

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525333	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2026
NAME OF PROVIDER OR SUPPLIER Watertown Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 121 Hospital Dr. Watertown, WI 53098	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on staff interview and record review, the facility did not ensure a Registered Nurse (RN) was on duty at least 8 consecutive hours per day 7 days per week. This practice had the potential to affect all 77 residents residing in the facility. The facility did not have an RN on duty for 8 consecutive hours per day 7 days per week on 5 of 10 days reviewed. Findings include: The Facility Assessment, dated 1/2026, indicates: .Part 3: Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies .3.3 The acuity of care is reviewed daily to determine the need of the current patient population. The facility utilizes a staffing template to assist with determining the staffing needs. In addition, the facility works to have continuity of assignments. Between 3/9/26 and 3/12/26, Surveyor reviewed the facility's staffing for fiscal year (FY) Quarter 1 2026 (October 1 - December 31). The facility's schedules and nurse staff postings did not include an RN on duty for at least 8 consecutive hours per day 7 days per week on 11/27/25, 11/29/25, 11/30/25, 12/26/25, and 12/27/25. In addition, the 11/27/25, 11/29/25, and 11/30/25 schedules included RN and Infection Preventionist (IP)-I's name handwritten on the bottom. The schedules did not indicate the hours that IP-I worked or in what capacity IP-I worked. On 3/12/26 at 1:42 PM, Surveyor interviewed Director of Nursing (DON)-B and Nursing Home Administrator (NHA)-A who stated the facility has an RN manager on-call who is expected to work on the floor if they are called in. DON-B confirmed IP-I was the RN manager on duty for the November dates. On 3/12/26 at 2:01 PM, Surveyor interviewed NHA-A who stated employee time clock punches should have been logged and submitted to the corporate office by the previous Business Office Manager (BOM). NHA-A stated the corporate office is responsible for submission of the hours on the payroll-based journal (PBJ) to the Centers for Medicare & Medicaid Services (CMS). NHA-A stated because IP-I is a salaried employee, there is not a time-stamp to confirm that IP-I was in the building and worked as an RN. NHA-A confirmed the facility did not have documentation to indicate an RN worked 8 consecutive hours per day on the dates listed above. On 3/12/26 at 2:40 PM, DON-B provided Surveyor with login data for IP-I in the facility's electronic medical record system on dates when IP-I was scheduled to be the RN on duty. The login data did not indicate the number of hours IP-I was in the facility or what tasks IP-I completed while working as the RN on duty.		

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not ensure food was stored and prepared in a sanitary manner. This practice had the potential to affect 71 of 77 residents residing in the facility. (Six residents received nutrition via tube feeding.) Kitchen equipment and food services areas were not in a clean and sanitary condition. The facility did not follow safe food cooling protocols. The facility did not ensure food was kept and served at a safe temperature. The facility did not ensure time/temperature control foods were labeled appropriately with open and use-by dates. Findings include: On 3/9/26 at 11:25 AM, Dietary Manager (DM)-C indicated the facility follows the Wisconsin Food Code as their standard of practice. Cleanliness: The 2022 Wisconsin Food Code documents at 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils: (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. 4-602.12 Cooking and Baking Equipment: (B) The cavities and door seals of microwave ovens shall be cleaned at least every 24 hours by using the manufacturer's recommended cleaning procedure. 4-903.11 Equipment, Utensils, Linens, and Single Service and Single-Use Articles: (B) Clean equipment and utensils shall be stored. (2) Covered or inverted. The facility's sanitization policy, dated January 2026, indicates: The food service area shall be maintained in a clean and sanitary manner. 1. All kitchens, kitchen areas, and dining areas shall be kept clean, free from litter and rubbish, and protected from rodents, roaches, flies, and other insects. 2. All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corruptions, open seams, cracks, and chipped areas that may affect their use or proper cleaning. Seals, hinges, and fasteners will be kept in good repair. 3. All equipment, food contact surfaces, and utensils shall be washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solution. On 3/9/26 during an initial kitchen tour with DM-C that began at 9:58 AM, Surveyor noted the following cleanliness issues: ~ The ceiling vents above the kitchen preparation and cooking areas contained black debris. ~ An oscillating fan that contained dust and dirt/debris was blowing directly onto clean dishes. ~ The inside of the food steamer contained white residue. ~ The stove top contained numerous food particles on all 6 burners and contained thick, greasy, black residue. The backsplash was soiled with splashes of residue that appeared to be from food or liquid. ~ The flat top grill contained yellow, brown, and black food and grease and was sticky to the touch. ~ Shelves, tabletops, and steamtable wells/covers in the prep area contained food debris and unidentified white and black debris. Many of the shelves and countertops were directly under a soiled ceiling ventilation system. ~ A plastic container of Thick It (a thickening agent) on a shelf in the food prep area contained an accumulation of white and black residue on the container and on the surface of the lid. The container was directly under a soiled ceiling ventilation system. On 3/9/26, Surveyor observed the kitchen's daily After Each Use Cleaning Schedule. Surveyor and DM-C noted several of the items listed had not been completed for each of the seven days during the prior week, including the grill. Surveyor interviewed DM-C regarding the cleanliness issues and cleaning log. DM-C indicated the cleaning log should be filled out every day and items should be cleaned after use. Surveyor asked if DM-C was aware the fan was blowing air and potential debris onto clean dishes. Surveyor and DMC-C observed (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Oatmeal~ Cream of Wheat~ Pureed eggs~ Shredded pork~ Bacon~ Turkey sausage~ Pork loins (approximately 12 still warm pork loins that were in a deep pan stacked on top of each other. The pork loins were not in a shallow pan, spread out, sliced, or on ice to help quickly cool them.)Surveyor interviewed DM-C who indicated the facility uses leftovers and should have a cooling log. DM-C and other kitchen staff were not sure where to find the cooling log. After looking in several binders, DM-C found cooling logs in a binder on a shelf in the kitchen. The most recent cooling log was dated November 2024. DM-C was not aware of any other cooling logs and verified staff should be logging all food that is cooled and kept. The cooling log indicated hot/cooked food should be temped every two hours and should reach 41 degrees Fahrenheit in six hours or less.Food Temperatures:The 2022 Wisconsin Food Code documents at 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding: (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under 3-501.19, and except as specified under (B)-(C) of this section, time/temperature control for safety food shall be maintained: (1) At 135 degrees Fahrenheit or above, except that roasts cooked to a temperature and for a time specified in 3-401.11 (B) or reheated as specified in 3-403.11 (E) may be held at a temperature of 130 degrees Fahrenheit or above; or (2) At 41 degrees Fahrenheit or less. The facility's Food Preparation and Service policy, dated January 2026, indicates: .Food Preparation, Cooking and Holding Temperatures and Times: 1.The danger zone for food temperatures is between 41 F and 135 F. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness. 2. Potentially Hazardous Foods (PHF) include meats, poultry, seafood, cut melon, eggs, milk, yogurt and cottage cheese. 3. The longer foods remain in the danger zone, the greater the risk for growth of harmful pathogens. Therefore, PHF must be maintained below 41 F or above 135 F .On 3/10/26 at 7:36 AM, Surveyor observed breakfast service in the kitchen which had begun prior to Surveyor's arrival. Surveyor observed a pan of 6 fried eggs on the stove. The eggs were not over a heating source and were not kept warm. Surveyor also observed raw (in the shell) pasteurized eggs in an open container and a bag of hard boiled eggs on the counter. Surveyor observed individual yogurt containers and individual serving cartons of Mighty Shakes in a bin on the counter. The yogurt and Mighty Shakes were not kept cold or on ice. Surveyor noted residents' trays contained cups of juice and were on a rack waiting for food.On 3/10/26 at 7:54 AM, Surveyor observed CK-G remove a fried egg from the pan on the stove. CK-G placed the egg on a plate and prepared to deliver it to a resident. Surveyor asked CK-G to temp the egg which was 115 F.On 3/10/26 at 7:54 AM, Surveyor interviewed CK-G who verified CK-G would have served the egg to a resident had Surveyor not intervened. After seeing the temperature of the egg, CK-G indicated the temperature was not good and the eggs should be remade. When asked if that is how eggs are typically made and kept for breakfast service, CK-G stated CK-G didn't know how fast CK-G needed to use them. When asked if they should be kept warm in the steamer or steam table, CK-G stated CK-G didn't think of that.On 3/10/26 at 8:01 AM, Surveyor observed Dietary Aide (DA)-H put yogurt on a resident's tray. Surveyor interviewed DA-H who indicated yogurt and Mighty Shakes are supposed to be kept cold and should be kept in the cooler until service and kept on ice during service. DA-H stated DA-H didn't have any ice because Certified Nursing Assistants (CNAs) take all the ice in the morning. Surveyor observed DA-H grab resident trays with pre-poured juice and use them throughout breakfast service.On 3/10/26 at 8:27 AM (the end of breakfast), Surveyor asked DA-H to temp items that had not been kept cold during food service including:~ Juice (that was on a tray ready to be used) - 66.5 F~ Yogurt - 56.3 F~ Hard boiled eggs - 51.4 [NAME] 3/10/26 at 8:27 AM, Surveyor observed a conversation between CK-G and DM-C in which CK-G and DM-C expressed uncertainty about holding and serving temperatures.Time/Temperature Controlled Food Storage:The 2022 Wisconsin Food Code (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	documents at 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking: (A) Except when packaging food using a reduced oxygen packaging method as specified under S 3-502.12, and except as specified in (E), (F), and (H) of this section, refrigerated, ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature and time combination of 5 degrees C (Celsius) (41 degrees F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1 .(2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety .(D) A date marking system that meets the criteria stated in (A) and (B) of this section may include: .(3) Marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (B) of this section .Disposition: (A) A food specified under 3-501.17 (A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3-501.17 (A) Except time that the product is frozen; (2) Is in a container or package that does not bear a date or day.The facility's Food Receiving and Storage policy, dated 12/2025, indicate: .7. Dry foods that are stored in bins will be removed from original packaging, labeled and dated (use-by date). Such foods will be rotated using a first in-first out system. 8. All foods stored in the refrigerator or freezer will be covered, labeled and dated (use-by date) .On 3/9/26 during an initial kitchen tour with DM-C that began at 9:58 AM, Surveyor observed the following food storage concerns:~ Bulk flour with a delivery date of 2/5 and no open or use-by date~ Bulk sugar with an open date of 3/3 and no use-by date~ Five pounds of open linguini pasta that was not sealed shut and contained two dates: 1/19 and 2/19~ An unlabeled container of white powder identified by CK-F as Thick-It powder that contained two dates: 10/8 and 1/8/26Surveyor interviewed DM-C who verified the facility uses a first in/first out food storage process. DM-C indicated staff should date items with an open or made date and a use-by date. DM-C did not know the use-by dates for the bulk flour or sugar and did not know if 2/19 was the use-by date for the linguini pasta. Surveyor observed DM-C ask CK-F about the dates on the linguini. CK-F stated CK-F guessed 2/19 was the use-by date but was not sure. DM-C stated the pasta should have been sealed and should have contained a use-by date. DM-C indicated the Thick It powder should contain a label and should have been thrown out by the use-by date. DM-C and CK-F were unsure of the dates on the Thick It powder.On 3/12/26 at 12:54 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B who indicated kitchen management and staff should be aware of and follow facility protocols for safe food storage, handling, preparation, and serving. NHA-A and DON-B indicated kitchen staff should keep the kitchen clean and notify maintenance staff of items that need cleaning that kitchen staff cannot reach or complete.		

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on staff interview and record review, the facility did not ensure the minimum required members of the facility's Quality Assessment and Assurance (QAA) committee met at least quarterly. This practice had the potential to affect all 77 residents in the facility. The facility did not have documentation that the minimum required members of the QAA committee met for quality assessment and assurance purposes on a quarterly basis. Findings include: The facility's QAPI plan, with an implementation date of 10/1/25, indicates: .2. The Quality Assessment and Assurance (QAA) Committee shall be interdisciplinary and shall: a. Consist at a minimum of: i. The Director of Nursing Services; ii. The Medical Director or his/her designee; iii. At least 3 other members of the facility's staff, at least one of which must be the Administrator, Owner, a Board Member or other individual in a leadership role; and iv. The Infection Preventionist. On 3/12/26, Surveyor reviewed the facility's QAA committee meeting sign-in sheets for the last year and noted the facility provided sign-in sheets for each month from February 2025 through February 2026. Surveyor noted the only months the facility met the minimum requirements for staff present (Medical Director (MD), Nursing Home Administrator (NHA), Director of Nursing (DON), Infection Preventionist (IP), and 2 other staff) were August 2025 and February 2026. The QAA committee meeting sign-in sheets indicated the following:~ During the February 2025 meeting, the MD and NHA were not present.~ During the March 2025 meeting, the NHA and IP were not present.~ During the April 2025 meeting, the NHA was not present. ~ During the May 2025 meeting, the DON and IP were not present.~ During the June 2025 meeting, the NHA and IP were not present.~ During the July 2025 meeting, the the NHA, IP, and MD were not present.~ During the August 2025 meeting, the required members attended the meeting. ~ During the September 2025 meeting, the MD and IP were not present.~ During the October 2025 meeting, the MD was not present. ~ During the November 2025 meeting, the MD was not present.~ During the December 2025 meeting, the MD was not present.~ During the January 2026 meeting, the MD was not present. ~ During the February 2026, the required memebbers attended the meeting. The MD attended via phone. On 3/12/26 at 1:39 PM, Surveyor interviewed NHA-A who acknowledged the requirement and indicated sometimes the Medical Director attended via phone. NHA-A verified the sign-in sheets should reflect who attends the meetings.		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interview and record review, the facility did not ensure grievances were thoroughly investigated and resolved for 6 residents (R) (R66, R14, R35, R7, R56, and R32) of 34 sampled residents. R66 reported concerns about the laundry process and missing items. R66 stated R66 was missing a sweater and a pair of pajama pants. R14 reported that laundry is frequently lost. R14 stated R14 was missing a nightgown with red cardinals that was reported to staff. R35, R7, and R56 reported concerns about the laundry process and missing items. R32 arrived at the facility in a wheelchair that was borrowed from a friend. R32 reported to staff that the wheelchair went missing approximately 4 days after R32 was admitted. The grievance was not thoroughly investigated or resolved. Findings include: The facility's Grievance policy, dated 9/15/25, indicates: The designated Grievance Official will: receive and track grievances through to resolution; provide written grievance resolutions to residents or representatives. Grievances should be resolved as promptly as possible with a goal of resolution within 5 working days. The facility's Personal Property policy, revised August 2022, indicates: .10. The resident's personal belongings and clothing are inventoried and documented upon admission and updated as necessary. On 3/9/26 at 12:51 PM, Surveyor interviewed R35 who stated laundry frequently went missing and the facility was aware. R35 was the Resident Council president and stated the issue was discussed at Resident Council meetings. R35 wanted staff to bring more personal items up from laundry like they did in the past so residents could go through them. On 3/9/26 at 12:55 PM, Surveyor interviewed R66 who stated R66 was missing a pair of pajama pants and a sweater. R66 stated Nursing Home Administrator (NHA)-A was aware of the missing items and stated they would be replaced, however, the items had not been replaced. On 3/9/26 at 12:04 PM, Surveyor interviewed R56 who stated laundry frequently went missing and R56 had issues with socks. On 3/9/26 at 12:10 PM, Surveyor interviewed R14 who stated R14 was missing a nightgown with cardinals. R14 and R14's roommate (R56) indicated staff were aware of the missing nightgown, however, it had not been found and R14 was not given an update. On 3/9/26 at 3:39 PM, Surveyor interviewed R7 who stated there were a lot of missing laundry items and the facility had been working on the process. R7 stated staff brought items to a Resident Council meeting in the past and residents went through the items to see if they knew who they belonged to. R7 stated R7 made a list of R7's clothing so R7 had something to refer to when items went missing. Between 3/10/26 and 3/12/26, Surveyor reviewed the facility's Resident Council minutes which indicated: (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	~ On 11/10/25, housekeeping staff discussed missing clothing and provided lost and found items for residents to look through and claim. ~ On 1/5/26, staff stated they were working on an improved process to decrease missing items. Residents reported that hangers had gone missing. The group was reminded to label all personal belongings. Surveyor reviewed the grievance log and noted there were no grievances for R66 or R14's missing items. On 3/11/26 at 1:55 PM, Surveyor completed a tour of the laundry area with Laundry Staff (LS)-BB and observed a bin of clothing. LS-BB stated the items were unlabeled and staff could not tell who they belonged to. LS-BB stated residents' items should be inventoried upon admission. Nursing staff should log residents' belongings on a form and put the form in a bag with the resident's clothing for laundry staff to label. LS-BB indicated the process was not consistent and residents' items are often laundered prior to being labeled. When Surveyor asked how LS-BB knows what to look for, LS-BB pointed to a bulletin board above the label maker. The bulletin board contained 6 pieces of paper with residents' names and missing items. LS-BB indicated the papers stay up until an item is found. LS-BB stated if laundry staff are told something is missing, they write it on paper and hang it on the board so they know what to look for. LS-BB was not aware of a grievance log to fill out. On 3/11/26 at 1:08 PM, Surveyor interviewed LS-AA via phone who expressed concerns about the inventory process which resulted in missing items. LS-AA indicated someone should take inventory when a resident is admitted or when they receive new items. An inventory sheet should be filled out and sent with the resident's clothing to be labeled. LS-AA indicated the process is not consistent which results in missing items. LS-AA also expressed a concern about the communication process and indicated residents can tell a manager, the Social Worker, a Certified Nursing Assistant (CNA), or laundry staff. If a resident tells LS-AA about a missing item, LS-AA asks for the description and size and puts a note on the board in the laundry room. LS-AA indicated sometimes a grievance form is filled out. When Surveyor asked about R14's cardinal nightgown and R66's sweater and pants. LS-AA was not aware of R14's missing nightgown. LS-AA was aware of R66's sweater but not the pajama pants. LS-AA stated when residents tell staff an item is missing, the message does not always make it to laundry staff. LS-AA stated at times when LS-AA is delivering laundry, residents ask if certain items were found, however, LS-AA did not know the items were missing. LS-A indicated items go missing on almost a daily basis. On 3/12/26 at 3:42 PM, Surveyor interviewed NHA-A who stated missing laundry items should be documented on grievance forms. NHA-A stated an investigation should be completed if a resident says they are missing clothing. NHA-A stated the facility orders new items for residents if they cannot locate the items. NHA-A stated the facility has an angel program where staff regularly speak to residents and try to capture grievances. NHA-A stated all missing laundry item concerns should be written on formal grievance forms that are assigned to laundry or housekeeping. 2. Between 3/10/26 and 3/12/26, Surveyor reviewed R32's medical record. R32 was admitted to the facility on [DATE] and had diagnoses including cellulitis of the right lower limb, spina bifida, major (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	depressive disorder, recurrent anxiety disorder, and acquired absence of the right leg above-the-knee. R32's Quarterly Minimum Data Set (MDS) assessment, dated 2/20/26, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R32 had intact cognition. The MDS assessment also indicated R32 used a wheelchair. On 3/10/26 at 1:30 PM, Surveyor interviewed R32 who stated R32 was admitted to the facility in a brown wheelchair that a friend lent to R32. Approximately 4 days after R32 was admitted , the wheelchair went missing. R32 stated R32 told multiple staff about the missing wheelchair and staff said they'd keep looking for it. Surveyor observed a blue facility wheelchair in R32's room. R32 stated, I want my friend's wheelchair back. Surveyor reviewed a grievance, dated 9/11/25, that indicated R32's care team reported that a brown wheelchair that R32 brought to the facility was missing. The grievance indicated the staff searched the facility but the wheelchair was not found. The receptionist was interviewed but did not recall a brown wheelchair when R32 was admitted . R32 was provided with a new wheelchair. The grievance indicated R32 was okay with the new wheelchair and had no further complaints about the brown wheelchair. The grievance did not contain interviews with other staff or residents to determine if anyone else saw the wheelchair or knew where it was. R32's medical record did not contain an inventory of R32's belongings upon admission. On 3/12/26 at 9:20 AM, Surveyor interviewed Assistant Director of Nursing (ADON)-I. When asked if residents' belongings are inventoried upon admission, ADON-I stated belongings are inventoried and documented on a form. ADON-I verified R32's medical record did not contain an inventory of belongings and indicated if a form was completed, it would be in the medical records office. Nursing Home Administrator (NHA)-A was present during the interview. NHA-A stated NHA-A investigated the grievance and R32 was fine with the new wheelchair. NHA-A was not aware the missing wheelchair was borrowed from a friend and R32 needed to return it. NHA-A was not sure if R32's belongings were inventoried upon admission and verified the information was not included with the grievance. NHA-A stated NHA-A would check the medical records office for an inventory of belongings and follow-up with Surveyor. An inventory of R32's belongings was not provided.		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on staff interview and record review, the facility did not implement written policies and procedures that prohibit and prevent abuse for 6 (Certified Nursing Assistant (CNA)-DD, CNA-EE, CNA-FF, Activity Aide (AA)-GG, Maintenance Staff (MS)-HH, and CNA-II) of 10 staff reviewed for caregiver background checks. The facility did not ensure timely completion of CNA-DD's caregiver background check. The facility did not ensure a caregiver background check was completed for CNA-EE. The facility did not ensure timely completion of CNA-FF's caregiver background check. The facility did not ensure a caregiver background check was completed before allowing AA-GG to work with residents. The facility did not ensure a caregiver background check was completed before allowing MS-HH to work in resident care areas. The facility did not ensure timely completion of CNA-II's caregiver background check. Findings include: The facility's undated Abuse/Neglect/Exploitation policy indicates: It is the policy of the facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property .I. Screening: A. Potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. 1) Background, reference, and credentials checks shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers, and consultants. On 3/11/26, Surveyor reviewed background check information for 10 staff and noted the following: ~ CNA-DD was hired on 6/24/16. CNA-DD's Background Information Disclosure (BID) form, dated 6/23/16, was not completed within the last four years. CNA-DD's Department of Justice (DOJ) and Government Findings (GF) Reports were completed on 3/11/26 following Surveyor's request to review CNA-DD's background check information. ~ CNA-EE was hired on 1/29/26. CNA-EE's BID form, dated 1/30/26, was completed after CNA-EE's hire date. The facility did not request DOJ or GF Reports for CNA-EE. ~ CNA-FF was hired on 11/2/04. CNA-FF's BID form was completed on 8/26/16. CNA-FF's DOJ and GF Reports were completed on 12/29/20 which was not within the last four years. ~ AA-GG was hired on 1/24/26. AA-GG's BID form was completed on 1/26/26. AA-GG's DOJ and GF Reports were completed on 1/27/26 which was after AA-GG's hire date. ~ MS-HH was hired on 12/8/25. MS-HH's DOJ and GF Reports were completed on 12/9/25 which was after MS-HH's hire date. ~ CNA-II was hired on 1/6/26. CNA-II's DOJ and GF Reports were completed on 1/8/26 which was after CNA-II's hire date. On 3/12/26 at 1:42 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B who stated the previous Business Office Manager (BOM) was responsible for completing employee background check. NHA-A stated the previous BOM left employment a couple weeks ago. NHA-A verified the hire dates for MS-HH, AA-GG, and CNA-II were the same dates the employees would have worked on the floor with or in resident care areas. NHA-A and DON-B verified background checks should be completed every four years and before employees work with residents.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident representative interview and record review, the facility did not ensure written bed hold, transfer, and Ombudsman notification was completed for 7 residents (R) (R6, R13, R79, R56, R11, R9, and R21) of 26 sampled residents. R6 was transferred to the hospital on [DATE], 12/2/25, and 1/22/26. The facility did not provide written bed hold or transfer notices and did not notify the Ombudsman of the transfers. R13 was transferred to the hospital on 1/19/26. The facility did not provide a written bed hold or transfer notice and did not notify the Ombudsman of the transfer. R79 was transferred to the hospital on [DATE] and did not return to the facility. The facility did not provide a written bed hold or transfer notice and did not notify the Ombudsman of the transfer. R56 was transferred to the hospital on 1/30/26. The facility did not provide a written bed hold or transfer notice and did not notify the Ombudsman of the transfer. R11 was transferred to the hospital on 1/17/26, 1/28/26, and 1/30/26. The facility did not provide written bed hold or transfer notices and did not notify the Ombudsman of the transfers. R9 was transferred to the hospital on [DATE], 1/6/26, 1/29/26, and 2/19/26. The facility did not provide written bed hold or transfer notices and did not notify the Ombudsman of the transfers. R21 was transferred to the hospital on 9/22/25 and 1/27/26. The facility did not provide written bed hold or transfer notices and did not notify the Ombudsman of the transfers. Findings include: The facility's Bed Hold Notice policy, dated 8/25/25, indicates: At the time of transfer for hospitalization or therapeutic leave, the facility will provide the resident and/or the resident's representative with a written notice which specifies the duration of the bed hold policy and addresses information explaining the return of the resident to the next available bed. The facility's Transfer and Discharge policy, dated 10/2025, indicates: The facility's transfer/discharge notice will be provided to the resident and the resident's representative in a language and manner in which they can understand. The Social Service Director or designee will provide copies of notices for emergency transfers to the Ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis, as long as the list meets all requirements for contents of such notices. 1. Between 3/9/26 and 3/12/26, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] and had diagnoses including history of cerebral vascular accident, respiratory failure, and dysphagia. R6's Minimum Data Set (MDS) assessment, dated 1/28/26, had a Brief Interview for Mental Status (BIMS) score of 0 out of 15 which indicated R6 had severe cognitive impairment. R6 had an activated Power of Attorney for Healthcare (POAHC). R6's medical record indicated R6 was sent to the hospital on [DATE], 12/2/25, and 1/22/26. R6's medical record did not contain written bed hold or transfer notices. (See interviews under example 8.) 2. Between 3/9/26 and 3/12/26, Surveyor reviewed R13's medical record. R13 was admitted to the (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility on [DATE] and had diagnoses including paraplegia, sepsis, and anxiety. R13's MDS assessment, dated 1/19/26, had a BIMS score of 15 out of 15 which indicated R13 had intact cognition. R13's medical record indicated R13 was transferred to the hospital on 1/19/26. R13's medical record did not contain a written bed hold or transfer notice. (See interviews under example 8.) 3. Between 3/9/26 and 3/12/26, Surveyor reviewed R79's medical record. R79 was admitted to the facility on [DATE] and had a diagnosis of esophageal cancer. R79's MDS assessment, dated 12/12/25, had a BIMS score of 15 out of 15 which indicated R79 had intact cognition. R79's medical record indicated R79 was transferred to the hospital on [DATE] and did not return to the facility. R79's medical record did not contain a written bed hold or transfer notice. (See interviews under example 8.) 4. Between 3/9/26 and 3/12/26, Surveyor reviewed R56's medical record. R56 was admitted to the facility on [DATE] and had diagnoses including muscle wasting and atrophy, and chronic pain syndrome. R56's MDS assessment, dated 1/27/26, had a BIMS score of 12 out of 15 which indicated R56 had moderate cognitive impairment. R56's medical record indicated R56 was transferred to the hospital on 1/30/26. R56's medical record did not contain a written bed hold or transfer notice. (See interviews under example 8.) 5. Between 3/9/26 and 3/12/26, Surveyor reviewed R11's medical record. R11 was admitted to the facility on [DATE] and had diagnoses including muscle wasting and atrophy and diabetes. R11's MDS assessment, dated 2/26/26, had a BIMS score of 15 out of 15 which indicated R11 had intact cognition. R11's medical record indicated R11 was transferred to the hospital on 1/17/26, 1/28/26, and 1/30/26. R11's medical record did not contain bed hold or transfer notices. (See interviews under example 8.) 6. Between 3/9/26 and 3/12/26, Surveyor reviewed R9's medical record. R9 was admitted to the facility on [DATE] and had diagnoses including anoxic brain damage, tracheostomy, epilepsy, and pneumonia. R9 was non-verbal and unresponsive and had a Guardian who was responsible for healthcare decisions. R9's medical record indicated R9 was transferred to the hospital on [DATE], 1/6/26, 1/29/26, and 2/19/26. R9's medical record did not contain bed hold or transfer notices. (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(See interviews under example 8.) 7. Between 3/9/26 and 3/12/26, Surveyor reviewed R21's medical record. R21 was admitted to the facility on [DATE] and had diagnoses including encephalopathy, malnutrition, and tracheostomy. R21 was non-verbal and had an activated POAHC (POAHC-Z) who assisted with medical decisions. R21's medical record indicated R21 was transferred to the hospital on 9/22/25 and 1/27/26. R21's medical record did not contain bed hold or transfer notices. On 3/9/26 at 2:00 PM, Surveyor interviewed POAHC-Z who stated the facility did not contact POAHC-Z regularly for updates. POAHC-Z did not recall receiving bed hold or transfer notices for R21's transfers. (See interviews under example 8.) 8. On 3/10/26, Surveyor requested to see Ombudsman notification for resident transfers and discharges. The facility provided an email to the Ombudsman, dated 3/10/26, with an attachment that included transfers. Surveyor reviewed the list of transfers and noted R6, R13, and R56 were not on the list. On 3/11/26 at 9:36 AM, Surveyor interviewed Social Services Designee (SSD)-J who was not aware Ombudsman notification was required. Surveyor reviewed the report that was attached to SSD-J's 3/10/26 email to the Ombudsman and noted the report did not contain all of the facility's transfers and discharges, including those for R6, R13, and R56. SSD-J stated SSD-J would determine which report to send and add it to SSD-J's duties. On 3/11/26 at 8:01 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-L who stated LPN-L did not complete bed hold or transfer notices and was not sure who did. LPN-L stated LPN-L ensures communication with the receiving hospital. On 3/11/26 at 3:53 PM, Surveyor interviewed Director of Nursing (DON)-B who stated when a resident leaves the facility, nursing staff should obtain the bed hold and transfer policy and SSD-J should follow-up. On 3/11/26 at 3:58 PM, Surveyor interviewed SSD-J who stated nursing staff are required to complete bed hold and transfer notices and Admissions Director (AD)-K follows-up. On 3/12/26 at 10:10 AM, Surveyor interviewed AD-K who stated AD-K does not do anything with bed hold and transfer notices. AD-K stated AD-K calls families on occasion but does not document the phone calls or do anything with paperwork. On 3/12/26 at 10:13 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who confirmed the facility did not have written bed hold and transfer notices for the above residents and did not notify the Ombudsman of transfers and discharges.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not accurately code Minimum Data Set (MDS) 3.0 assessments for 6 residents (R) (R21, R62, R22, R29, R7, and R36) of 26 sampled residents. R21 was admitted to the facility on [DATE] with a tracheostomy. R21's MDS assessment, dated 2/12/26, did not indicate R21 had a tracheostomy. In addition, R21's MDS assessments, dated 11/12/26 and 2/12/26, inaccurately indicated that R21 was comatose. R62's MDS assessment, dated 2/6/26, inaccurately indicated that R62 was comatose. R22 signed onto Hospice services on 1/14/26. R22's MDS assessment, dated 2/18/26, did not indicate R22 received Hospice services. R29 was prescribed levetiracetam (an anticonvulsant medication). R29's MDS assessment, dated 1/2/26, did not indicate R29 received anticonvulsant medication. R7's MDS assessment, dated 1/2/26, indicated R7 received insulin. R7 did not have an order for insulin. R36 had an indwelling Foley catheter. R36's MDS assessment, dated 12/16/25, did not indicate R36 had a catheter. Findings include: The facility's undated MDS 3.0 Completion policy indicates: Residents are assessed, using a comprehensive assessment process in order to identify care needs and develop an interdisciplinary care plan .1. According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate, and standardized assessment of each resident's functional capacity, using the Resident Assessment Instrument (RAI) specified by the state. The Centers for Medicare & Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (October 2025) defines comatose as a pathological state in which neither arousal (wakefulness, alertness) or awareness exists. The person is unresponsive and cannot be aroused; they do not open their eyes, do not speak, and do not move their extremities on command or in response to noxious stimuli (e.g., pain). 1. Between 3/9/26 and 3/12/26, Surveyor reviewed R21's medical record. R21 was admitted to the facility on [DATE] and had diagnoses including encephalopathy, cerebrovascular disease, tracheostomy, and seizures. R21's Quarterly MDS assessments, dated 11/12/25 and 2/12/26, indicated R21 was comatose. R21's Quarterly MDS assessment, dated 2/12/26, did not indicate R21 required tracheostomy care. On 3/11/26 at 10:22 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-U who stated R21 was alert and able to respond to questions by shaking R21's head yes or no or using facial expressions. On 3/11/26 at 12:02 PM, Surveyor noted R21 had a tracheostomy and responded to staff with a head nod. On 3/11/26 at 11:10 AM, Surveyor interviewed MDS Coordinator (MDSC)-N who stated MDSC-N was the interim MDS Coordinator for the facility. MDSC-N verified that R21 was not comatose and stated the MDS assessment was coded incorrectly. MDSC-N confirmed R21 had a tracheostomy which was missed on R21's recent MDS assessment. 2. Between 3/9/26 and 3/12/26, Surveyor reviewed R62's medical record. R62 was admitted to the facility on [DATE] and had diagnoses including chronic respiratory failure with hypoxia, history of traumatic brain injury, tracheostomy, and nontraumatic intracerebral hemorrhage. R62's Quarterly MDS assessment, dated 2/6/26, indicated R62 was comatose. On 3/11/26 at 10:22 AM, Surveyor interviewed CNA-U who stated R62 was alert but non-verbal. CNA-U stated R62 responded to pain and staff anticipated R62's needs. On 3/11/26 at 11:10 AM, Surveyor interviewed MDSC-N who verified R62 was not comatose and stated R62's MDS assessment was coded incorrectly. 3. Between 3/9/26 and 3/12/26, Surveyor reviewed R22's medical record. R22 was admitted to the facility on [DATE] and had diagnoses including critical illness myopathy, hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side, seizures, tracheostomy, and malignant neoplasm of the tongue. R22's Quarterly MDS assessment, dated 2/18/26, did not indicate R22 received Hospice (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	services. On 3/11/26 at 10:25 AM, Surveyor interviewed Hospice CNA-V who stated CNA-V often cared for R22 who had received Hospice services for a couple of months. On 3/11/26 at 11:10 AM, Surveyor interviewed MDSC-N who stated R22 did not receive Hospice services. MDSC-N referenced a progress note from 2/19/26 that indicated R22 refused Hospice services. When Surveyor informed MDSC-N of the conversation with CNA-V, MDSC-N stated MDSC-N was not aware that R22 had started Hospice services. The facility provided R22's Hospice Election Statement, dated 1/13/26, that indicated R22 signed onto Hospice services on 1/14/26. On 3/12/26 at 1:47 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B who confirmed R22's MDS assessment should have indicated that R22 received Hospice services. 4. Between 3/9/26 and 3/12/26, Surveyor reviewed R29's medical record. R29 was admitted to the facility on [DATE] and had a diagnosis of seizures. R29 had a physician order for levetiracetam 500 milligrams (mg) every 12 hours. R29's Quarterly MDS assessment, dated 1/2/26, did not indicate R29 received anticonvulsant medication. On 3/11/26 at 11:20 PM, Surveyor interviewed MDSC-N who verified R29 received anticonvulsant medication which was not reflected on R29's MDS assessment. 5. Between 3/9/26 and 3/12/26, Surveyor reviewed R7's medical record. R7 was admitted to the facility on [DATE] and had a diagnosis of diabetes. R7's diabetic care plan, dated 7/1/25, indicated R7 was non-insulin dependent. R7 did not have an order for insulin. R7's Quarterly MDS assessment, dated 1/2/26, indicated R7 received insulin, however, R7 did not have an order for insulin. On 3/11/26 at 11:20 PM, Surveyor interviewed MDSC-N who confirmed R7 did not receive insulin and R7's MDS assessment was coded inaccurately. 6. Between 3/9/26 and 3/12/26, Surveyor reviewed R36's medical record. R36 was admitted to the facility on [DATE] and had a diagnosis of obstructive and reflux uropathy. R36 had a Foley catheter. R36's Comprehensive MDS assessment, dated 12/16/25, did not indicate R36 had a catheter. On 3/11/26 at 11:20 PM, Surveyor interviewed MDSC-N who confirmed R36 had a Foley catheter which was missed on R36's MDS assessment.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not develop and/or implement an individualized comprehensive care plan for 3 residents (R) (R82, R74, and R72) of 26 sampled residents. R82 reported an allegation of misappropriation. The facility's investigation indicated a safe keeping of valuables care plan would be implemented. The facility did not implement a safe keeping of valuables care plan for R82. R74 received dialysis services. The facility did not implement a dialysis care plan for R74. R72 had a diagnosis of Alzheimer's disease. The facility did not implement an Alzheimer's disease/dementia care plan for R72. Findings include: The facility's Comprehensive Care Plans policy, dated 1/2026, indicates: .3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The facility's Dementia-Clinical policy, revised November 2018, indicates: .1. For the individual with confirmed dementia, the Interdisciplinary Team (IDT) will identify a resident-centered care plan to maximize remaining function and quality of life .5. The IDT will identify and document the resident's condition and level of support needed during care planning and review changing needs as they arise .The IDT will adjust interventions and the overall plan depending on the individual's response to the progression of dementia, development of new acute medical conditions or complications, changes in resident or family wishes, and other relevant factors. 1. On 3/9/26, Surveyor reviewed R82's medical record. R82 was admitted to the facility on [DATE] and had diagnoses including muscle wasting and atrophy, diabetes, encephalopathy, schizoaffective disorder, and seizures. R82's Minimum Data Set (MDS) assessment, dated 2/3/26, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R82 had intact cognition. R82 was responsible for R82's healthcare decisions. On 3/9/26, Surveyor reviewed a facility-reported incident (FRI) that contained an allegation of misappropriation (theft of money) for R82. The facility's investigation indicated a safe keeping of valuables care plan would be implemented for R82. R82's medical record did not contain a safe keeping of valuables care plan. On 3/10/26 at 11:05 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, and Chief Nursing Office (CNO)-S. CNO-S verified R82's care plan did not address safe keeping of valuables. DON-B verified safe keeping of valuables should have been added to R82's care plan. 2. Between 3/9/26 and 3/12/26, Surveyor reviewed R74's medical record. R74 was admitted to the facility on [DATE] and had a diagnosis of end stage renal disease. R74's MDS assessment, dated 1/27/26, had a BIMS score of 15 out of 15 which indicated R74 had intact cognition. The MDS assessment also indicated R74 was on dialysis. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R74's medical record did not contain a dialysis care plan. On 3/11/26 at 3:13 PM, Surveyor interviewed DON-B who verified R74 did not have a dialysis care plan. 3. Between 3/9/26 and 3/12/26, Surveyor reviewed R72's medical record. R72 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, anxiety, and depression. R72's MDS assessment, dated 2/9/26, had a BIMS score of 11 out of 15 which indicated R72 had moderate cognitive impairment. R72 had an activated Power of Attorney for Healthcare (POAHC) to assist with healthcare decisions. On 3/11/26 at 10:33 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-T who stated R72 had dementia. CNA-T indicated R72 sometimes refused to get out of bed and CNA-T would reapproach R72 at a later time. Surveyor noted R72's care plan did not contain interventions for Alzheimer's disease/dementia care. On 3/11/26 at 2:56 PM, Surveyor interviewed DON-B who verified R72 did not have an Alzheimer's disease/dementia care plan.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **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 the accurate administration of medication for 9 residents (R) (R71, R13, R66, R67, R14, R15, R23, R58, and R63) of 9 sampled residents. R71 had an order for acetic acid that was unclear regarding application and use. R71 was not administered 11 of 44 doses. R13's methenamine hippurate for frequent urinary tract infections (UTIs) was not restarted timely after a hospital stay. Medications for R66, R67, R14, R15, R23, R58, and R63 were not administered timely or in accordance with physician orders. n 3/9/26. Findings include: The facility's Medication Administration policy, dated 10/25/14, indicates: Medications are administered as prescribed in accordance with good nursing principles and practices .The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions. A schedule of routine dose administration times is established by the facility and utilized on administration records. Medications are administered within (60 minutes) of the scheduled time, except before, with, or after meal orders which are administered (based on mealtimes). Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the facility .Medications designed to be administered over a 24-hour period (sustained-release) are scheduled accordingly. In these cases, an order for twice daily, for example, shall be interpreted as every 12 hours .Documentation (including electronic): 1) The individual who administers the medication dose records the administration on the resident's Medication Administration Record (MAR) directly after the medication is given. At the end of each medication pass, the person administering the medication reviews the MAR to ensure necessary doses were administered and documented. In no case should the individual who administered the medication report off-duty without first recording the administration of any medications .The resident's MAR is initialed by the person administering the medication, in the space provided under the date, and on the line for that specific medication dose administration. Initials on each MAR are cross- referenced to a full signature in the space provided .If a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled dose time, or a starter dose of antibiotic i The facility's Medication Administration policy, dated 10/25/14, indicates: Medications are administered as prescribed in accordance with good nursing principles and practices .The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions. 4. Five rights: .right time are applied for each medication being administered. Administration: .2. Medications are administered in accordance with the written orders of the prescriber. Medications are administered within 60 minutes of the scheduled time, except before, with, or after meal orders, which are administered (based on meal times) .13. Medications designed to be administered over a 24-hour period (i.e., sustained release) are scheduled accordingly. In these cases, an order for twice daily, for example, shall be interpreted as every 12 hours. 1. Between 3/9/26 and 3/12/26, Surveyor reviewed R71's medical record. R71 was admitted to the facility on [DATE] and had diagnoses including acute osteomyelitis-multiple sites, pressure ulcer of (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	lower left back (unstageable), pressure ulcer of left buttock (unstageable), pressure ulcer of other site (unstageable), pressure ulcer of right hip (stage 4), pressure ulcer of left hip (stage 4), pressure ulcer of sacral region (stage 4), pressure ulcer of left heel (stage 4), pressure ulcer of left upper back (stage 4), pressure ulcer of other site (stage 3), hemiplegia and hemiparesis following cerebral infarction, and severe protein calorie malnutrition. R71's admission Minimum Data Set (MDS) assessment, dated 2/23/26, had a Brief Interview for Mental Status (BIMS) score of 6 out of 15 which indicated R71 had severely impaired cognition. R71 had an activated Power of Attorney for Healthcare (POAHC) to assist with medical decisions. R71's Medication Administration Record (MAR) contained the following wound care order: ~ Acetic acid 5%. Apply externally every day and evening shift for Medical Doctor (MD) order until 3/18/26. (Start date: 2/16/26). Surveyor noted 11 of 44 scheduled doses were not documented as administered. Surveyor noted 10 of the 44 scheduled doses contained code 7 other and 1 entry contained code 2 refused. (Of note: the acetic acid order did not specify the location for application, method of application, or treatment parameters.) R71's progress notes did not indicate why 10 doses of acetic acid were marked as other. R71's medical record indicated R71 had multiple significant pressure injuries and a serious infection. The lack of clear direction on the acetic acid order and missed doses created the potential for inconsistent or inappropriate application which could put R71 at risk for ineffective wound treatment. On 3/12/26, Surveyor interviewed Licensed Practical Nurse (LPN)-KK who was unsure of the indication for R71's acetic acid. LPN-KK verified LPN-KK signed out some of R71's acetic acid doses but could not recall where LPN-KK applied the medication. LPN-KK indicated the order was not clear and should have been clarified with the physician. LPN-KK indicated when a medication is documented with code 7 or other, there should be a progress note that indicates why the medication wasn't administered. LPN-KK indicated medications should be administered as ordered and documented appropriately on the MAR or in a progress note if not administered. On 3/12/26 at 12:54 PM, Surveyor interviewed Director of Nursing (DON)-B who did not know where acetic acid should be applied for R71 and verified the order was unclear. DON-B did not know why the medication was prescribed. DON-B indicated staff should clarify an order from the prescriber if the order is not complete or is unclear. DON-B indicated medication should be documented on the MAR when given. On 3/19/26 at 10:20 AM Surveyor interviewed Confidential Staff (CS)-OO who stated CS-OO had never applied acetic acid for R71 even though CS-OO had documented it as administered multiple times on R71's MAR. CS-OO stated the wound nurse completes all wound care, including acetic acid. CS-OO stated CS-OO tried to refuse signing out medications and treatments that CS-OO did not administer or complete, but has been pressured by the wound care nurse to sign out medications and treatments. Surveyor and CS-OO reviewed R71's acetic acid order. CS-OO stated CS-OO did not know where acetic acid should be applied because the order was unclear and needed clarification from the physician. DON-B indicated staff should indicate why a medication was not administered if code 7 or (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	other is used. CS-OO indicated all medications should be signed out when administered by the person who administered them. 2. Between 3/9/26 and 3/12/26, Surveyor reviewed R13's medical record. R13 was admitted to the facility on [DATE] and had diagnoses including paraplegia, sepsis, anxiety, and depression. R13's MDS assessment, dated 1/19/26, had a BIMS score of 15 out of 15 which indicated R13 had intact cognition. R13's medical record contained an order for one 1 gram (gm) methenamine hippurate tablet 2 times daily for frequent urinary tract infections (starting 7/17/25). The medication was discontinued on 1/23/26. R13 was hospitalized from [DATE] to 1/23/26. R13's hospital Discharge summary, dated [DATE], indicated R13 was diagnosed with sepsis with an etiology of right lower extremity cellulitis versus a urinary tract infection (UTI). Discharge instructions indicated R13 was prescribed oral Bactrim for 7 days and to hold methenamine hippurate until 3 days after Bactrim was completed. The discharge summary indicated under important outpatient follow-up/medications: Hold methenamine - May resume on 2/1/26. R13's methenamine hippurate was not resumed until 2/12/26. On 3/12/26 at 1:05 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-I who was also the facility's Infection Preventionist. ADON-I confirmed R13's methenamine hippurate should have resumed on 2/1/26 or 3 days after Bactrim ended per the hospital instructions. ADON-I indicated the order must have been missed. 3. Between 3/9/26 and 3/12/26, Surveyor reviewed R66's medical record. R66 was admitted to the facility on [DATE] and had diagnoses including anxiety disorder, hallucinations, and delusional disorder. R66's MDS assessment, dated 1/19/26, had a BIMS score of 15 out of 15 which indicated R66 had intact cognition. On 3/9/26 at 12:35 PM, Surveyor interviewed R66 who indicated medications are sometimes late and R66 was still waiting for R66's AM medications. Surveyor reviewed R66's Medication Administration Record Audit Report for 3/9/26 and noted the following: ~ R66 had an order for 7.5 milligrams (mg) of olanzapine twice daily for delusions, hallucinations, and anxiety. R66's AM dose was scheduled at 8:00 AM. The report indicated R66 did not receive olanzapine until 12:55 PM. ~ R66 had an order for one tablet of glipizide extended release 24-hour tablet for type 2 diabetes. The medication was scheduled at 8:00 AM. The report indicated R66 did not receive the medication until 12:51 PM. ~ R66 had an order for 30 mg of fluoxetine once daily for major depressive disorder and anxiety disorder. The medication was scheduled at 8:00 AM. The report indicated R66 did not receive the medication until 12:50 PM. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. On 3/9/26, Surveyor reviewed R67's medical record. R67 was admitted to the facility on [DATE] and had diagnoses including atrial fibrillation, hypertension, peripheral vascular disease, anxiety, and depression. R67's MDS assessment, dated 2/6/26, had a BIMS score of 15 out of 15 which indicated R67 had intact cognition. R67 was responsible for R67's healthcare decisions. R67 was admitted to the facility on [DATE] at 12:20 PM and had the following physician orders (dated 2/4/26): ~ Amiodarone HCL 200 mg, give 1 tablet by mouth once daily for arrhythmia ~ Hydroxychloroquine sulfate 200 mg, give 1 tablet by mouth two times daily for rheumatoid arthritis ~ Metoprolol tartrate 100 mg, give 1 tablet by mouth two times daily for hypertension ~ Sulfasalazine oral 500 mg, give 1 tablet by mouth every morning and at bedtime for rheumatoid arthritis Surveyor reviewed R67's February 2026 MAR which indicated the following: ~ On 2/11/26, 2/12/26, and 2/13/26, amiodarone was not administered because the medication was unavailable. ~ On 2/4/26, 2/11/26, 2/12/26, 2/13/26, and 2/21/26, hydroxychloroquine sulfate was not administered because the medication was unavailable. ~ On 2/15/26, 2/19/26, and 2/27/26, metoprolol tartrate was not administered because the medication was unavailable. ~ On 2/11/26, 2/12/26, and 2/13/26, sulfasalazine was not administered because the medication was unavailable. On 3/10/26 at 3:53 PM, Surveyor interviewed DON-B who indicated staff should administer medications as prescribed by the provider. DON-B stated staff may also obtain medications from the facility's contingency stock. 5. On 3/9/26, Surveyor reviewed R14's medical record. R14 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, dementia, diabetes, and hypertension. R14's MDS assessment, dated 1/19/26, had a BIMS score of 11 out of 15 which indicated R14 had moderate cognitive impairment. R14 was responsible for R14's healthcare decisions. On 3/9/26 at 9:38 AM, Surveyor observed Registered Nurse (RN)-Y prepare and administer R14's medications. R14's physician order for metformin indicated the medication should be administered at 7:00 AM. R14's physician orders for methenamine, acetaminophen, amlodipine, apixaban, gabapentin, glimepiride, and senna plus indicated the medications should be administered at 8:00 AM. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(See interview under example #8.) 6. On 3/9/26, Surveyor reviewed R15's medical record. R15 was admitted to the facility on [DATE] and had diagnoses including schizophrenia, hypertension, renal insufficiency, and obstructive uropathy. R15's MDS assessment, dated 2/16/26, had a BIMS score of 9 out of 15 which indicated R15 had moderate cognitive impairment. R15 had an activated POAHC for healthcare decisions. On 3/9/26 at 9:51 AM, Surveyor observed RN-Y prepare and administer medications for R15. R15's physician orders for benztropine, fenofibrate, acetaminophen, and olanzapine indicated the medications should be administered at 8:00 AM. (See interview under example #8.) 7. On 3/9/26, Surveyor reviewed R23's medical record. R23 was admitted to the facility on [DATE] and had diagnoses including hypertension, renal insufficiency, hyperlipidemia, anxiety, and depression. R23's MDS assessment, dated 2/16/26, had a BIMS score of 10 out of 15 which indicated R23 had moderate cognitive impairment. R23 had an activated POAHC for healthcare decisions. On 3/9/26 at 9:58 AM, Surveyor observed RN-Y prepare and administer medications for R23. R23's physician orders for amlodipine, buspirone, carvedilol, risperidone, aspirin, clopidogrel, docusate sodium, doxycycline, pantoprazole, and paroxetine indicated the medications should be administered at 8:00 AM. (See interview under example #8.) 8. On 3/9/26, Surveyor reviewed R58's medical record. R58 was admitted to the facility on [DATE] and had diagnoses including cerebrovascular accident, dementia, anxiety, depression, and hypertension. R58's MDS assessment, dated 1/27/26, had a BIMS score of 3 out of 15 which indicated R58 had severe cognitive impairment. R58 had an activated POAHC for healthcare decisions. On 3/9/26 at 9:29 AM, Surveyor observed RN-Y prepare and administer medications for R58. R58's physician orders for acetaminophen, citalopram, quetiapine, amlodipine, and losartan indicated the medications should be administered at 8:00 AM. On 3/9/26 at 10:08 AM, Surveyor interviewed RN-Y who verified the medications were administered late and stated morning medications should be given between 7:00 and 11:00 AM. RN-Y stated RN-Y attempts to administer all medications timely and starts with diabetic medications. On 3/10/26 at 3:53 PM, Surveyor interviewed DON-B who indicated staff should administer medications timely. DON-B stated medications should be administered an hour before or an hour after the prescribed time. 9. Between 3/9/26 and 3/12/26, Surveyor reviewed R63's medical record. R63 was admitted to the facility on [DATE] and had diagnoses including epilepsy, diabetes, asthma, and anxiety. R63's MDS assessment, dated **, had a BIMS score of 15 out of 15 which indicated R63 had intact cognition. R63 (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	made R63's own healthcare decisions. On 3/9/26 at 5:06 PM, Surveyor interviewed R63 who stated R63 needs R63's seizure medication timely, however, it was administered 2 hours late. R63 stated R63 took Keppra and another seizure medication twice daily. R63 stated R63 had small seizures because the medications were not administered timely. R63 stated R63 can tell when R63 is having a seizure because a table next to R63 ends up farther away and a pillow under R63's right knee ended up on the floor. R63 stated R63's seizure medications were administered late that morning. R63 told the nurse that R63 had a seizure, however, the nurse stated the seizure was not due to the medications. R63 also told DON-B who also indicated the seizure was from something else. R63's progress notes did not indicate R63 had any seizures. A pharmacy note, dated 3/10/26 at 10:23 AM, indicated R63's medication regimen review was completed and did not contain recommendations for lacosamide or levetiracetam. R63's MAR contained the following medications to control seizures: ~ Lacosamide oral tablet 200 mg, give 1 tablet by mouth two times daily for seizures (ordered 2/26/26 and scheduled for 8:00 AM and 4:00 PM) ~ Levetiracetam (Keppra) oral tablet 750 mg, Give 1 tablet by mouth two times daily for seizures (ordered 2/26/26 and scheduled for 8:00 AM and 4:00 PM) R63's lacosamide administration history indicated the following: ~ On 2/26/26, R63's 4:00 PM dose was documented as code 7 (other/see nurse notes) at 5:12 PM. ~ On 2/27/26, R63's 8:00 AM dose was documented as code 7 at 10:17 AM. ~ On 2/27/26, R63's 4:00 PM dose was documented as code 7 at 6:02 PM. ~ On 2/28/26, R63's 4:00 PM dose was documented as code 5 (leave of absence) at 5:54 PM. ~ On 3/1/26, R63's 4:00 PM dose was administered at 5:33 PM. ~ On 3/3/26, R63's 8:00 AM dose was administered at 1:22 PM. ~ On 3/4/26, R63's 8:00 AM dose was administered at 9:12 AM. ~ On 3/8/26, R63's 4:00 PM dose was administered at 5:39 PM. ~ On 3/9/26, R63's 8:00 AM dose was administered at 9:25 AM. ~ On 3/10/26, R63's 4:00 PM dose was administered at 5:10 PM. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(Surveyor was unable to review nurses' notes for the above listed dates) R63's levetiracetam administration indicated the following: ~ On 2/26/26, R63's 4:00 PM dose was administsered at 9:06 PM. ~ On 2/27/26, R63's 4:00 PM dose was administered at 5:18 PM. ~ On 2/28/26, R63's 4:00 PM dose was administered at 5:54 PM. ~ On 3/1/26, R63's 4:00 PM dose was administered at 5:33 PM. ~ On 3/3/26, R63's 8:00 AM dose was administered at 1:22 PM. ~ On 3/9/26, R63's 8:00 AM dose was administered at 9:22 AM. ~ On 3/10/26, R63's 4:00 PM dose was administered at 5:25 PM. On 3/10/26 at 10:23 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-T and CNA-NN who had not witnessed R63 have a seizure or complain of seizure-like symptoms. On 3/11/26 at 2: 20 PM, Surveyor interviewed LPN-QQ who had not witnessed R63 have a seizure or complain of seizure-like symptoms. Surveyor contacted DON-B via email on 3/17/26 at 9:19 AM and received a response on 3/17/26 at 1:21 PM. DON-B indicated DON-B was not aware of any seizure activity and stated R63 did not report any seizure symptoms to DON-B. On 3/24/26 at 2:50 PM, Surveyor interviewed Pharmacist (PH)-PP regarding dosage frequency of lacosamide and levetiracetam and if the medications needed to be given every 12 hours. PH-PP indicated for any medication that is ordered twice daily, it is recommended the medications be administered at least eight hours apart but closer to 12 hours; considering medication administration specifics like food and sleep. PH-PP stated there was a refill request on 2/26/26 prior to admission and 3 levetiracetam tablets were sent to the facility on 2/27/26. PH-PP stated the prescription could not be filled since levetiracetam was filled on 2/18/26 at another pharmacy and insurance would not authorize a refill until 3/24/26. A three-day supply was sent to the facility so R63 would have a few doses upon arrival. PH-PP indicated R63 may have had medication from home to cover the time until levetiracetam was delivered on 3/24/26. PH-PP indicated lacosamide was last filled on 2/27/26 with a quantity of 60. PH-PP indicated certain medications require dosing frequency every 12 hours, however, lacosamide and levetiracetam do not a need to be administered every 12 hours and are well tolerated if not administered every 12 hours.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interview, and record review, the facility did not establish and maintain an infection prevention and control program designed to prevent the transmission of communicable disease and infection. This practice had the potential to affect more than 4 of the 77 residents residing in the facility. Certified Nursing Assistant (CNA)-NN did not complete appropriate hand hygiene during cares for R72. R13 was on contact precautions. Assistant Administrator (AA)-M entered R13's room without completing hand hygiene or donning appropriate personal protective equipment (PPE). Registered Nurse (RN)-Y did not complete appropriate hand hygiene during medication preparation and administration for R14, R15, R23, and R58. Hand hygiene was not offered to multiple residents prior to dining, including R73 and R66. Findings include: The facility's hand hygiene policy, dated 2023, indicates: Bedrock Healthcare facilities recognize hand hygiene as the primary measure to prevent the transmission of healthcare-associated infections (HAIs). All personnel must follow proper hand hygiene practices to protect residents, staff, and visitors and reduce the spread of infection within the facility. Indications for Hand Hygiene: Hand hygiene must be performed: Before touching a resident; Before performing aseptic tasks; After contact with blood or body fluids; After touching a resident; After touching a resident's environment; Before moving from a soiled body site to a clean body site; Immediately after glove removal. Glove Use: Gloves should be worn when anticipating contact with blood or body fluids, performing aseptic procedures, or when caring for residents on contact precautions. Gloves do not replace hand hygiene. The facility's Infection Prevention and Control Program policy, revised 7/2025, indicates: Enhanced Barrier Precautions: a. Enhanced Barrier Precautions (EBP) use gowns and gloves during high-contact care to prevent the spread of resistant germs. b. EBP is recommended for residents with: i. Wounds or medical devices, regardless of multidrug-resistant organism (MDRO) status. ii. MDRO infection or colonization. c. High-contact resident care (includes): i. Dressing; ii. Bathing/showering; iii. Transferring; iv. Toileting; v. Providing hygiene; vi. Changing linens or briefs; vii. Device care or use (central line, urinary catheter, feeding tube, tracheostomy, or wound care); viii. Chronic wound; ix. Therapy sessions. Isolation Protocol (Transmission-Based Precautions). A. A resident with an infection or communicable disease shall be placed on transmission-based precautions (TBP) as recommended by current Centers for Disease Prevention and Control (CDC) guidelines. CDC.gov indicates: Carbapenem-resistant Acinetobacter baumannii (CRAB) are bacteria resistant to nearly all antibiotics and difficult to remove from the environment. As a result, CRAB can cause deadly infections and large outbreaks among hospitalized patients and nursing home residents. Patients can become colonized with CRAB, meaning that the organism can live on the skin or another part of the body, but is not causing signs or symptoms of disease. Both infected and colonized patients can shed CRAB into the environment, which contaminate surfaces and shared medical equipment. Implementation of infection prevention interventions in healthcare settings, such as use of Transmission-Based Precautions and thorough environmental cleaning and disinfection, are critical in preventing the spread. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Watertown Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 121 Hospital Dr. Watertown, WI 53098	
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Administering Medications policy, dated 10/2014, indicates: Medications are administered as prescribed in accordance with good nursing principles and practices and only by person legally authorized to do so .A. Preparation .2. Handwashing and Hand Sanitization: The person administering medications adheres to good hand hygiene, which includes washing hands thoroughly before beginning a medication pass, prior to handling any medication, after coming into direct contact with a resident . The facility's Assistance with Meals policy, revised July 2017, indicates: .3. All employees who provide resident assistance with meals will be trained and shall demonstrate competency in the prevention of foodborne illness, including personal hygiene practices and safe food handling. All residents will be offered hand hygiene prior to meals. The Centers for Disease Control About Handwashing information from CDC.gov, dated 2/16/24, indicates: Many diseases and conditions are spread by not washing hands with soap and clean, running water. Hand washing with soap is one of the best ways to stay healthy. If soap and water are not readily available, use a hand sanitizer with at least 60% alcohol to clean your hands. Washing hands can keep you healthy and prevent the spread of respiratory and diarrheal infections. Germs can spread from person to person or from surfaces to person when you: Touch your eyes nose and mouth with unwashed hands; Prepare or eat food and drinks when with unwashed hands; Touch surfaces or objects that have germs on them; Blow your nose, cough, or sneeze into hands and then touch other people's hands or common objects. You can keep yourself and your loved ones healthy by washing your hands often, especially during these key times when you are likely to get and spread germs: Before, during, after preparing food; Before and after eating food . 1. Between 3/9/26 and 3/12/26, Surveyor reviewed R72's medical record. R72 was admitted to the facility on [DATE] and had diagnoses including diabetes, polyneuropathy, Alzheimer's disease, anxiety, sacral pressure injury stage 3, and non-pressure ulcer left foot. R72 had an activated Power of Attorney for Healthcare (POAHC) and was on EBP due to a catheter and a wound. On 3/11/26 at 9:17 AM, Surveyor observed an enhanced barrier precautions (EBP) sign and a personal protective equipment (PPE) cart outside R72's room. Surveyor observed CNA-NN wash R72's upper body and anterior peri area and complete catheter care. CNA-NN did not remove soiled gloves, cleanse hands, and don clean gloves before touching R72 and R72's gown. When CNA-NN removed soiled gloves, CNA-NN removed a bottle of hand sanitizer from under CNA-NN's gown and reached into CNA-NN's scrub top without completing hand hygiene. CNA-NN washed R72's peri rectal area and did not remove soiled gloves, cleanse hands, or don clean gloves. CNA-NN touched R72 and a bottle of lotion before removing gloves, cleansing hands, and donning clean gloves. Director of Nursing (DON)-B was present during most of the observation. DON-B verified that when going from dirty to clean, staff should remove soiled gloves, cleanse hands, and don clean gloves. Surveyor interviewed CNA-NN who did not understand the breach in hand hygiene. 2. Between 3/9/26 and 3/12/26, Surveyor reviewed R13's medical record. R13 was admitted to the facility on [DATE] and had diagnoses including history of Carbapenem-resistant Acinetobacter baumannii (CRAB), paraplegia, sepsis, and anxiety. R13's MDS assessment, dated 1/19/26, had a BIMS score of 15 out of 15 which indicated R13 had intact cognition. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R13 had an order for contact isolation due to open wound due to CRAB (initiated 5/10/25). On 3/9/26 at 10:54 AM, Surveyor observed a sign on R13's door that indicated: Contact Precautions, everyone must clean their hands, including before entering and when leaving room. Providers and staff must also: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. On 3/9/26 at 10:55 AM, Surveyor observed AA-M enter R13's room without completing hand hygiene or donning PPE. AA-M then exited R13's room and entered a room across the hall without completing hand hygiene. When Surveyor asked AA-M about the contact precautions sign near the door, AA-M pointed to the sign on the wall and stated if it wasn't on the resident's door, it wasn't active. Surveyor observed Registered Nurse (RN)-Y near R13's door. RN-Y looked in R13's electronic medical record and indicated R13 was on precautions due to open wounds and CRAB. Surveyor informed AA-M of the sign and what it meant. AA-M then asked about an enhanced barrier precautions (EBP) sign and what to do for EBP. AA-M verified AA-M should have followed the appropriate precautions. 3. On 3/9/26 from 9:29 AM through 9:59 AM, Surveyor observed RN-Y prepare and administer medications for R14, R15, R23, and R58. RN-Y did not complete hand hygiene at the start of medication preparation or before administering medications to the residents. On 3/9/26 at 10:08 AM, Surveyor interviewed RN-Y who stated RN-Y usually completes hand hygiene between every several residents unless there are bodily fluids visible. On 3/10/26 at 3:53 PM, Surveyor interviewed DON-B who indicated staff should complete hand hygiene prior to medication preparation and after medication administration. 4. On 3/9/26 at approximately 12:00 PM, Surveyor observed staff deliver lunch trays on the 400 wing. Surveyor noted there were no hand hygiene wipes on the trays and residents were not offered hand hygiene prior to receiving their meal tray. On 3/9/26 at 12:07 PM, a second Surveyor observed staff deliver lunch trays on the 200 wing. Surveyor noted there were no hand hygiene wipes on the trays and residents were not offered hand hygiene prior to receiving their meal tray. On 3/10/26 at 8:33 AM, Surveyor observed breakfast in the main dining room. There were eight residents in the dining room. Surveyor noted the tables did not contain hand wipes or bottles of hand sanitizer and residents were not offered hand hygiene prior to eating their meals. On 3/10/26 at 8:37 AM, Surveyor interviewed CNA-MM who stated CNA-MM did not offer residents hand hygiene in the dining room prior to breakfast. CNA-MM indicated residents should be offered hand hygiene prior to eating. CNA-MM stated if a resident's hands are dirty or sticky after a meal, CNA-MM gets a wet paper towel from the kitchen. CNA-MM stated staff used to bring hand wipes to the dining room from from the supply closet. On 3/10/26 at 12:17 PM, Surveyor interviewed R73 who had just finished lunch. R73 stated R73 was (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not offered hand hygiene prior to or after the meal but it would be a good idea if R73 was offered hand hygiene. Surveyor noted there were no visible hand hygiene wipes in the dining area. On 3/10/26 at 12:18 PM, Surveyor interviewed R66 who had just finished lunch. R66 stated R66 was not offered hand hygiene prior to or after the meal but would like to be offered hand hygiene during meals. Surveyor noted there were no visible hand hygiene wipes in the dining area. On 3/10/26 at 2:43 PM, Surveyor interviewed Dietary Manager (DM)-C who indicated residents should be offered hand hygiene prior to meals. DM-C indicated staff can use hand hygiene wipes or a bottle of hand sanitizer to offer hand hygiene. On 3/12/26 at 12:54 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and DON-B who indicated staff should follow the facility's infection control and hand hygiene policies. DON-B indicated residents should be offered hand hygiene in the dining room and hand wipes should be on room trays for all meals.		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure 3 residents (R) (R20, R3, and R72) of 5 sampled residents had documentation that indicated the residents or their legal representatives were thoroughly informed in advance of the risks and benefits of prescribed psychotropic medication. R20 was prescribed Seroquel (an antipsychotic medication) for anxiety/depression and buspirone (an antipsychotic medication) for anxiety. The facility did not ensure informed consent for medication forms were thoroughly reviewed and completed with R20. R3 was prescribed risperidone (an antipsychotic medication) for agitation, sertraline (an antidepressant medication) for depression, and trazodone (an antidepressant medication) for insomnia. The facility did not ensure informed consent for medication forms were thoroughly reviewed and completed with R3's activated Power of Attorney for Healthcare (POAHC). R72 was prescribed risperidone for schizophrenia. The facility did not ensure an informed consent for medication form was thoroughly reviewed and completed with R72's POAHC. Findings include: According to the Food and Drug Administration (FDA), psychotropic medications contain a black box warning (the strictest warning on the label of prescription drugs or drug products by the FDA when there is reasonable evidence of an association of a serious hazard with the drug). 1. On 3/11/26, Surveyor reviewed R20's medical record. R20 was admitted to the facility on [DATE] and had diagnoses including anxiety, major depression, and mood disorder. R20's Minimum Data Set (MDS) assessment, dated 12/29/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R20 had intact cognition. R20 made R20's own medical decisions. Surveyor reviewed R20's Medication Administration Record (MAR) and noted the following orders: ~ Buspirone 10 milligrams (mg), give 1 tablet two times daily for anxiety ~ Seroquel 50 mg, give 2 tablets two times daily for depression/anxiety ~ Seroquel 25 mg, give 1 tablet two times daily for mood disorder, take with 100 mg dose for total dose of 125 mg twice daily. R20's medical record contained informed consent forms for Seroquel and buspirone that were not thoroughly completed, including initials and dates on each page and a signature and date on the last page. On 3/11/26 at 3:12 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-P (who was also the Unit Manager) who verified R20's informed consent forms for Seroquel and buspirone were not thoroughly completed. LPN-P indicated the facility's process after receiving orders for psychotropic medications includes reviewing consent forms with the resident or POAHC, initials and dates on each page, and a signature and date on the last page. LPN-P indicated if the resident's POAHC is not available to sign the form, the facility obtains verbal consent and has the POAHC sign the form as soon as possible. LPN-P indicated informed consent forms should be signed before psychotropic medications are administered. On 3/11/26 at 3:54 PM, Surveyor interviewed Director of Nursing (DON)-B who verified R20's informed consent forms were not thoroughly completed. 2. On 3/11/26, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] and had diagnoses including dementia, anxiety, insomnia, and post-traumatic stress disorder (PTSD). R3's MDS assessment, dated 1/14/26, had a BIMS score of 9 out of 15 which indicated R3 had moderate cognitive impairment. R3 had an activated POAHC. Surveyor reviewed R3's MAR and noted the following orders: ~ Risperidone 1 mg and risperidone 0.25 mg, give 1 tablet along with 1 tablet of 0.25 mg two times daily for dementia with psychotic disturbance ~ Trazodone 50 mg, give 1 tablet at bedtime for insomnia ~ Sertraline 100 mg, give 1 tablet daily for anxiety. R3's medical record did not contain informed consent forms for risperidone, trazodone, or sertraline. On 3/11/26 at 3:28 PM, Surveyor interviewed LPN-P who was unsure if R3's informed consent forms were signed and thought nursing staff were waiting for R3's (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	POAHC to sign the forms. On 3/11/26 at 4:08 PM, Surveyor interviewed DON-B who verified R3 did not have completed informed consent forms for the above listed medications. On 3/11/26, Surveyor reviewed R72's medical record. R72 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, schizophrenia, anxiety, insomnia, and depression. R72's MDS assessment, dated 2/9/26, had a BIMS score of 11 out of 15 which indicated R72 had moderate cognitive impairment. R72 had an activated POAHC. Surveyor reviewed R72's MAR and noted the following order: ~ Risperidone 0.5 mg, give 1 tablet daily for schizophrenia. R72's medical record did not contain an informed consent form for risperidone. On 3/11/26 at 3:26 PM, Surveyor interviewed LPN-P who verified the facility did not complete an informed consent form for risperidone for R72. On 3/11/26 at 4:12 PM, Surveyor interviewed DON-B who verified R72 should have an informed consent form for risperidone.		

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident representative interview and record review, the facility did not ensure care conferences were held regularly for 1 resident (R) (R3) of 1 sampled resident. R3 did not have regularly scheduled care conferences. Findings include: The facility's undated Interdisciplinary Care Conference policy indicates: The facility will conduct interdisciplinary care conferences according to the Minimum Data Set (MDS) assessment schedule and whenever there is a significant change in the resident's condition. Residents and/or their legal representatives will be invited to participate in care conferences; however, the conferences will proceed as scheduled even if the resident or representative chooses not to participate. On 3/9/26, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] and had a diagnosis of vascular dementia with psychotic disturbance. R3's Minimum Data Set (MDS) assessment, dated 1/19/26, had a Brief Interview for Mental Status (BIMS) score of 9 out of 15 which indicated R3 had moderately impaired cognition. R3 had an activated Power of Attorney for Healthcare (POACH). On 3/9/26 at 2:35 PM, Surveyor interviewed R3's POAHC via phone who indicated they used to be invited to care conferences, however, it had been more than a year since they were invited to a care conference. On 3/11/26 at 9:23 AM, Surveyor interviewed Social Services Designee (SSD)-J who had worked at the facility since August of 2025. SSD-J verified R3 had not had a care conference since SSD-J started working. SSD-J stated SSD-J schedules care conferences for new admissions and as needed but verified the facility had not been doing regular quarterly care conferences. SSD-J stated the facility planned to start coordinating care conferences and POAHC invites with Quarterly MDS assessments. On 3/11/26 at 2:21 PM, Chief Nursing Officer (CNO)-S confirmed the facility had not been doing care conferences and had a training set up to educate staff.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure a Power of Attorney for Healthcare (POAHC) document was completed or offered for 2 residents (R) (R7 and R74) of 26 sampled residents. R7 and R74's medical records did not contain a POAHC document or documentation that indicated the facility offered to assist with one. Findings include: The facility's Advanced Directives policy, revised September 2022, indicates: Determining Existence of Advance Directive: Prior to or upon admission of a resident, the Social Services Director or designee inquires of the resident, his/her family members, and/or his or her legal representative about the existence of any written advanced directives. If a resident does not have an advanced directive: .Facility staff will offer assistance in establishing advanced directives. A. The resident or representative is given the option to accept or decline assistance and care will not be contingent on either decision. B. Nursing staff will document in the medical record the offer to assist and the resident's decision to accept or decline assistance. 1. Between 3/9/26 and 3/10/26, Surveyor reviewed R7's medical record. R7 was admitted to the facility on [DATE] and had diagnoses including diabetes and coronary artery disease. R7's Minimum Data Set (MDS) assessment, dated 3/16/26, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R7 had intact cognition. On 3/10/26 at 11:00 AM, Surveyor asked to review R7's POAHC document. A social services progress note, dated 3/10/26 at 1:57 PM, indicated the writer asked if R7 was interested in completing POAHC paperwork. R7 stated R7 was interested and wanted R7's family members listed. R7 stated R7 would tell the writer when R7's family came to visit and would complete the paperwork. 2. Between 3/9/26 and 3/10/26, Surveyor reviewed R74's medical record. R74 was admitted to the facility on [DATE] and had a diagnosis of end stage renal disease. R74's MDS assessment, dated 1/27/26, had a BIMS score of 15 out of 15 which indicated R74 had intact cognition. On 3/10/26 at 11:00 AM, Surveyor requested to review R74's POAHC document. A social services progress note, dated 3/10/26 at 1:54 PM, indicated the writer asked if R74 was interested in completing POAHC paperwork. R74 stated R74 had designated family and would try to find the paperwork. The writer could not locate paperwork from the hospital. A progress note, dated 3/10/26 at 3:46 PM, indicated Nursing Home Administrator (NHA)-A contacted R74's family to complete R74's POAHC paperwork. An email was sent to R74's family to set up a time to complete the paperwork. On 3/11/26 at 9:32 AM, Surveyor interviewed Social Services Designee (SSD)-J who had worked at the facility since August of 2025. SSD-J stated R7 and R74 were admitted shortly before or after SSD-J started employment and their POAHC paperwork may have been missed.		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not provide written notification of coverage change and the financial liability for continued stay at the facility when Medicare Part A benefits were ending for 1 resident (R) (R77) of 3 sampled residents. The facility did not provide R77 with Notice of Medicare Non-Coverage (NOMNC) (which details appeals rights) or Advanced Beneficiary Notice (ABN) forms for a Medicare Part A stay scheduled to end on 1/30/26. Findings include: The Centers for Medicare and Medicaid Services (CMS)-10123 form indicates a Notice of Medicare Non-Coverage (NOMNC) form must be delivered at least two calendar days before Medicare-covered services end or the second-to-last day of service if care is not being provided daily. Note: The two-day advance requirement is not a 48-hour requirement. The provider must ensure the beneficiary or representative signs and dates the NOMNC form to demonstrate the beneficiary or representative received the notice and understands the termination decision can be disputed. The CMS-10055 Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (ABN) form indicates: The ABN provides information to the beneficiary so the beneficiary can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility. The ABN form is only issued if the beneficiary intends to continue services and the skilled nursing facility believes the services may not be covered under Medicare. Between 3/9/26 and 3/11/26, Surveyor reviewed R77's medical record. R77 was admitted to the facility on [DATE] and had diagnoses including peripheral vascular disease, respiratory failure, anxiety, and depression. R77's Minimum Data Set (MDS) assessment, dated 2/27/26, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R77 had intact cognition. On 3/11/26, Surveyor requested NOMNC and ABN forms for R77's Medicare Part A stay that ended on 1/30/26. On 3/12/26 at 1:48 PM, Surveyor interviewed Social Services Director (SSD)-J who indicated NOMNC and ABN forms were not provided for R77's Medicare Part A stay that ended on 1/30/26.		

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure a Significant Change Minimum Data Set (MDS) assessment was completed for 1 resident (R) (R22) of 26 sampled residents. The facility did not complete a Comprehensive Significant Change MDS assessment when R22 started Hospice services. Findings include: The facility's undated MDS 3.0 Completion policy indicates: Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan .1. According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate, and standardized assessment of each resident's functional capacity using the Resident Assessment Instrument (RAI) specified by the state. The Centers for Medicare & Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (October 2025) indicates: A Significant Change in Status Assessment (SCSA) is required to be performed when a terminally ill resident enrolls in a Hospice program (Medicare-certified or State-licensed Hospice provider) or changes Hospice providers and remains a resident at the nursing home. The Assessment Reference Date (ARD) must be within 14 days from the effective date of the Hospice election (which can be the same or later than the date of the Hospice election statement, but not earlier than). An SCSA must be performed regardless of whether an assessment was recently conducted on the resident. This is to ensure a coordinated plan of care between the Hospice and nursing home is in place. A Medicare-certified Hospice must conduct an assessment at the initiation of its services. This is an appropriate time for the nursing home to evaluate the MDS information to determine if it reflects the current condition of the resident, since the nursing home remains responsible for providing necessary care and services to assist the resident in achieving their highest practicable well-being at whatever stage of the disease process the resident is experiencing. Between 3/9/26 and 3/12/26, Surveyor reviewed R22's medical record. R22 was admitted to the facility on [DATE] and had diagnoses including critical illness myopathy, hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side, seizures, tracheostomy, and malignant neoplasm of the tongue. R22's medical record contained a Hospice Election Statement, dated 1/13/26, that indicated R22 started Hospice services on 1/14/26. R22's medical record did not contain a Comprehensive Significant Change MDS assessment within 14 days of R22 starting Hospice services. On 3/11/26 at 10:25 AM, Surveyor interviewed Hospice Certified Nursing Assistant (CNA)-V who stated CNA-V often cared for R22 who had received Hospice services for a couple of months. On 3/11/26 at 11:10 AM, Surveyor interviewed MDS Coordinator (MDSC)-N who stated MDSC-N did not initiate a Comprehensive Significant Change MDS assessment because R22 did not receive Hospice services. MDSC-N referenced a progress note from 2/19/26 that indicated R22 refused Hospice services. When Surveyor informed MDSC-N of the conversation with CNA-V, MDSC-N stated MDSC-N was not aware that R22 received Hospice services. On 3/11/26 at 12:07 PM, Surveyor interviewed Regional MDS Coordinator (RMDSC)-O who was not aware that R22 received Hospice services. RMDSC-O stated when a resident signs onto Hospice, staff should complete a Comprehensive Significant Change MDS assessment. On 3/12/26 at 1:47 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B who confirmed R22 received Hospice services and a Comprehensive Significant Change MDS assessment should have been completed.		

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure timely transmittal of Resident Assessment Information (RAI)/Minimum Data Set (MDS) assessments for 2 residents (R) (R55 and R64) of 37 sampled and supplemental sampled residents. The facility did not timely transmit RAI/MDS assessments for R55 and R64. Findings include: The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.17.1, dated October 2025, indicates: All Medicare and/or Medicaid-certified nursing homes must transmit required MDS records to the Centers for Medicare & Medicaid Services (CMS). Required MDS records include: Admission, Quarterly, Annual, Discharge assessments, and entry tracking records. Transmitted means electronically transmitting an MDS record that passes CMS' standard edits and is accepted into the system within 14 days of the assessment reference date (ARD) (last day of the resident assessment period). Between 3/9/26 and 3/12/26, Surveyor reviewed the facility's MDS submissions and noted the following: ~ R55 was admitted to the facility on [DATE]. The facility completed a Quarterly MDS assessment on 12/17/25. The facility did not transmit the Quarterly MDS assessment until 3/11/26. ~ R64 was admitted to the facility on [DATE] and discharged from the facility on 10/24/25. The facility completed a Discharge - Return Not Anticipated (DC-RNA) MDS assessment on 10/27/25. The facility did not transmit the DC-RNA MDS assessment until 3/11/26. On 3/11/26 at 12:07 PM, Surveyor interviewed Regional MDS Coordinator (RMDSC)-O who was aware of a glitch in the electronic medical record (EMR) system. RMDSC-O stated RMDSC-O regularly ran a missing MDS report to check for missing assessments. RMDSC-O noted when a resident is listed on the report, it's because the resident's assessment is stuck in Complete status instead of Export Ready status in the EMR. RMDSC-O stated the EMR system pre-populates Section A of the MDS assessment and will code in error that the facility is not Medicare/Medicaid certified. Therefore, MDS assessments are not transmitted when they are completed. RMDSC-O stated the missing report was last run in early January. RMDSC-O did not know why R55 and R64's MDS assessments were not listed.		

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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 staff interview and record review, the facility did not ensure a Pre-admission Screening and Resident Review (PASRR) was completed appropriately for 2 residents (R) (R2 and R9) of 6 sampled residents. R2 had diagnoses of schizoaffective disorder, anxiety, and depression. The facility did not complete a PASRR Level II Screen for R2. R9 had diagnoses of epilepsy, major depressive disorder, and anxiety disorder. R9's PASRR Level I Screen was completed inaccurately, therefore, a Level II Screen was not completed. Findings include: The facility's undated Pre-admission Screening and Resident Review (PASRR) policy indicates: The facility will comply with all federal and state of Wisconsin requirements regarding PASRR to ensure individuals with serious mental illness, intellectual disabilities, or related conditions are appropriately evaluated prior to admission and throughout their stay in the facility. PASRR Screening Requirement: All individuals applying for admission to the facility must have a PASRR Level 1 Screen completed prior to admission unless they qualify for an allowable PASRR exemption. The PASRR Level 1 screening identifies whether the individual may have: serious mental illness (SMI), intellectual disability (ID), or related conditions. If indicators are present, a PASRR Level II evaluation will be required prior to admission unless an approved exemption applies. 1. Between 3/9/26 and 3/12/26, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE]. R2's Minimum Data Set (MDS) assessment, dated 12/30/25, indicated R2 had diagnoses including schizoaffective disorder, anxiety disorder, and depression and had long and short term memory impairment. The MDS assessment also indicated R2 was not considered by the state PASRR Level II process to have a serious mental illness, intellectual disability, or related condition. R2's medical record contained a PASRR Level I Screen which indicated R2 did not have a diagnosis of a major mental disorder. A PASRR Level II Screen was not completed. On 3/11/26 at 9:45 AM, Surveyor interviewed Admissions Director (AD)-K who verified AD-K completed PASRRs for residents. AD-K confirmed R2's PASRR Level I Screen was marked incorrectly and a Level II Screen was not completed. 2. Between 3/9/26 and 3/12/26, Surveyor reviewed R9's medical record. R9 was admitted to the facility on [DATE] and had diagnoses including epilepsy, major depressive disorder, and anxiety disorder. R9 was non-verbal and unresponsive. R9 had a Guardian who was responsible for healthcare decisions. On 3/9/26 at 2:56 PM, Surveyor reviewed R9's PASRR Level I Screen (admission date 10/20/25) which indicated R9 did not have a diagnosis of a major mental illness or an intellectual/developmental disability. As a result, a PASRR Level II Screen was not completed. On 3/12/26 at 11:22 AM, Surveyor interviewed AD-K who confirmed R9's PASRR Level I Screen was inaccurately completed and a PASRR Level II Screen was not completed. AD-K verified a Level II Screen should have been completed for R9.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interview, and record review, the facility did not ensure the resident environment remained as free of accident hazards as possible for 2 residents (R) (R3 and R20) of 3 sampled residents. R3's plan of care contained interventions for anti-roll back bars on R3's wheelchair and a fall mat in R3's room. The interventions were not consistently implemented. In addition, the facility did not complete neuro checks and a root cause analysis for R3's falls on 11/1/25 and 1/1/26. The facility did not complete a smoking assessment for R20 to determine if R20 was able to smoke independently. In addition, R20's care plan did not address smoking. Findings include: The facility's Falls Management process indicates: .8. Obtain neurological checks (neuro checks) per policy for any unwitnessed fall or any fall with evidence of injury to the head .11. The nurse will complete an event documentation report .12. The nursing supervisor will determine the most appropriate intervention, implement the intervention, and update the care plan. The facility's Resident Smoking policy, dated 7/15/25, states: It is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Safety protections apply to smoking and non-smoking residents .6. Residents who smoke will be further assessed, using the resident Safe Smoking Assessment, to determine whether or not supervision is required for smoking, or if resident is safe to smoke at all .14. The Interdisciplinary Team (IDT), with guidance from the physician, will help support the resident's right to make an informed decision regarding smoking by: 1. Including the resident, family, and/or resident representative in discussions regarding the risks associated with smoking. b. Offering pharmacological and/or behavioral interventions to assist with smoking cessation. c. Providing educational materials regarding smoking and smoking cessation. d. Developing a safe smoking plan or an individualized plan to quit smoking. 15. Documentation to support decision making will be included in the medical record, including but not limited to: a. Resident's wishes .b. Assessment of relevant functional and cognitive factors affecting ability to smoke safely. c. Response to smoking cessation interventions. d. Compliance with smoking policy. 16 .The smoking area may be an outside area provided that residents remain safe. 1. Between 3/9/26 and 3/12/26, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] and had a diagnosis of vascular dementia with psychotic disturbance. R3's Minimum Data Set (MDS) assessment, dated 1/19/26, had a Brief Interview for Mental Status (BIMS) score of 9 out of 15 that indicated R3 had mild cognitive impairment. R3 had an activated Power of Attorney for Healthcare (POAHC) (POAHC-W) who assisted with medical decisions. A care plan, dated 5/9/23, indicated R3 was at risk for falls related to a recent fall with fracture, decreased mobility, and poor safety awareness. The care plan contained interventions for an anti-rollback device on R3's wheelchair (dated 10/22/25) and a mat on the side of the bed (dated 11/1/25). R9's medical record indicated R9 had unwitnessed falls on 11/1/25 and 1/1/26. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note, dated 11/1/26 at 6:35 AM, indicated R3 was found face down in R3's room. Staff observed a hematoma on the back of R3's head. R3 was on Eliquis (an anticoagulant medication). R3 was sent to the hospital for a computed tomography (CT) scan which was negative. A progress note, dated 1/1/26 at 8:45 PM, indicated R3 fell and hit R3's head on the way to the bathroom. R3 had a hematoma on the left side of the forehead. R3 complained of a headache and pain. R3 was on Eliquis and was sent to the hospital. On 3/9/26 at 2:35 PM, Surveyor interviewed POAHC-W who stated R3 had a number of falls. POAHC-W stated POAHC-W requested multiple times that a fall mat be put in R3's room to prevent injury or another trip to the emergency room (ER), however, a fall mat was not provided. POAHC-W stated POAHC-W's spouse went to the facility and spoke to staff about it. On 3/9/26 at 11:12 AM, Surveyor observed R3 in bed. There was not a fall mat next to R3's bed. On 3/12/26 at 1:22 PM, Surveyor observed R3 in a wheelchair. The wheelchair did not contain an anti-rollback device. On 3/12/26 at 1:22 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-X who stated when staff put R3 in bed, the bed is in a low position even though there is not a fall mat. CNA-X also confirmed R3's wheelchair did not have an anti-rollback device. CNA-X thought R3 was recently given a different wheelchair to use. Surveyor requested fall reports, including neuro checks for R3's falls on 11/1/25 and 1/1/26. Surveyor did not receive neuro checks or the root cause analysis for R3's fall on 11/1/25 and did not receive a risk management report, neuro checks, or a root cause analysis for R3's fall on 1/1/26. On 3/12/26, Surveyor requested the missing documentation from Director of Nursing (DON)-B. The information was not provided as of this writing. When Surveyor informed DON-B that a fall mat and an anti-roll back device were not in place for R3, DON-B verified the interventions should be in place. 2. Between 3/9/26 and 3/12/26, Surveyor reviewed R20's medical record. R20 was admitted to the facility on [DATE] and had diagnoses including muscle wasting and atrophy, asthma, diabetes, affective mood disorder, anxiety, and polyneuropathy. R20's MDS assessment, dated 12/29/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R20 had intact cognition. R20 made R20's own medical decisions. A Smoking Assessment, dated 3/9/26, did not identify any safety concerns for R20. On 3/9/26 at 2:19 PM, Surveyor interviewed R20 who indicated R20 smoked in the smoking section and did not wear a smoking apron. R20 stated R20 had not had any accidents while smoking, including burning or dropping ashes on R20. R20 stated there were receptacles for cigarette butts near the smoking area. On 3/10/26 at 1:37 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-Q who stated R20 (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	kept cigarettes and a lighter at the nurses' station. CNA-Q indicated R20 smoked independently and did not wear an apron. CNA-Q was not aware of any smoking concerns for R20. On 3/10/26 at 4:09 PM, Surveyor observed R20 independently smoking a cigarette on the patio in a wheelchair with 12 other residents. One resident wore a smoking apron. CNA-R was supervising the residents. Surveyor observed a cigarette receptacle in a corner of the patio. R20 extinguished R20's cigarette without putting the butt in the receptacle or giving it to CNA-R to extinguish. Surveyor was uncertain where R20 extinguished the cigarette. When R20 returned to the building, R20 gave the cigarette butt to CNA-R. R20 stated R20 could not reach the receptacle on the patio because other residents were in the way. On 3/10/26 at 4:19 PM, Surveyor interviewed CNA-R who verified R20 should have given the cigarette butt to CNA-R to extinguish. CNA-R was not aware of any other smoking concerns for R20. On 3/10/26 at 5:44 PM, Surveyor interviewed DON-B and Chief Nursing Officer (CNO)-S. When asked if it was okay for R20 to extinguish a cigarette and keep the cigarette butt, CNO-S stated CNA-R reported the incident because it was something that R20 should not have done. CNO-S verified R20 should have given the cigarette to CNA-R to extinguish and put in the receptacle. On 3/11/26 at 3:01 PM, Surveyor interviewed DON-B who verified R20 did not have a smoking assessment or smoking care plan prior to 3/9/26.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interview and record review, the facility did not ensure 2 residents (R) (R71 and R7) of 26 sampled residents received the necessary care and services to prevent or monitor weight loss or gain. R71 received nutrition though enteral feeding and had significant weight loss. Staff did not monitor R71's weight as ordered. Staff did not monitor R7's weight as ordered or notify the physician of weight changes. Findings include: The facility's Weight Assessment and Intervention policy, revised March 2022, indicates: Resident weights are monitored for undesirable or unintended weight loss or gain. 1. Residents are weighed upon admission and at intervals established by the Interdisciplinary Team (IDT). 2. Weights are recorded in each unit's weight record chart and the individual's medical record. 3. Any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation. a. If the wait is verified, nurses will immediately notify the Dietitian in writing. 4. Unless notified of a significant weight change, the Dietitian will review the unit weight record monthly to follow individual weight trends over time. 5. The threshold for significant unplanned and undesired weight loss will be based on the following criteria (where percentage of body weight loss = (usual weight-actual weight)/(usual weight) x 100): a. 1 month - 5% weight loss is significant; greater than 5% is severe. b. 3 months - 7.5% weight loss is significant; greater than 7.5% is severe. c. 6 months - 10% weight loss is significant; greater than 10% is severe. 6. If the weight change is desirable, this is documented. The facility's undated Notification of Changes policy indicates: The purpose of this policy is to ensure the facility promptly informs the resident .consults the resident's physician, and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification .2. Significant change in the resident's physical, mental, or psychosocial condition such as deterioration in health, mental, or psychosocial status . 1. Between 3/9/26 and 3/12/26, Surveyor reviewed R71's medical record. R71 was admitted to the facility on [DATE] and had diagnoses including acute osteomyelitis-multiple sites, pressure ulcer of lower left back (unstageable), pressure ulcer of left buttock (unstageable), pressure ulcer of other site (unstageable), pressure ulcer of right hip (stage 4), pressure ulcer of left hip (stage 4), pressure ulcer of sacral region (stage 4), pressure ulcer of left heel (stage 4), pressure ulcer of left upper back (stage 4), pressure ulcer of other site (stage 3), hemiplegia and hemiparesis following cerebral infarction, and severe protein calorie malnutrition. R71's admission Minimum Data Set (MDS) assessment, dated 2/23/26, had a Brief Interview for Mental Status (BIMS) score of 6 out of 15 which indicated R71 had severely impaired cognition. R71 had an activated Power of Attorney for Healthcare (POAHC) to assist R71 with medical decisions.R71's Medication Administration Record (MAR) contained the following orders:~ Daily weights for three days upon admission. Every day shift for three days (Start date: 2/17/26). Surveyor noted R71's weights were not documented on 2/17/26 (documented as other), 2/18/26, or 2/19/26. ~ Weekly weight for 4 weeks upon admission. Every day shift every Thursday for four weeks (Start date: 2/17/26) R71 weighed 103.1 pounds (lbs) on 2/26/26. Surveyor noted R71's weight was not documented on (Thursday) 2/19/26, 3/5/26, or 3/12/26.~ Monthly weight. Every day shift starting on the 1st and ending on the 3rd every month (Start date: 2/17/26) Surveyor noted R71's weight was not documented on 3/1/26, 3/2/26, or 3/3/26.R71 had a gastronomy tube (G-tube) and received nutrition via enteral feeding. R71 had a physician's order to administer 1.5 cans (356 milliliters (ml)) of Jevity formula three times daily.Surveyor reviewed vital signs for R71, including weight measurements and noted the following two entries were the only measurements documented:~ On 2/26/26, R71 weighed 103.1 lbs via (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mechanical lift~ On 3/5/26, R71 weighed 97.0 lbs via mechanical lift. The accompanying note indicated R71 had a loss of 6.1 lbs and 5.9% body weight since R71 was last weighed on 2/26/26 (7 days prior). Surveyor noted a re-weight was not obtained on 3/6/26 following a weight loss of 5% or more. There were no other vitals/weights documented for R71 from 3/5/26 through 3/12/26. On 3/12/26 at 12:54 PM, Surveyor interviewed Director of Nursing (DON)-B and Nursing Home Administrator (NHA)-A who indicated weights should be obtained as ordered and documented in the resident's medical record. DON-B indicated staff should document weight refusals and try again to obtain the weight. DON-B indicated if there is a significant weight change, a Certified Nursing Assistant (CNA) should notify the nurse. The nurse should re-weigh the resident and notify the Registered Dietician (RD), physician, and the resident's POAHC (if indicated) of the weight changes.2. On 3/11/26, Surveyor reviewed R7's medical record. R7 was admitted to the facility on [DATE] and had a diagnosis of congestive heart failure. R7's MDS assessment, dated 1/2/26, had a BIMS score of 15 out of 15 which indicated R7 had intact cognition. R7 made R7's own medical decisions. R7 had a physician order for daily weights and to update the physician for a weight gain of more than 3 lbs in one day or more than 5 lbs in one week. R7's medical record did not indicate the physician was notified of the following weight gains:~ 1/12/26 - 237.0 lbs. ~ 1/13/26 - 240.0 lbs (which was a 3 lb weight gain in one day).~ 1/14/26 - 243.0 lbs (which was a 3 lb weight gain in one day).~ 1/15/26 - 247.0 lbs (which was a 4 lb weight gain in one day and a 10 lb weight gain in one week).~ 1/20/26 - 243.3 lbs.~ 1/21/26 - 246.9 lbs (which was a 3.6 lb weight gain in one day).~ 2/8/26 - 245.4 lbs.~ 2/10/26 - 244.0 lbs.~ 2/11/26 - 255.0 lbs (which was an 11 lb weight gain in one day and 10.4 lb weight gain in one week).~ 2/24/26 - 255.0 lbs.~ 2/25/26 - 258.0 lbs (which was a 3 lb weight gain in one day).~ 3/3/26 - 257.3 lbs.~ 3/4/26 - 262.5 lbs (which was a 5.2 lb weight gain in one day). On 3/11/26 at 3:25 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-P who indicated R7 should have been re-weighed and the physician should have been notified of R7's increased weights. On 3/11/26 at 4:08 PM, Surveyor interviewed DON-B who indicated R7 should have been re-weighed and the physician should have been notified of R7's weight.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure monitoring for high-risk medications was in place for 3 residents (R) (R3, R7, and R29) of 5 sampled residents. R3 was prescribed levetiracetam (an anticonvulsant medication). R3 was not monitored for adverse reactions or side effects of the high-risk medication. R7 was prescribed oxycodone hydrochloride (an opioid medication) and oxycodone (an opioid medication) as needed (PRN) for pain. R7 was not monitored for adverse reactions or side effects of the high-risk medications. R29 was prescribed morphine sulfate (an opioid medication) PRN for pain. R29 was not monitored for adverse reactions or side effects of the high-risk medication. Findings include: The facility's Medication Management policy, dated 10/25/14, indicates: In order to optimize the therapeutic benefit of medication therapy and minimize or prevent potential adverse consequences, facility staff .perform ongoing monitoring for appropriate, effective, and safe medication use .Members of the Interdisciplinary Team (IDT) participate in the care process to identify, assess, address, advocate for, monitor, and communicate resident's needs and changes in condition .A. The IDT reviews the resident's medication regimen for efficacy and actual or potential medication related problems .3) Information gathered during the initial and ongoing evaluations are incorporated .that reflects appropriate medication related goals and parameters for monitoring the resident's condition and ongoing need for the medication(s), including, but not limited to, what is monitored, who will be responsible for monitoring .a. quantitative and qualitative monitoring parameters using a variety of resources including .manufacturers' package inserts and box warnings; facility policies and procedures .clinical practice guidelines or clinical standards of practice; medication references .6.b. The resident is monitored for .possible adverse consequences .1. On 3/11/26, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] and a diagnosis of epilepsy. R3's Minimum Data Set (MDS) assessment, dated 1/14/26, had a Brief Interview for Mental Status (BIMS) score of 9 out of 15 which R3 had moderate cognitive impairment. R3 had an activated Power of Attorney for Healthcare (POAHC). R3's medical record indicated R3 was prescribed levetiracetam for epilepsy. R3's medical record did not contain monitoring interventions for adverse reactions or side effects of levetiracetam. On 3/11/26 at 3:32 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-P who verified staff should monitor R3 for adverse reactions/side effects of levetiracetam. On 3/11/26 at 4:08 PM, Surveyor interviewed Director of Nursing (DON)-B who confirmed R3 was not monitored for adverse reactions/side effects of levetiracetam. 2. On 3/11/26, Surveyor reviewed R7's medical record. R7 was admitted to the facility on [DATE] and had a diagnosis of rheumatoid arthritis. R7's MDS assessment, dated 1/2/26, had a BIMS score of 15 out of 15 which indicated R7 had intact cognition. R7 made R7's own healthcare decisions. R7's medical record indicated R7 was prescribed oxycodone for pain. R7's medical record did not contain monitoring interventions for adverse reactions or side effects of oxycodone. On 3/11/26 at 4:02 PM, Surveyor interviewed DON-B who verified staff should monitor R7 for adverse reactions/side effects of oxycodone. 3. On 3/11/26, Surveyor reviewed R29's medical record. R29 was admitted to facility on 10/8/24 and had a diagnosis of osteoarthritis. R29's MDS assessment, dated 1/2/26, had a BIMS score of 6 out of 15 which indicated R29 had severe cognitive impairment. R29 had an activated POAHC. R29's medical record indicated R29 was prescribed morphine as needed (PRN) for pain. R29's medical record did not contain monitoring interventions for adverse reactions or side effects of morphine. On 3/11/26 at 3:18 PM, Surveyor interviewed LPN-P who verified staff should monitor R29 for adverse reactions/side effects of morphine. On 3/11/26 at 3:56 PM, Surveyor interviewed DON-B who confirmed R29 was not monitored for adverse reactions/side effects of morphine.		

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NAME OF PROVIDER OR SUPPLIER Watertown Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 121 Hospital Dr. Watertown, WI 53098	
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure 2 residents (R) (R71 and R84) of 26 sampled residents were free of significant medication errors. R71 was admitted to the facility with a diagnosis of osteomyelitis. R71 did not receive three doses of intravenous (IV) antibiotics as ordered. R84 was admitted to the facility with sepsis from a soft tissue infection and right calf cellulitis and abscess. R84 did not receive two scheduled doses of IV antibiotics. R84 requested to go to the hospital so R84 would not miss another dose. Findings include: The facility's Medication Administration policy, dated 10/25/14, indicates: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the facility's medication distribution system .Preparation: .4. Five Rights - Right resident, right drug, right dose, right route, and right time are applied for each medication being administered. A triple check of these five rights is recommended at three steps in the process of preparation of a medication for administration: (1) When the medication is selected, (2) When the dose is removed from the container, and (3) Just after the dose is prepared and the medication put away .Administration: .2. Medications are administered in accordance with written orders of the prescriber .Documentation (including electronic): 1. The individual who administers the medication records the administration on the resident's Medication Administration Record (MAR) directly after the medication is given. At the end of each medication pass, the person administering the medication reviews the MAR to ensure necessary doses were administered and documented. In no case should the individual who administered the medication report off-duty without first recording the administration of any medication .6. If a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time .an exploratory note is entered .If (xx consecutive doses) of a vital medication are withheld, refused, or not available, the physician is notified. Nursing documents the notification and physician response . 1. Between 3/9/26 and 3/12/26, Surveyor reviewed R71's medical record. R71 was admitted to the facility on [DATE] and had diagnoses on admission including acute osteomyelitis-multiple sites, pressure ulcer of lower left back (unstageable), pressure ulcer of left buttock (unstageable), pressure ulcer of other site (unstageable), pressure ulcer of right hip (stage 4), pressure ulcer of left hip (stage 4), pressure ulcer of sacral region (stage 4), pressure ulcer of left heel (stage 4), pressure ulcer of left upper back (stage 4), pressure ulcer of other site (stage 3), hemiplegia and hemiparesis following cerebral infarction, and severe protein calorie malnutrition. R71's admission Minimum Data Set (MDS) assessment, dated 2/23/26, had a Brief Interview for Mental Status (BIMS) score of 6 out of 15 which indicated R71 had severely impaired cognition. R71 had an activated Power of Attorney for Healthcare (POAHC) to assist with medical decisions. (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R71's medical record contained the following physician orders: ~ Ceftriaxone sodium intravenous solution (Rocephin), reconstituted 1 gram (gm). Use 1 gram intravenously once daily for osteomyelitis for two weeks (Order date: 2/24/26 at 3:48 PM). ~ Vancomycin HCl intravenous solution 1000 mg/200 milliliters (ml). Use 1000 mg intravenously in the evening for osteomyelitis for 3 days (Order date: 2/24/26 at 3:48 PM). ~ Vancomycin HCl intravenous solution use 1.5 grams intravenously every 24 hours for osteomyelitis (Order date: 3/2/26 at 12:27 PM). Surveyor reviewed R71's February and March 2026 Medication Administration Records (MARs) which indicated R71 did not receive ceftriaxone or vancomycin on the following dates: ~ On 2/25/25, ceftriaxone was not administered. Licensed Practical Nurse (LPN)-JJ documented code 7 on the MAR which meant Other, see Nurse's note. ~ On 2/25/26, Vancomycin was not administered. LPN-KK documented code 3 on the MAR which meant Hold, see Nurse's note. Surveyor noted vancomycin was only administered on 2 days because of the missed dose on 2/25/26. ~ On 3/8/26, Ceftriaxone was not administered. LPN-JJ documented code 7 on the MAR which meant Other, see Nurse's note. A progress note, dated 2/24/26 at 3:54 PM by Director of Nursing (DON)-B, indicated the wound doctor requested a culture and would assess R71's wounds. R71 had orders for IV Rocephin and vancomycin for 2 weeks. A vanco trough (a test to monitor antibiotic levels to guide antibiotic therapy) was ordered. R71 also had orders for a peripherally-inserted central catheter (PICC) line and stat (immediate) labs. A medication administration note, dated 2/25/26 at 7:01 AM by LPN-JJ, indicated R71's PICC line had not been placed. A nursing note, dated 2/25/26 at 9:24 AM by LPN-P, indicated LPN-P contacted R71's POAHC for PICC line placement consent due to a new order for IV antibiotics. A medication administration note, dated 2/25/26 at 9:52 PM by LPN-KK, indicated the facility was awaiting vancomycin from the pharmacy. A nursing note, dated 3/2/26 at 9:26 AM by Registered Nurse/Unit Manager (RNUM)-LL, indicated staff called the pharmacy regarding R71's vancomycin trough level of 11.9. The pharmacist stated vancomycin was discontinued on 2/28/26 and recommended the facility call the physician to see if antibiotic therapy should be extended. The wound doctor ordered a comprehensive metabolic panel and to continue antibiotic therapy with no end date. The pharmacist was updated and stated they would fax a copy of the dose recommendation to the facility. (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing note, dated 3/2/26 at 12:23 PM by RNUM-LL, indicated the pharmacy called with an order for 1.5 grams of vancomycin every 24 hours starting that night. The pharmacy stated to pull the first dose from the Nexus machine. A medication administration note, dated 3/8/26 at 8:48 AM by LPN-JJ, indicated ceftriaxone was not available. R71's medical record did not indicate the physician was notified of the two missed doses on 2/25/26 or the missed dose on 3/8/26. On 3/12/26 at 1:49 PM, Surveyor interviewed LPN-KK who indicated sometimes there is a delay in starting IV antibiotics because the facility uses an outside agency to insert PICC lines which can take 1 to 2 days. LPN-KK verified the physician should be notified of a missed dose of antibiotics. LPN-KK stated the physician might send the resident to the hospital for PICC line placement or change and extend the antibiotic order. LPN-KK could not recall the 2/25/26 dosing issue for the original vancomycin order and was unsure if it was a PICC line issue or if the medication hadn't arrived. On 3/12/26 at 12:54 PM, Surveyor interviewed DON-B who indicated medications should be administered as ordered. DON-B stated staff should initial medications on the MAR when they are administered and should use codes on the MAR if a medication is not administered. DON-B stated medications that are not initialed or contain a code are considered to be not administered. DON-B stated there should be no blanks on the MAR. DON-B confirmed an IV medication should be started right away if the medication is available. Staff should notify the physician if the medication will not start until the next day and document the notification in the resident's medical record. If the physician changes the start date, the order should reflect the new start date. Chief Nursing Officer (CNO)-S was present during the interview and indicated medications should be started within 24 hours. When asked when a PICC line should be placed for an order dated 2/24/26 at 3:54 PM, DON-B stated a PICC line should be placed that day if possible. DON-B verified documentation of physician notification for the missed IV antibiotics should be in R71's medical record. CNO-S indicated the facility needed to be better about physician notification and documentation. 2. Between 3/10/26 and 3/12/26, Surveyor reviewed R84's medical record. R84 was admitted to the facility on [DATE] and had diagnoses including type 2 diabetes, cutaneous abscess of limb, and non-pressure chronic ulcer of right foot. R84's MDS assessment, dated 11/20/25, had a BIMS score of 15 out of 15 which indicated R84 had intact cognition. R84 made R84's own medical decisions. A care plan, dated 11/14/25, indicated R84 was admitted to the facility on IV antibiotics related to sepsis and right extremity cellulitis. The care plan contained interventions to administer antibiotics and treatments as ordered (dated 11/14/25). A care plan, dated 11/14/25, indicated R84 was at risk for potential infection/complication related to IV use/PICC line. The care plan contained an intervention to administer IV fluids/medications per physician's orders. R84 was admitted to the facility after an acute hospital stay with sepsis from a soft tissue infection (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and right calf cellulitis and abscess. A hospital discharge summary indicated R84 was non-compliant with diabetic medications and diet prior to the hospital stay. Magnetic resonance imaging (MRI) for evolving osteomyelitis was started but could not be completed due to an issue with R84 lying in a supine (lying flat on one's back face upward) position. A progress note, dated 11/15/25, indicated R84 was concerned about R84's wounds and antibiotic therapy and the pharmacy would stat medication to the facility. The note indicated R84 wanted to go to the Emergency Department (ED) for evaluation and did not want to go twenty-four hours without antibiotics. R84 was transported to the ED. Emergency Department documentation, dated 11/15/25, indicated R84 had missed three doses of IV antibiotics. R84 had chronic lower leg edema. The documentation indicated there was no redness to the lower legs and R84 did not appear septic. R84's medical record contained the following order: ~ Cefazolin sodium injection solution reconstituted 2 grams intravenously three times daily for infection (Order date: 11/14/25 at 12:28 PM). R84's MAR indicated the medication was scheduled at 7:00 AM, 2:00 PM, and 9:00 PM. R84's November 2025 MAR indicated the order was started on 11/15/25 at 7:00 AM but was not administered at 7:00 AM and 2:00 PM. (Of note, R84 was admitted to the facility on [DATE] prior to 5:00 PM, however, cefazolin was not scheduled to start until 7:00 AM on 11/15/25.) A health note, dated 11/17/25, indicated R84 had a history of methicillin-resistant Staphylococcus aureus (MRSA) (a type of staph bacteria resistant to several common antibiotics) infection and had wounds on both lower extremities. The note indicated R84 had missed antibiotics due to pharmacy issues. On 3/11/26 at 1:25 PM, Surveyor interviewed LPN-QQ who verified residents miss doses of medications that are not delivered timely from the pharmacy. LPN-QQ indicated the pharmacy (which is in a neighboring state) delivers medications nightly but can send stat medications (which take approximately 2 hours) if requested. LPN-QQ stated if LPN-QQ calls the pharmacy on the AM shift to request a medication, the medication will be in the facility the next day when LPN-QQ arrives for work. On 3/11/26 at 10:00 AM, Surveyor interviewed DON-B who indicated R84's cefazolin was scheduled to arrive after midnight on 11/14/25. DON-B indicated R84 was upset that the facility didn't have the IV medication upon admission. DON-B stated when R84 expressed concerns on 11/15/25 about the missed antibiotic doses, the facility obtained an order to give an oral antibiotic in the meantime. R84 refused the oral antibiotic and went to the ED for an IV dose. DON-B stated the facility's process is to let the provider know if a medication hasn't arrived so the provider can either hold the medication or offer an alternative until the medication is delivered. DON-B indicated the provider was first contacted on 11/15/25 (which was after R84 had already missed multiple doses of the antibiotic). DON-B was unsure what time the physician was notified of the missed doses. R84's medical record did not indicate when or if the physician was notified.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure 1 resident (R) (R72) of 5 sampled residents was offered the influenza vaccine.R72 was admitted to the facility on [DATE]. The facility did not offer or obtain R72's consent or declination for the influenza vaccine. In addition, R72 did not receive education about the vaccine.Findings include: The facility's Infection Prevention and Control Program policy, revised 7/2025, indicates: .9. Influenza and Pneumococcal Immunization: a. Residents will be offered the influenza vaccine each year between October 1 and March 31, unless contraindicated or they received the vaccine elsewhere during that time .c. Education will be provided to residents and/or their representatives regarding the benefits and potential side effects of the immunizations prior to offering the vaccines. d. Residents will have the opportunity to refuse the immunizations. e. Documentation will reflect the education provided and details regarding whether or not the resident received the immunizations.On 3/11/26, Surveyor reviewed R72's medical record. R72 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, schizophrenia, diabetes mellitus, and coronary atherosclerosis. R72's Minimum Data Set (MDS) assessment, dated 2/9/25, had a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated R72 had moderately impaired cognition. R72 had an activated Power of Attorney for Healthcare (POAHC) for medical decisions.R72's medical record indicated R72's most recent influenza vaccine was administered on 10/31/23.On 3/11/26 at 11:30 AM, Surveyor interviewed Infection Preventionist (IP)-I who confirmed IP-I did not offer the influenza vaccine to R72, did not obtain consent or declination for vaccine, and did not provide education about the vaccine. IP-I indicated the vaccine should be offered and consent or declination obtained within 24 to 48 hours of admission. IP-I indicated education should be provided when the vaccine is offered and at the time of administration. IP-I verified it is IP-I's responsibility to review a resident's vaccination status, obtain consent, provide education, and administer vaccines at the time of admission.		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure 2 residents (R) (R2 and R72) of 5 sampled residents were offered a COVID-19 vaccine. R2 was admitted to the facility on [DATE]. The facility did not offer R2 a COVID-19 vaccine or obtain R2's consent or declination for the vaccine. In addition, the facility did not provide education regarding the vaccine. R72 was admitted to the facility on [DATE]. The facility did not offer R72 a COVID-19 vaccine or obtain R72's consent or declination for the vaccine. In addition, the facility did not provide education regarding the vaccine. Findings include: The facility's Infection Prevention and Control Program policy, revised 7/2025, indicates: .10. COVID-19 Immunization: a. Residents and staff will be offered the COVID-19 vaccine when vaccine supplies are available to the facility. b. Residents and staff will be screened prior to offering the vaccination for prior immunization, medical precautions, and contraindications to determine candidacy for vaccination. c. Education about the vaccine, risks, benefits, and potential side effects will be given to residents or their representatives and staff prior to offering the vaccine. d. Residents or resident representatives will have the opportunity to accept or refuse a COVID-19 vaccination, and change their decision based on current guidance. e. Staff will have the opportunity to receive the COVID-19 vaccination or apply for a religious or medical exemption for facility consideration per current guidelines and facility policy. f. Documentation will reflect the education provided and details regarding whether or not the resident or staff received the vaccine. 1. On 3/11/26, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including traumatic subdural hemorrhage with loss of consciousness, chronic obstructive pulmonary disease, and altered mental status. R2's Minimum Data Set (MDS) assessment, dated 12/22/25, indicated R2 was rarely/never understood. The MDS assessment also indicated R2 could not effectively participate in the Brief Interview for Mental Status (BIMS) due to severe cognitive impairment, communication barriers, or non-sensical/absent responses. R2 had an activated Power of Attorney for Healthcare (POAHC) for medical decisions. R2's medical record indicated R2's most recent COVID-19 vaccine was on 2/16/21. On 3/11/26 at 11:30 AM, Surveyor interviewed Infection Preventionist (IP)-I who confirmed IP-I did not offer R2 a COVID-19 vaccine and did not provide education about the vaccine. IP-I stated the vaccine should be offered and consent/declination obtained within 24 to 48 hours of admission. IP-I indicated education should be provided when the vaccine is offered and at the time of administration. IP-I verified it is IP-I's responsibility to review residents' vaccines, obtain consent, provide education, and administer vaccines at the time of admission. 2. On 3/11/26, Surveyor reviewed R72's medical record. R72 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, schizophrenia, diabetes mellitus, and coronary atherosclerosis. R72's MDS assessment, dated 2/9/25, had a BIMS score 11 out of 15 which indicated R72 had moderately impaired cognition. R72 had an activated POAHC for medical decisions. R72's medical record indicated R72's most recent COVID-19 vaccine was on 2/21/23. On 3/11/26 at 11:30 AM, Surveyor interviewed IP-I who confirmed IP-I did not offer R72 a COVID-19 vaccine and did not provide education about the vaccine. IP-I indicated the vaccine should be offered and consent/declination obtained within 24 to 48 hours of admission. IP-I indicated education should be provided when the vaccine is offered and at the time of administration. IP-I verified it is IP-I's responsibility to review residents' vaccines, obtain consent, provide education, and administer vaccines at the time of admission.		