADON-C provide RN assessment information, however, none was provided.) On 5/13/26 at 10:32 AM, Surveyor interviewed Director of Nursing (DON)-B. When Surveyor asked if R4's provider was updated about the wound's seropurulent drainage upon admission, DON-B stated R4's wound was icky in the hospital and DON-B would provide Surveyor with the documentation. When Surveyor asked DON B when DON-B would expect an RN assessment be completed for a newly admitted resident with wounds, DON-B stated DON-B would expect the assessment within 24 hours of admission. When Surveyor asked if the order for daily or every other day showers was transcribed, DON-B indicated DON-B talked to R4 regarding increasing showers, however, R4 stated R4 would not take additional showers. When Surveyor asked DON-B if the conversation was documented and reported to the provider, DON-B stated DON-B did not enter a progress note. When Surveyor asked who completes weekly wound rounds, DON-B stated the wound doctor comes weekly. When Surveyor asked if R4 is seen by the wound care doctor, DON-B stated yes. When Surveyor asked if DON-B had documentation of the visits, DON-B stated DON-B would provide it. (No additional information was provided to Surveyor.) It is also important to note, R4 was admitted to the hospital on [DATE] after an appointment at the clinic. Hospital documentation, dated 5/12/26, states in part: (R4) presented to the clinic today and continues to have sternal wound drainage. Decision to admit from clinic for sternal debridement and possible wound vac. (This example is being cited at a level G (actual harm/isolated.) 2. Surveyor requested the facility's bowel protocol policy and received a Colostomy/Ileostomy care policy, dated October 2010, and a Bowel (Lower Gastrointestinal Tract) Disorders - Clinical Protocol. Neither policy discussed documentation of bowel movements for residents or when to contact a physician or provide as needed medications related to constipation. Between 5/12/26 and 5/13/26, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] after a hospital stay due to a bowel obstruction while residing at home. R5 underwent surgery for a colostomy (a procedure that creates an opening, called a stoma, in the abdominal wall. A section of the large intestine (colon) is brought to the surface so that stool bypasses the anus and empties into an external pouch, commonly known as a colostomy bag.) R5 was at the facility for rehabilitation. R5 had diagnoses including Parkinson's disease, unspecified intestinal obstruction, and generalized anxiety disorder. R5's MDS assessment, dated 1/9/26, stated R5 had a BIMS score of 15 out of 15, indicating intact cognition. R5 did not have an activated healthcare decision maker. R5's care plan, initiated 1/8/26, related to gastrointestinal distress due to a large bowel obstruction. The care plan contained interventions (dated 1/8/26) to observe and document vital signs, bowel sounds, amount and consistency of stool .Notify physician of significant changes, observe for presence of nausea/vomiting or weight changes, intake and difficulty chewing. A pain management care plan, initiated 1/8/26, contained an intervention (dated 1/8/26) to evaluate the need for a bowel management regimen. An additional care plan, initiated 1/8/26, contained an intervention for bowl medication as ordered. On 2/25/26, Nurse Practitioner (NP)-R saw R5 and noted R5's colostomy bag was recently changed. R5 reported minimal output since then. R5 received daily Miralax (a laxative used to treat occasional (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	constipation) and a mechanical soft diet. R5 actively participated in physical and occupational therapy and felt R5 was getting stronger with therapy. R5 denied any new headaches, dizziness, shortness of breath, palpitations, or other acute symptoms. Bowel movements were a concern due to minimal ostomy output, but R5 was passing some gas. R5 was encouraged to increase mobility to promote bowel activity On 2/26/26, a change in condition assessment was completed because R5 complained of nausea and constipation. NP-R was notified and prescribed zofran (used to prevent and treat moderate to severe nausea and vomiting) as needed (PRN), senna 2 tablets daily (used to treat constipation and empty the bowels), and Miralax PRN daily. On 2/27/26, NP-R saw R5 and noted R5 reported good bowel movements on (2/25/26) and (2/26/26) after a previous period of reduced output. R5 ate as best as R5 could and urinated adequately with no swelling. R5 was preparing for discharge next week. R5's medical record indicated the following: ~ R5 did not have a documented bowel movement on 3/5/26, 3/6/26, 3/7/26, or 3/8/26. On 3/9/26 at 10:24 AM, R5 received a dose of PRN Miralax. Later that day, R5 had a bowel movement. R5's medical record did not indicate the physician was notified. ~ R5's bowel documentation contained missing documentation for multiple shifts. In January 2026, 22 shifts were missed; In February 2026, 11 shifts were missed; In March 2026, 16 shifts were missed. ~ R5 was admitted to the facility with a surgical wound. The wound clinic followed R5 weekly until R5's surgical wound healed, however, weekly skin checks were only completed on the following dates for R5 since admission: [DATE], 1/21/26, 1/27/26, 1/28/26, and 2/18/26. The facility could not provide any other weekly skin checks for R5. On 5/13/26, Surveyor interviewed NP-R who indicated NP-R would want to be notified if R5 had not had a bowel movement after 72 hours. NP-R indicated R5 had concerns of constipation and NP-R was concerned with how R5's stoma looked (it had turned whitish/gray) on 3/10/26. NP-R indicated R5 had a follow-up appointment with the surgeon later that day. NP-R indicated if R5 had not had the appointment, NP-R would have sent R5 for evaluation. NP-R indicated the surgeon was not concerned with R5's stoma and did not change any of R5's orders. 3. Between 5/12/26 and 5/13/26, Surveyor reviewed R16's medical record. R16 was admitted to the facility on [DATE] and had diagnoses including schizophrenia, secondary Parkinsonism. R16's MDS assessment, dated 2/16/26, stated R16 had a BIMS score of 9 out of 15, indicating moderate cognitive impairment. R16's care plan, dated 1/13/23, indicated R16 was a limited assist of one for toileting and transfers to the bathroom and occasionally incontinent of bowel. Surveyor reviewed R16's bowel records for March, April, and May 2026 and noted the following: - Bowel documentation was not completed every shift. In March 2026, documentation was missing for 6 shifts; In April 2026, documentation was missing for 23 shifts; In May 2026, documentation was missing for 4 shifts. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	- From 4/25/26 through 5/3/26, R16 did not have a bowel output recorded. The facility could not provide physician notification or if a PRN bowel medication was offered. - From 5/5/26 through 5/9/26, R16 did not have a bowel output recorded. The facility could not provide physician notification or if a PRN bowel medication was offered. On 5/13/26 at 2:30 PM, Director of Nursing (DON)-B confirmed skin checks should be completed weekly and documented. DON-B also confirmed bowel movements should be documented every shift. DON-B confirmed residents should be provided PRN medication to assist with bowel movements if available after 3 days and the physician should be notified. DON-B indicated the facility does not have a bowel protocol, however, providers should be notified to determine next steps if there are no PRN medications available for the resident. 4. Between 5/12/26 and 5/13/26, Surveyor reviewed R8's medical record. R8 was admitted to the facility on [DATE] and discharged on 3/19/26. R8 was admitted with diagnoses including cerebral palsy, acute and chronic respiratory failure with hypoxia, severe protein-calorie malnutrition, quadriplegia, seizures, pneumonia, and sepsis due to enterococcus. R8's MDS assessment, dated 3/12/26, stated R8 had a BIMS score of 0 out of 15, indicating severely impaired cognition. R8 had an activated healthcare decision maker. Surveyor reviewed R8's Medication Administration Record (MAR) which indicated the following medications were not administered: ~ 2/27/26 8:00 AM doses: Benzoyl peroxide external gel 10% apply to affected area topically once daily for acne; Diprolene AF (augmented formulation) external cream 0.05% apply to scalp topically once daily for abrasion; Hydrocortisone external cream 1% apply to rash on abdomen topically two times daily ~ 2/27/26 12:00 PM doses: Gabapentin oral solution 250 milligrams (mg)/5 milliliters (ml) give 10 ml via gastrostomy tube (g-tube (a small medical device inserted directly through the abdomen into the stomach) three times daily for neuropathic pain; Non-pharmacological interventions used every shift - pain monitoring every shift; simethicone oral liquid 40 mg/0.6 ml give 1.8 ml via g-tube three time daily for gas 2/27/26 AM shift: G-Tube: Stoma care every day and evening shift; Check air mattress to ensure proper functioning, inflation, and settings. Notify maintenance if mattress is not functioning and in need of repair every shift; Check oxygen (O2) saturation every shift; Colostomy care every shift; Ensure O2 foam protectors are in place and replace every shift; Head of bed 30 degrees every shift; Monitor blanchable redness to right upper thigh, update MD if worsening, every shift for monitoring; Oral care every shift; Oxygen: 1-3 liters via nasal cannula (NC) continuous to maintain oxygenation greater than 90% every shift; Behavior monitoring due to use of antipsychotic medication every shift ~ 3/12/26 night (NOC) shift: Change graduated cylinder and syringe nightly every shift; Check air mattress to ensure proper functioning, inflation, and settings. Notify maintenance if mattress is not functioning and in need of repair every shift; Check 02 saturation every shift; Colostomy care every shift; Ensure O2 foam protectors are in place and replace as needed every shift; Head of bed at 30 degrees every shift; Oral care every shift; Oxygen: 1-3 liters via NC continuous to maintain oxygenation greater than 90% every shift; Behavior monitoring due to antipsychotic medication every shift (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	~ 3/15/26 PM shift: Record output every shift ~ 3/17/26 NOC shift: Record output every shift On 5/13/26 at 11:50 AM, Surveyor interviewed DON-B who stated documentation should be complete so nurses can take credit for what they administer. DON-B indicated missing documentation does not mean the order was not implemented as staff can be forgetful at times.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interview and record review, the facility did not ensure the necessary care and services were provided to prevent pressure injuries from developing and/or promote healing for 1 resident (R) (R10) of 5 sampled residents.R10 developed an unstageable deep tissue injury on the sacrum and bilateral buttocks. Repositioning was not documented in accordance with the facility's policy. In addition, air mattress function was not documented on R10's Treatment Administration Record (TAR) for multiple shifts from 4/10/26 through 4/19/26.Findings include:The facility's Repositioning policy, revised 5/2013, indicates: The purpose of this procedure is to provide guidelines for the evaluation of resident repositioning needs, to aid in the development of an individualized care plan for repositioning, to promote comfort for all bed- or chair-bound residents, and prevent skin breakdown, promote circulation, and provide pressure relief for residents .1. Repositioning is a common, effective intervention for preventing skin breakdown, promoting circulation, and providing pressure relief .Documentation: The following information should be recorded in the resident's medical record: 1. The position in which the resident was placed. This may be on a flow sheet. 2. The name and title of the individual who gave the care. 3. Any change in the resident's condition. 4. Any problems or complaints made by the resident related to the procedure. 5. If the resident refused the care and the reason(s) why. 6. Observations of anything unusual exhibited by the resident .Reporting: 1. Notify the supervisor if the resident refuses the procedure. 2. If the resident refuses care, an evaluation of the basis for refusal, and the identification and evaluation of the potential alternatives is indicated .Surveyor reviewed R10's medical record. R10 was admitted to the facility on [DATE]. R10's diagnoses included complete paraplegia, morbid obesity, neuromuscular dysfunction of the bladder, tracheostomy, anxiety, and unspecified injury at T7-T10 level of thoracic spinal cord. R10's Minimum Data Set (MDS) assessment, dated 4/20/26, stated R10 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. A care plan, dated 4/10/26, indicated R10 was at risk for altered skin integrity related to paraplegia, morbid obesity, and the need for staff assistance with positioning. The care plan was revised on 4/21/26 and indicated R10 had a skin tear on the right buttock and an unstageable deep tissue injury on the sacrum and bilateral buttocks. The care plan contained interventions for assistance to reposition every hour from side-to-side and provide pressure reduction/relieving mattress set at 350. The care plan indicated R10 required the assistance of 2 staff for bed mobility. R10's TAR contained an order (dated 4/10/26) that indicated staff should check the setting and function of R10's air mattress. Set at 350 every shift for functioning starting on the 4/10/26 PM shift. (There was no documentation on the 4/10/26 night (NOC) shift, from 4/11/26 to 4/14/26, the 4/15/26 AM shift, the 4/15/26 NOC shift, the 4/16/26 NOC shift, on 4/17/26, the 4/18/26 NOC shift, or the 4/19/26 PM and NOC shifts.) (Of note: R10's weight on admission was 362 pounds.)An admission activity of daily living (ADL) status assessment, dated 4/10/26, indicated R10 was totally dependent with physical assist of 2 for bed mobility.A skin assessment, dated 4/15/26, indicated R10 had a deep tissue injury on the sacrum.R10's MDS assessment, dated 4/20/26, indicated R10 was not on a turning/repositioning program.A provider note, dated 4/21/26, indicated the wound physician debrided R10's sacral and bilateral buttock wound at the bedside. R10 had the following orders: ~ Check the setting and function of the air mattress. Setting at 350 every shift for functioning (dated 4/10/26)~ Apply Xeroform and bordered gauze to right buttock skin tear once daily one time a day for skin tear (dated 4/15/26; discontinue 4/21/26) ~ Apply skin prep to bilateral buttocks twice daily for deep tissue injury (dated 4/15/26; discontinue 4/21/26). ~ Wound care bilateral buttocks: Cleanse with 1/2 strength Dakin's solution. Protect peri-wound with skin prep. Apply Dakin's moistened gauze to wound bed, cover with ABD, and secure with tape every day and evening shift for wound care and as needed (PRN) if soiled or dislodged (dated 4/21/26) ~ Posterior inner left thigh: Cleanse with saline, pat dry, apply skin prep to (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	peri-wound, Xeroform to wound bed, cover with bordered gauze. Change daily and PRN every day shift for wound care and PRN for soiling/dislodgement (dated 4/23/26)On 5/12/26 at 3:27 PM, Surveyor interviewed Nurse Practitioner (NP)-R who indicated repositioning should be an order for anyone who needs assistance with repositioning. NP-R verified R10 needed assistance with repositioning due to paraplegia and obesity. On 5/14/26 at 10:59 AM, Surveyor interviewed Speech Therapist (ST)-D who indicated physical and occupational therapy notes indicated R10 was unable to reposition independently.On 5/13/26 at 10:44 AM, Surveyor interviewed Registered Nurse (RN)-S who discovered R10's sacral pressure injury that extended to the bilateral buttocks. RN-S indicated R10 was to be repositioned every 2 hours when admitted on [DATE] through 4/15/26. RN-S indicated the order was changed to every 1 hour on 4/15/26 due to R10's pressure injury. RN-S indicated R10 was an assist of 2 to reposition due to obesity, a cervical neck collar, and the need for the head of the bed to be at least 30 degrees. RN-S indicated nursing staff do not document repositioning. RN-S indicated R10 had an air mattress when R10 was admitted and used an air mattress throughout R10's stay at the facility. RN-S indicated staff document functioning of the air mattress each shift on the TAR. On 5/13/26 at 11:55 AM, Surveyor interviewed Assistant Director of Nursing (ADON)-C who indicated staff do not document repositioning because it is a standard of care. ADON-C indicated ADON-C thinks staff should have a way to document repositioning. ADON-C indicated R10 was originally repositioned every 2 to 3 hours when admitted then repositioned every 1 to 2 hours due to the pressure injury.On 5/13/26 at 12:05 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated repositioning is a standard of care and staff do not document it. DON-B indicated staff document R10's refusals to reposition in a progress note but do not document each time R10 is repositioned. DON-B indicated R10 had an air mattress upon admission due to R10's size and lack of mobility. DON-B acknowledged the missing documentation for functioning of the air mattress. DON-B indicated the facility does not have a documentation policy but staff are expected to document function of the air mattress each shift as ordered.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not provide the necessary respiratory care and services for 1 resident (R) (R8) of 1 sampled resident.R8 had a physician order for bronchial hygiene using Cough Assist (a device that clears secretions from the lungs by gradually applying positive air pressure to the airway and then rapidly shifting to negative air pressure, stimulating a deep natural cough to assist with clearing mucus and secretions) treatments twice daily. The treatments were not consistently completed.Findings include: According to the National Institutes of Health (NIH) article PMC7902008 retrieved 5/13/26, .Cough Assist (or Mechanical Insufflator/Exsufflator): The Mechanical Insufflator/Exsufflator (I/E) is a device that produces changes in the airflow inside the bronchial tree in such a way as to vicariate the cough .It is used mainly in patients with neuromuscular pathologies or respiratory muscle deficiency, who have a hypovalid or ineffective cough. An ineffective cough causes retained secretions, chronic inflammation and infections, increased airway resistance, decreased lung compliance, and respiratory failure . The facility's Non-Controlled Medication Order Documentation policy indicates: .E. Documentation of the Medication Order: 1) Each medication order is documented in the resident's medical record with the date, time, and signature of the person receiving the order. The order is recorded on the physician order or the telephone order or entered into the electronic medical record system .c. Written Transfer Orders (sent with a resident by a hospital or other health care facility) .1. Implement a transfer order without further validation if it is signed and dated by the resident's current attending physician, unless the order is unclear or incomplete or the date signed is different from the date of admission. 2. If the order is unsigned or signed by another prescriber or the date is other than the date of admission, the receiving nurse verifies the order with the current attending physician .4. The nurse who transcribes the orders to the physician order sheet and MAR or electronic system documents on the admission form the date, the time and by whom the orders were noted .d. Renewed or Recapitulated (Recapped) Orders (to continue a medication therapy beyond a previous order with limited duration): .1. The nurse on duty at the time the order is received notes the order and enters it on the physician order sheet or enters into the electronic medical record system .Between 5/13/26 and 5/14/26, Surveyor reviewed R8's medical record. R8 was admitted to the facility on [DATE] and discharged on 3/19/26. R8 had diagnoses including cerebral palsy (a group of lifelong neurological disorders that affect body movement, muscle coordination, and balance), acute and chronic respiratory failure with hypoxia (a condition where body tissues are deprived of adequate oxygen to function properly), severe protein-calorie malnutrition, quadriplegia (the partial or total loss of motor and sensory function in all four limbs and the torso), seizures, pneumonia, and sepsis (an extreme, life-threatening response to an infection). R8's Minimum Data Set (MDS) assessment, dated 3/12/26, stated R8 had a Brief Interview for Mental Status (BIMS) score of 0 out of 15, indicating severely impaired cognition. R8 had a Guardian for healthcare decisions.R8's medical record included a Hospitalist admission History and Physical, dated 1/18/26. The document was 10 pages. The first page was an admission Record cover sheet with R8's personal information. The following 9 pages were numbered but not in order and contained information from R8's hospital admission through 2/18/26:~ General Instructions: Bronchial Hygiene: Cough Assist treatments twice daily (BID) and as needed (PRN) via large full mask. Do 5 breaths for 3 cycles per treatment. Settings: inspiratory pressure 25, expiratory pressure -25, inhale time 2.5 seconds, exhale time 2.5 seconds, pause time 2.5 seconds. Oral suction with Yankauer (oral suction equipment to clear secretions from the airway) PRN. May need to be suctioned after Cough Assist treatments .Page 10 indicated: .The orders on this document are my transfer orders to be active at the new facility after discharge from the hospital. The orders replace any other lists of orders or medications. Electronically signed by Medical Doctor (MD)-Q on 2/18/26 at 11:03 AM.Surveyor reviewed R8's active and discontinued orders, Treatment Administration Record (TAR), (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and Medication Administration Record (MAR) and noted the Cough Assist order was not transcribed in R8's TAR. R8 did not receive treatment with the Cough Assist in the facility from 2/18/26 through 3/19/26 as ordered. R8 was hospitalized on 3 occasions during R8's stay at the facility:~ 2/22/26 to 2/24/26: R8 was diagnosed with respiratory difficulty. Documentation noted recurrent aspiration associated with severe scoliosis and cerebral palsy. A Cough Assist machine was used during the hospitalization. ~ 3/3/26 to 3/6/26: R8 was diagnosed with hypoxia, acute respiratory failure, and left-sided pneumonia with sepsis secondary to recurrent pneumonia. Hospitalization documentation included a recommendation for a more distal tube placement (GJ tube) (a procedure that inserts a feeding tube through the abdominal wall into the stomach with an extension reaching the small intestine (jejunum)). A Cough Assist machine was used during the hospitalization. ~ 3/19/26: R8 exhibited increased breathing and heart rate, respiratory distress, and fever. The facility obtained hospital admitting diagnoses of encephalopathy and aspiration pneumonia. (R8 did not return to the facility following this hospitalization.)On 5/13/26 at 1:26 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-N who worked with R8. LPN-N stated R8 did not have an order for a Cough Assist. LPN-N stated LPN-N needed to suction R8 due to thick mucus. LPN-N stated R8's cough was not productive without the help of suctioning.On 5/13/26 at 2:00 PM, Surveyor interviewed LPN-O who entered admission orders into R8's medical record. LPN-O stated LPN-O normally uses the After Visit Summary to enter orders into a newly admitted resident's medical record. LPN-O stated sometimes LPN-O puts a check mark next to an order and another nurse has to double check the order. LPN-O was not sure who double checked R8's admission orders. LPN-O stated once the orders are entered, the paper copy is sent to medical records and scanned into the resident's medical record. When Surveyor asked about R8's Cough Assist order, LPN-O did not recall entering a Cough Assist order, but did recall informing the Interdisciplinary Team (IDT) during morning meeting that R8 needed a Cough Assist. LPN-O did not recall who was in the meeting and did not recall seeing a Cough Assist machine for R8. LPN-O stated if a Cough Assist machine is ordered, the order is in the resident's TAR. The Cough Assist machine is set to the correct settings and the nurse just has to turn it on to begin treatment.On 5/13/26 at 2:47 PM, Surveyor interviewed Director of Nursing (DON)-B who stated there was a Cough Assist machine in R8's room and DON-B thought R8 had an order. DON-B reviewed R8's medical record and did not observe an order for a Cough Assist machine or find evidence that a Cough Assist machine was provided for R8. On 5/13/26 at approximately 3:00 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-C who stated ADON-C entered the settings into a Cough Assist machine in R8's room and completed one Cough Assist treatment for R8. ADON-C did not recall documenting the treatment in R8's medical record. ADON-C verified the order for a Cough Assist was not entered in R8's TAR. On 5/14/26 at 9:52 AM, Surveyor interviewed MD-P (R8's primary care provider) who stated it was extremely unlikely that not using a Cough Assist machine as ordered caused R8's hospitalizations. MD-P shared data and information supporting MD-P's opinion. MD-P stated R8 had multiple comorbidities, including cerebral palsy, which contributed to R8's hospitalizations. On 5/14/26 at 10:44 AM, Surveyor interviewed MD-Q (the hospital discharge physician who signed the Cough Assist order). MD-Q stated R8 used a Cough Assist machine at some point during R8's hospitalization. MD-Q stated with R8's dysphagia (difficulty swallowing), aspiration could occur. MD-Q stated a Cough Assist would have been useful to help clear secretion buildup, however, MD-Q did not think use of a Cough Assist machine would negate hospitalizations or would have prevented aspiration with R8's comorbidities.

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F 0774 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Help the resident with transportation to and from laboratory services outside of the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interview and record review, the facility did not assist in making transportation arrangements to and from the source of service for 1 resident (R) (R2) of 1 sampled resident.R2 missed a dentist appointment due to transportation issues on 4/16/26. R2 stated R2 missed other appointments in the past.Findings include:The facility's Transportation for Medical Appointments Policy states in part: .will assist residents with coordinating transportation to medically necessary appointments outside the facility while supporting resident choice and ensuring appropriate communication and documentation .R2 was admitted to the facility on [DATE] with diagnoses including chronic pain syndrome, anxiety disorder, post-traumatic stress disorder, and contusion of left upper arm.On 5/12/26 at 10:30 AM, R2 indicated R2 missed a dentist appointment on 4/16/26 and had to reschedule due to transportation issues. R2 indicated R2 missed a lot of appointments in the past.Surveyor reviewed R2's progress notes. A progress note, created by Director of Social Services (DSS)-M, indicated R2 missed a dentist appointment due to transportation issues.On 5/12/26 at 11:00 AM, DSS-M indicated DSS-M had a conversation with R2 regarding a dentist appointment. The appointment had to be rescheduled due to transportation issues. DSS-M indicated DSS-M has been more involved with appointments and transportation in the last week. DSS-M indicated there is a new receptionist who also schedules transportation for appointments. DSS-M indicated there was confusion in the past about who was supposed to schedule transportation for appointments, if it was the resident's Managed Care Organization (MCO) or the facility.On 5/13/25 at 8:30 AM, Receptionist (RCP)-K indicated RCP-K's first day of employment was 4/28/26 and RCP-K could not speak about R2's missed dental appointment on 4/16/26. RCP-K indicated there were previous issues with transportation and scheduling the correct transportation services.On 5/13/26 at 1:15 PM, Nursing Home Administrator (NHA)-A indicated there were past issues with scheduling appointments and transportation and the previous receptionist left employment with the facility.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure therapy services were provided for 1 resident (R) (R10) of 2 sampled residents.R10 had an order for Speech Therapy evaluation and treatment (dated 4/10/26). R10 was not seen by Speech Therapy while residing in the facility from 4/10/26 through 4/29/26.Findings include:The facility's undated Therapy policy indicates: .Therapy departments will have an established procedure for receiving and responding to requests for therapy services whether it be a referral directly from a physician to assume responsibility for management of one or more of a resident's specified problems, or for consultation or screening to determine if a resident is a candidate for skilled therapy services .The Director of Rehabilitation (DOR) will establish a process for distributing therapy referrals to the appropriate therapy discipline(s) .The DOR will ensure therapists are provided with clear expectations for how quickly therapy responds to all referrals .All referrals must be tracked by the DOR to ensure timely response by the applicable therapy department.Between 5/13/26 and 5/14/26, Surveyor reviewed R10's medical record. R10 was admitted to the facility on [DATE]. R10's diagnoses included complete paraplegia, morbid obesity, neuromuscular dysfunction of the bladder, tracheostomy, anxiety, and unspecified injury at T7-T10 level of thoracic spinal cord. R10's Minimum Data Set (MDS) assessment, dated 4/20/26, stated R10 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. R10 had the following orders:~ Speech therapy to evaluate and treat (dated 4/10/26)~ Shiley uncuffed size 4 (dated 4/10/26) ~ Head of bed (HOB) 30 to 45 degrees at all times, expect for repositioning and cares every shift (dated 4/10/26)~ Trach cares every shift (dated 4/10/26)~ R10's trach to remain capped; May remove if needed every shift for tracheostomy (dated 4/25/26)A progress note, dated 4/13/26, indicated R10 refused to use a trach inner cannula due to R10's capped trach. R10 explained to staff R10 is able to use the inner cannula due to the style, but cannot tolerate it and doesn't need it.A provider note, dated 4/14/26, indicated R10 should continue R10's current therapeutic regimen including Physical, Occupational, and Speech Therapy to optimize functional recovery.On 5/14/26 at 10:59 AM, Surveyor interviewed ST-D who indicated R10 was not evaluated by Speech Therapy. ST-D indicated ST-D was the only Speech Therapist at the facility during R10's admission. ST-D indicated ST-D works as needed and currently works Monday, Wednesday, and Friday until a full-time Speech Therapist can be hired. ST-D indicated ST-D was not informed of R10's order for Speech Therapy evaluation and treatment and indicated therapy orders are received by the therapy director. ST-D indicated the Therapy Director screens therapy referrals, coordinates therapist schedules, and distributes daily schedules to the therapists. ST-D indicated the Regional Therapy Director has been filling in as the previous Therapy Director's last day was 4/16/26. ST-D indicated R10 did not receive Speech Therapy as ordered due to a communication error. On 5/14/26 at 11:05 AM, Surveyor interviewed Therapy Director (TD)-E who indicated TD-E is the Regional Therapy Director and is training a new Therapy Director. TD-E indicated the therapy department is working on process improvements. TD-E indicated it is the Therapy Director's responsibility to ensure new therapy orders are followed and residents that are referred are added to the daily schedule. TD-E confirmed ST-D is the only Speech Therapist at the facility and verified R10 was not seen for Speech Therapy.On 5/14/26 at 12:05 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated R10 should have been seen by Speech Therapy within days of the Speech Therapy order.