STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525346	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Williams Bay Health Services	146 Clover St Williams Bay, WI 53191

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure 1 (R14) of 2 sampled residents with pressure injuries received the necessary care and treatment based upon standards of practice to prevent pressure injuries from developing, promote healing, and prevent new areas from developing.R14 developed an abrasion to her right buttock 13 days after admission. The abrasion deteriorated to a Stage 4 pressure injury (PI) requiring hospitalization, surgical debridement, and a wound VAC. The wound became infected requiring antibiotic treatment, 2 different times. Surveyor's observations of wound care completed by facility staff identified concerns with infection control and care plan interventions not being implemented or in place.The facility's failure to provide care and treatment to a resident who was at risk for pressure injuries and developed a wound that deteriorated to a stage 4 pressure injury requiring antibiotics for infection, hospitalization, surgical debridement, and a wound vac created a finding of immediate jeopardy that began on 2/11/26. Surveyor notified Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B and [NAME] President of Success (VP)-C of the Immediate Jeopardy The immediate jeopardy was removed 5/22/26. The deficient practice continues at a scope/severity of E (potential for harm/pattern) as the facility continues to implement their action plan for resident's at risk for and with pressure injuries. Findings include:The facility's policy Pressure Injuries and Non pressure injuries with review date 7/20/22 documents: .b. Assess current wounds at least every seven days or more frequently as needed (e.g. decline in wound, presence of infection, wound healed). If a wound fails to show some evidence of progress toward healing within 2-4 weeks, the area and the resident's overall clinical condition should be reassessed. Reevaluation of the treatment plan includes determining whether to continue or modify the current interventions. Results may vary depending on the resident's overall condition and interventions/treatments used. The complexity of the resident's condition may limit responsiveness to treatment or tolerance for certain treatment modalities. The clinicians, if deciding to retain regimen should document the rationale for continuing the present treatment to explain why some, or all, of the plan's interventions remain relevant despite little or no apparent healing.For a resident to exercise his or her right appropriately to make informed choices about care and treatment or to decline treatment, the center and the resident (if applicable, the resident representative) must discuss the resident's condition, treatment options, expected outcomes, and consequences of declining treatment or interventions. Centers should document this discussion in the Risk vs Benefit UDA (User Defined Assessment) in the electronic medical record. The care plan should be updated to reflect the resident's choice and what interventions will be in place to minimize risk to the resident .R14 was admitted to the facility on [DATE] with diagnoses of cerebral palsy, deafness, and quadriplegia. R14's quarterly Minimum Data Set (MDS) dated [DATE] documents R14 is cognitively intact and is dependent for all activities of daily living (ADL) including transfers and bed mobility. MDS also documents R14 is incontinent of bladder and bowel. R14's MDS assessed R14 as being at risk for pressure injuries with 1 stage 4 pressure injury; not present on admission or reentry. R14 also had an unstageable deep tissue injury that was present upon readmission/reentry. R14's MDS indicated R14 should receive pressure relieving devices for chair, bed, nutritional services, and pressure injury care. (continued on next page)

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

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

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R14 is not assessed as having/needing a turning & repositioning program.R14's comprehensive admission MDS with a reference date of 12/9/25 assessed R14 as dependent upon staff for ADLs. R14 is dependent upon staff for rolling left to right in bed. R14 is also assessed to be at risk for pressure injuries with no existing pressure injuries. R14 is assessed as having a pressure relieving device for their bed but not for wheelchair and no turning and repositioning program. R14's Care Area Assessment was triggered for further care planning review during this assessment.R14's care plan for alteration in skin integrity dated 12/8/25 documents the following interventions: assist and encourage to float heels when in bed, assist to reposition approximately every 2 hours; use assistive devices as needed, barrier cream to peri area/buttocks as needed, pressure redistributing device on chair, provide preventative skin care routinely and PRN (as needed,) and use pillows/positioning devices as needed.R14's non pressure weekly tracker dated 12/16/25 documents R14 was found with an abrasion to the right buttock measuring 5.5 cm (centimeters) by 5.0 cm by 0.1 cm with 30% skin and 70% epithelial tissue. R14's care plan for skin alteration was updated on 12/18/25 with the following interventions: alternating pressure mattress setting at 200 lbs., encourage fluids, observe skin condition with ADL care daily; report abnormalities. On 1/6/26, R14's wound to the right buttock deteriorated measuring 4.0 cm by 4.5 cm by 0.1 cm with 50% granulation and 50% necrotic tissue.R14's care plan was updated on 1/6/26 with the intervention to offload resident's right hip/buttock; out of bed only for meals and therapy at this time.R14's care plan was updated again on 1/15/26 to include the intervention of a special gel cushion.On 1/28/26, R14's wound deteriorated again measuring 6.0 cm by 4.5 cm by 0.2 cm with 80% granulation and 20% necrotic with signs of infection noted to the wound and doxycycline (antibiotic) 100 mg (milligrams) twice a day (BID) for 10 days was ordered.On 2/4/26, Wound Medical Doctor (MD)-R's assessment documents the wound deteriorated to 50% granulation and 50% necrotic tissue. Wound MD-R documented a suggested surgical evaluation for debridement and possible postoperative vac.On 2/5/26, R14 was sent to the hospital due to the necrosis in the wound. R14 was hospitalized from [DATE]-[DATE] for debridement of the wound. Hospital documentation indicated R14's wound is a stage 4 pressure injury after debridement. Hospital documentation indicated they were unable to diagnose osteomyelitis but R14 did have an infection in the wound and R14 was discharged back to the facility with two antibiotics. R14 also returned to the facility with orders for a wound vac dressing. The hospital Discharge summary dated [DATE] documented: following debridement, the wound appeared clean with no further purulence or malodor, and the patient reported improvement in pain and overall wellbeing. Serial laboratory monitoring showed resolution of leukocytosis and down trending inflammatory markers. Infectious disease ruled out osteomyelitis recommended de-escalation to oral cephalexin and metronidazole at the time of discharge, with continued wound care and offloading measures.On 2/20/26, (9 days after R14 returned from hospitalization,) a care plan was initiated for a stage 4 pressure ulcer of the right ischium/buttock. The following interventions were documented: administer treatments as ordered and monitor for effectiveness, assess/record/monitor wound healing every 7 days. Measure length, width, and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD, avoid positioning the resident on right side, follow facility policies/protocols for the prevention/treatment of skin breakdown, monitor dressing to coccyx to ensure it is intact and adhering. Report loose dressing to treatment nurse, monitor nutritional status, obtain and monitor lab work.On 3/24/26, the facility received an order from Wound Nurse Practitioner (NP)-Q for R14 to receive lab work. The lab work ordered was for C reactive protein and sed rate (Both labs measure how much inflammation and infection is in the body.) Lab results showed the C reactive protein was 36.5 which is high, as the normal range is 5.0 and below; the sed rate was 50 which is high, as the normal range is 0-20. On 3/27/26, R14 was treated with Levaquin 750 mg (antibiotic) for 7 days and Cephalexin 500 mg (antibiotic) for 14 days due to the lab work results which indicated infection. On 5/19/26 at 8:56 a.m. and 1:43 p.m., Surveyor observed R14 in bed laying on her back with the head of the bed greater than 30 degrees; R14's heels were (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	offloaded.On 5/20/26 at 10:25 a.m., Surveyor observed R14's pressure injury treatment to the right buttock. Registered Nurse (RN)-O performed the treatment while RN-P assisted with holding R14 on her left side. Surveyor observed RN-O break infection control standards during the treatment by removing tape that was stuck to their glove using their mouth, placing clean scissors on a surface that was not clean, then using the scissors again without cleaning them, and touching clean packages and items with their used gloves. There were times when RN-P would assist RN-O with the tape for the wound vac and there were no observations of RN-O or RN-P removing gloves and performing hand hygiene when moving from one task to another. (Cross-Reference F880).On 5/20/26 at 11:00 a.m., Surveyor observed RN-P and Certified Nursing Assistant (CNA)-U provide incontinence care for R14. Surveyor observed concerns with glove changes and hand hygiene not being performed. R14 remained on her back, and her heels were observed to be not offloaded following cares.On 5/20/26 at 7:35 a.m., Surveyor interviewed Wound NP-Q. Wound NP-Q stated they started working with R14 a little bit into the progression of the wound. Wound NP-Q stated when they saw R14's wound it was already a stage 4 pressure injury. Wound NP-Q stated they heard it started from an incontinence brief abrasion. Wound NP-Q stated they were told it deteriorated due to R14's noncompliance and wanting to stay in the wheelchair. Wound NP-Q stated the facility discussed with R14 the risk vs benefits regarding offloading. Wound NP-Q stated while at the hospital, R14 had a surgical debridement and osteomyelitis was ruled out, but an infection was still in the wound, so antibiotics were prescribed. Wound NP-Q stated after R14 returned to the facility from her hospitalization, Wound NP-Q still had concerns with the depth of the wound. Wound NP-Q stated they ordered lab work, and it confirmed another infection, but they couldn't confirm if it was osteomyelitis. Wound NP-Q stated because the wound was so deep, they were concerned for infection, so they prescribed two antibiotics. Surveyor noted during this interview, Wound NP-Q stated she was told R14 was non-compliant with repositioning and laying down in bed, however, Surveyor could not locate any documentation stating R14 is noncompliant or any interventions in place to address any noncompliance. Surveyor explained there is no evidence that a discussion with R14 was held regarding risk vs benefits of being noncompliant with laying down and repositioning. During the survey, Surveyor spoke with R14 on several occasions (5/19/26 and 5/20/26). R14 indicated she was agreeable to stay in bed to heal the pressure injury.On 5/21/26 at 8:06 a.m., Surveyor interviewed CNA-U and asked if R14 can be noncompliant with care. CNA-U stated R14 is very nice and will do what you ask.On 5/21/26 at 8:07 a.m., Surveyor interviewed RN-P and asked if R14 can be noncompliant with care. RN-P stated R14 is a sweetheart and she was very compliant with her lay down schedule.On 5/21/26 at 8:51 a.m., Surveyor interviewed Wound MD-R. Wound MD-R stated he assessed R14's wound when it was first discovered. Wound MD-R stated the staff told him the wound was because of the brief. Wound MD-R stated with the progression of the wound, it was then assessed as a pressure injury due to R14 not laying down. Wound MD-R stated the worsening of the wound is due to no offloading of the area.The facility's failure to provide care and treatment to a resident who was at risk for pressure injuries and implement interventions to prevent the development of pressure injuries caused R14 to develop a wound which deteriorated to a stage 4 pressure injury. R14 developed infections in the stage 4 pressure injury that required hospitalization, surgical intervention, antibiotics, and a wound VAC; this noncompliance created a situation of immediate jeopardy for R14.The immediate jeopardy was removed 5/22/26 when the facility implemented the following action plan:*The identified resident (R14) had wound assessed by Director of Nursing or designee on 5/21/26. Primary care physician and responsible party notified of wound assessment and treatment orders. Treatment orders were reviewed to ensure appropriate. Identified resident's care plan was reviewed to ensure interventions are individualized and in place to prevent wound worsening.* In house residents at risk for development of a pressure injury or those with pressure injuries were identified as having the potential to be affected by alleged deficient practice. A skin sweep was initiated by Director of Nursing or designee on 5/21/26. Primary care physician and responsible party were notified of any (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	new or worsening pressure injuries. DON/Designee reviewed the care plans to validate individualized interventions are in place.*On 5/21/26, Director of Nursing or designee implemented re-education and training plan with nursing staff (CNAs and licensed nurses) on Pressure Injury and Non Pressure Injury policy. This education included but not limited to: implement interventions to prevent the development of a pressure injury.*If a resident refuses cares/treatments to prevent the development of a pressure injury, staff are to promptly notify licensed nurse/DON/designee. Licensed nurse/DON/and or designee will provide education to the resident and/or responsible party on the risks of such refusal. Licensed nurse/DON/and/or designee will notify MD and update care plan, as necessary.*Ensuring new or worsening pressure injury include a review that includes a root cause analysis of pressure injury to ensure interventions and treatments are completed and are personalized to resident. Identified education will occur prior to start of next scheduled shift.*On 5/21/26, Director of Nursing and Executive Director reviewed Pressure injury and Non-pressure injury policy with Medical Director. Policy meets current standards of practice and no changes were determined necessary.*DON/designee to complete audit on residents with new or worsening pressure injuries 3x/weekly for 8 weeks to ensure root cause analysis is completed and interventions put in place to prevent worsening of the pressure injury.*DON/designee to complete interview audits with nursing staff 3x/weekly for 8 weeks. These audits will include questions from established Pressure Injury and Non Pressure Injury policy to ensure training plan is effective.*DON/designee to complete audit of pressure injury weekly documentation to ensure assessments are complete and include interventions for the prevention of wound worsening. Audits will be completed weekly x 8 weeks.*Results of the audits will be presented to the QAPI committee for review and recommendations.*Ad hoc QAPI meeting was held on 5/21/26 to review this plan.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility did not ensure 4 (R20, R34, R32 and R24) of 4 sampled residents had services that prevented accident hazards. On [DATE] R34 had an unwitnessed fall and was sent to the hospital R34. R34 sustained a left intertrochanter fracture. On [DATE] R20 had an unwitnessed fall and was sent to the hospital. R20 sustained a zygomatic arch (cheek bone) fracture. On [DATE] and [DATE] R32 was observed to be drinking with a straw in her sippy cup. R32 had been assessed and care planned they should not drink through a straw due to swallowing concerns. On [DATE], R24 was overheard by staff calling a physician office and asking for an appointment. When staff asked if R24 needed assistance and why they needed the appointment R24 replied to get an order for a gun to shoot herself with. The facility did not implement interventions to maintain R24's safety. Additionally, R24 was determined to be at risk for falls on admission to the facility. R24 sustained 10 unwitnessed falls. The facility did not complete a thorough investigation of each of the falls. On [DATE], R24 had a fall and R24 sustained nondisplaced fractures of proximal phalanx of the 4th and 5th digits. The citation examples regarding R34, R20, and R24 are examples cited at the scope and severity of G (actual harm/isolated). Findings include: 1.) R34 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD), bipolar disorder, macular degeneration, legal blindness, and was dependent on supplemental oxygen. The significant change Minimum Data Set (MDS) dated [DATE] documents R34 had moderate cognitive impairment, needed supervision with dressing, independent with transfers and hygiene. It also documents R34 was independent to walk 10 feet with a walker and 50 feet with supervision. R34 was always continent of bowel and occasionally incontinent of bladder. R34's at risk for falls care plan dated [DATE] documented R34 was at risk for falls related to multiple diagnoses that included COPD, legal blindness etc. The risk factor also included difficulty in walking and weakness. The care plan included the following interventions: Fall risk (FYI), have commonly used articles within easy reach, reinforce need to call for assistance, report development of pain, bruises, change in mental status, ADL (activity of daily living) function, appetite or neurological status post fall. On [DATE] R34 was admitted to hospice services due to COPD. Review of R34's record indicated medication changes were made to R34's morphine and ativan medications in the days leading up to R34's fall with a major injury. Nursing staff documented in the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	days leading up to R34's fall that R34 was anxious and restless. Documentation indicated R34 was experiencing heightened and at times, uncontrolled pain. It was also noted at the time the medication changes were ordered R34 was experiencing changes in respiratory status. Daily skilled notes dated [DATE], [DATE], [DATE], [DATE], and [DATE] all document for neuromuscular R34 was demonstrating decreased ability in movement with increased weakness with weakness/balance problems. R34's weakness and balance concerns were not addressed in R34's care plan for increased safety. On [DATE] at 05:05 AM a General Note documented: Resident noted to be up and down all night, walking in hall without walker, walking around in her room looking for oxygen that was on the floor and all wrapped up in her walker wheels. New oxygen tubing with mas in place, resting in recliner at this time. Very restless during NOC (night shift), PRNs utilized as well as non-pharmalogical (sic) comfort. On [DATE] at 22:10 (10:10 PM) a nursing note documented continued safety concerns related to R34's actions when nursing staff discussed with R34 it was safer for R34 to sit on her bed vs. wheeled walker to rest. The daily skilled nursing note dated [DATE] at 10:00 documented R34 cognitively was demonstrating poor decision making skills and cues/supervision was required for R34. This daily skilled note indicated increased weakness in R34 but did not address safety concerns. R34's daily skilled nursing note dated [DATE] at 10:29 am documented cognitively, R34 was demonstrating poor decision making and required cues/supervision. R34 was demonstrating increased weakness and balance issues related to weakness. Safety was not addressed in the daily skilled review. On [DATE] at 1:08 a.m. a nurse's note documented R34 was sent to the hospital. Surveyor reviewed a [DATE], 12:45 a.m. fall investigation report. The fall report documented Licensed Practical Nurse (LPN)-V found R34 on the floor with her head by the bed and legs towards the recliner. LPN-V asked Certified Nursing Assistant (CNA)-N to bring the vitals equipment. The report documented R34 was by her recliner, and the call light was attached to the recliner. R34 stated she fell backwards but did not hit her head, but her leg was broken. The fall report documented R34 was seen at 11:30 p.m. walking out of her room with her walker and was redirected back to her recliner. When R34 was found on the floor, R34 was telling LPN-V she wanted to get into bed. LPN-V told her they needed to call 911 and the paramedics would get her off the floor. R34 was anxious and insisted they assist her in (sic) bed. LPN-V and CNA-N assisted R34 into bed while waiting for paramedics to arrive. The fall report also documented there was no evidence of shortening of the legs noticed upon assessment. On [DATE] the interdisciplinary team (IDT) note documented upon investigating the fall the facility discovered R34's lorazepam was not administered as ordered and the combination of R34's prescribed pain medication, her altered mental status and the lorazepam not given as ordered contributed to R34 fall with left intertrochanter fracture. R34 did not return to the facility and died at the hospital. On [DATE] at 12:55 p.m. Surveyor interviewed Medical Examiner-II. Surveyor asked Medical Examiner-II when did R34 die and what was (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	the cause of the death. Medical Examiner-II Stated R34 died on [DATE] and the death was ruled accidental due to intertrochanter fracture of left femur and COPD. On [DATE] at 10:10 a.m. Surveyor interviewed Nursing Home Administrator (NHA)-A. NHA-A stated the team felt R34 receiving more than the prescribed dose of lorazepam contributed to R34's fall. NHA-A stated R34 did not have any falls prior to this fall On [DATE] at 2:21 p.m. Surveyor interviewed CNA-N. Surveyor asked CNA-N if he remembers working on [DATE] when R34 sustained a fall and was sent to the hospital. CNA-N stated he remembers LPN-V was administering medications to the resident in the room across the hall from R34, when LPN-V saw R34 on the floor. CNA-N stated LPN-V called him over to assist with R34. CNA-N stated R34 wanted to get into bed, but they told her she needed to wait for the paramedics. CNA-N stated R34 insisted, and they lowered the bed all the way to the floor and assisted R34 into bed. Surveyor asked CNA-N how was R34 behaving on his shift prior to the fall. CNA-N stated she was more out of it. Surveyor asked CNA-N what he meant by more out of it. CNA-N stated she was slow getting her words out and more confused. Surveyor asked CNA-N if this behavior was prior to R34 fall and CNA-N stated yes. CNA-N stated he just thought it was an off night for R34. On [DATE] at 3:00 p.m. during the daily exit meeting with NHA-A and Director of Nursing (DON), Surveyor explained the concern with R34's medications not being clarified and not being administered as ordered which was determined to be the root cause to R34's fall with fracture. Surveyor noted R34 was demonstrating increased safety risk behaviors with increased restlessness, anxiety, poor decision making skills, and increased weakness that were not assessed and addressed for R34's safety and R34 received medications incorrectly that increased R34's fall risk without increased supervision or interventions to ensure R34's safety. 2.) R20 was admitted to the facility on [DATE] with diagnoses of cerebral infarction (CVA) with hemiplegia on right dominant side, aphasia, on palliative care. The admission Minimum Data Set (MDS) dated [DATE] documents R20 has severe cognitive impairment and is dependent with transfers, dressing and hygiene. The Care Assessment Area (CAA) dated [DATE] documents R20 has a history of cerebral infarction with aphasia and hemiplegia, hypertension, and pressure ulcers, currently followed by hospice. R20 requires assistance with activities of daily living (ADL), and bed mobility. His impaired mobility put him at risk for falls/injuries related to falls, worsening wounds, incontinence and pain. Staff to anticipate R20's needs due to aphasia as it relates to his communication/understanding limitations. He is followed by hospice services, some decline anticipated, the goal is minimize any decline and keep him comfortable while honoring his wishes and plan of care. Care plan will be reviewed in order to manage risks. R20's at risk for falls care plan dated [DATE] documents the following intervention dated [DATE] fall: 30 minute safety checks, fall mat beside bed and medications as ordered. On [DATE] the following interventions: bed in low position, encourage to transfer and change positions slowly with assist of 2 and mechanical lift, have commonly used articles within easy reach, put in Broda chair when up, reinforce need to call for assistance, report development of pain, bruises, change in mental status, activities of daily living (ADL) function, appetite, or neurological status post fall. A general note dated [DATE] at 10:00 a.m. documented writer was coming down D hall, after giving a (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	patient medications. As (sic) approached the nurses station writer heard a thump and then the other nurse dashed around the nurses station. Writer went too and patient was noted to be face down on the ground in front of wheelchair. Patient's right arm was under him and patient moving left arm around. patient trying to roll self over. Patient moaning and calling out. Patient unable to answer staffs' questions about pain or injury. Patient not following staff direction. Writer placed Hoyer sling over patients back in case of need to get off the floor and avoid further rolling. Staff rolled patient onto back. Patient noted with blood to right side of face and left arm. Patients right side flaccid from previous medical condition. No injury noted to left arm or leg. ROM within normal limits. Patient anxious and reaching out to corner of nurses' station and then rolling onto side. Patient grabbing at staff to try and use as leverage to move. Due to patients' location on floor by nurses' station and patients exiting the dining room, risk of injury outweighed the benefit of keeping patient on the floor till rescue arrived. Staff trying to keep patient in one place but then scotting with left foot. Patient trying to keep patient calm and stay still. Writer cleansed blood off left arm and right side of face, patient noted with laceration to right side of face. Patient with repetitive calling out but with no specific request. Patient was assisted up to wc (wheelchair) with Hoyer and sitting with staff at nurses station waiting for rescue. The [DATE] Interdisciplinary team (IDT) note documents R20 demonstrated physical restlessness and frequently attempts to sit up in his chair or bed, requiring frequent reminders and redirection for safety. The note also documented R20 returned from the hospital with an open fracture of right zygomatic arch (cheekbone). The note documented the probable root cause of the fall was determined to be R20 leading forward in his wheelchair, resulting in the fall. IDT determined a safer and more appropriate wheelchair for R20 would be a Broda chair. On [DATE] at 8:44 a.m. Surveyor observed R20 in bed with a large mattress on the floor besides the bed. On [DATE] at 10:04 a.m. Surveyor interviewed Nursing Home Administrator (NHA)-A. Surveyor asked NHA-A if there was anything in place regarding supervision upon admission because R20 is aphasic and post CVA. NHA-A stated R20 was jittery like he is now, and nursing staff had R20 sitting by the nurse's station. Surveyor asked NHA-A if any nurses were nearby and she stated the nurses were on the floor passing medications or had their back to R20 at the time R20 fell. NHA-A stated they realized R20's wheelchair was not appropriate for him so he was placed in a Broda chair. Review of R20's fall history indicated R20 continued to experience repeated falls (9), most often from bed, following the [DATE] fall. Review of the fall investigations indicated many of R20's falls were related to attempts for R20 to go to the bathroom. The facility failed to assess and address R20's need for supervision related to their safety and impulse concerns. R20's fall was an avoidable fall that resulted in a major injury as facility staff were aware of R20's jittery, restless behavior and need for increased supervision and staff failed to implement increased supervision at the time for R20's [DATE] fall. 3.) R32 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease and dysphagia. The quarterly Minimum Data Set (MDS) dated [DATE] documents R32 has severe cognitive impairments, needs set up for eating and is dependent for dressing, hygiene and transfers. On [DATE] 12:41 p.m. Surveyor observed R32 in the dining room eating lunch and drinking from a (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	sippy cup with a straw in the cup. Surveyor observed R32 drink from the straw. A physician order dated [DATE] documents R32's diet as mechanical soft diet with thin liquids and no straws. The nutritional care plan dated [DATE] documents adaptive equipment: 2 handled cup, no straw. On [DATE] at 10:01 a.m. Surveyor observed R32 in the dining room eating breakfast. Surveyor observed Dietary Aide-NN pour chocolate milk in a double handled sippy cup and placed a straw in the cup. Surveyor observed R32 drink using the straw and cough. On [DATE] at 10:03 a.m. Surveyor interviewed Dietary Aide-NN. Surveyor asked Dietary Aide-NN if R32 normally has a straw in the cup. Dietary Aide-NN stated yes, R32 does use straws. Surveyor asked to see R32's dietary slip. Dietary Aide-NN gave Surveyor R32's dietary slip which documented R32 may have straws to drink with. On [DATE] at 3:00 p.m. during the daily exit meeting with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B, Surveyor explained the concern that R32 was observed to be drinking from a straw during meals and the dietary slip documented R32 can use straws. Surveyor explained that R32's physician orders and care plan indicated R32 is not to have straws. On [DATE] at 8:55 a.m. DON-B explained to Surveyor they investigated the straw concern related to R32. DON-B stated apparently something went wrong with the kitchen electronic system and the use of a straw was not removed from the system. DON-B stated it has now been fixed. 4.) R24 was admitted to the facility on [DATE] with diagnoses that included Type 2 Diabetes Mellitus (adult onset of trouble controlling blood sugar), Anxiety Disorder (mental health disorder characterized by feelings of worry, fear that interfere with daily activities), and Depression (mood disorder that causes persistent feelings of sadness and loss of interest). R24's Annual Minimum Data Set (MDS) dated [DATE], indicated that R24's Brief Interview for Mental Status (BIMS) score was 15, indicating R24 was cognitively intact for daily decision-making skills. R24's Patient Health Questionnaire (PHQ-9) score is 1 however, the mood section of R24's MDS assessed R24 felt down, depressed, having little interest or pleasure for 2-6 days of the assessment period. R24 had no documented behaviors. R24's MDS also documented R24 had a range of motion (ROM) impairment on one side of lower extremity. R24 required supervision for upper/lower dressing and partial/moderate assistance for showers. R24 is independent for mobility and transfers and was always incontinent of bladder and occasionally incontinent of bowel. *Falls R24's hospital history and physical dated [DATE] documented R24 had difficulty with transfers and bed mobility. R24 had impaired safety, will work on R24's safety and fall prevention. R24's admission fall assessment completed dated [DATE] was disabled in the electronic medical record (EMR) and not completed. R24's fall assessment dated [DATE] had a score of 12.0 which indicated R24 was at moderate risk for falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R24's certified nursing assistant (CNA) instructions for caring for R24 documented: Safety: *Attempt to keep frequently used items within easy reach *Bright green tape on each side of door frame of bathroom and entrance to decrease risk of injury due to vision impairment *Dycem placed in wheelchair *Education to resident that staff are to provide assistance with bed making after getting up for the day *Encourage resident to sleep in bed *Environmental modification-room change per residents request *Frequent verbal reminders to use call light for assistance and wear gripper socks *Gripper strips placed on the bathroom floor in front of the toilet *Motion-activated night lights to be installed in residents room to assist with visual orientation *Ortho shoe to be worn to right foot when out of bed *Reinforce wheelchair safety as needed such as locking brakes *Resident will be closely monitored in the activity room to ensure they remain in a safe location due to impaired eyesight and vision R24's care plan for falls initiated [DATE] documented R24 was at risk for falls due to history of falls, impaired balance/poor condition, potential medication side effects, unsteady gait. Interventions initiated [DATE]: - Be sure call light is within reach and encourage to use it for assistance as needed - Environment free of clutter - Physical therapy evaluate and treat as ordered or as needed - Remind and ensure resident(R24) is wearing appropriate footwear when ambulating/ transferring as needed, gripper socks Surveyor reviewed R24's 9 Fall Investigations. The investigations documented: (1.) [DATE] Unwitnessed Fall at 11:30 AM. R24 was observed on floor in sitting position with wheelchair on side. No injury noted, was making bed, and fell back onto butt. No staff statements were obtained to describe R24 at the time of the fall and care provided prior to the fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Care plan interventions implemented on [DATE]: - Dycem placed in wheelchair - Education to resident (R24) that staff are to provide assistance with bed making after getting up for the day (2.) On [DATE], Former Director of Nursing (FDON)-JJ documented in R24's electronic EMR that R24 had dropped a marker and stated R24 slipped off R24's wheelchair cushion when bending over to pick up. Surveyor noted the facility did not provide a facility investigation of the fall. (3.) [DATE] Unwitnessed fall at 12:00 PM. R24 was found in private bathroom sitting on buttock between toilet and sink. Facing doorway, was getting off toilet lost balance and fell, hit shoulder on sink. No staff statements were obtained to describe R24 at the time of the fall and care provided prior to the fall. Care plan intervention implemented on [DATE]: - Raised toilet seat in place of the over the toilet commode for more stability (4). [DATE] Unwitnessed fall at 10:05 PM. R24 was found on floor next to bed sitting in front of wheelchair, legs in front of R24, wheelchair locked and angled to bed, R24 had socks on and legs slipped, overbed light on in room, trying to get back in bed. The one staff statement obtained did not describe R24 at the time of the fall and care provided prior to the fall. The investigation did not indicate if the bed was locked and what kind of socks R24 was wearing at the time of the fall. Care plan intervention implemented on [DATE]: - Frequent verbal reminders to use call light for assistance and wear gripper socks (5.) [DATE] Unwitnessed fall at 11:15 PM. R24 was found lying on left side in front of recliner with pillow under head, had regular slippers on, landed on butt. R24 self-transferred from wheelchair to recliner. The two staff statements obtained did not describe R24 at the time of the fall and care provided prior to the fall. Care plan intervention implemented on [DATE]: - Therapy acclamation to new room for safety awareness - Therapy to screen for recliner safety and appropriate use Surveyor noted that R24 did not transfer rooms. (6.) [DATE] Unwitnessed fall at 5:00 AM. R24 found on floor sitting next to bed, leaning on bed, gripper socks on, slipped off bed, was trying to go to bathroom. The one staff statement obtained did not describe R24 at the time of the fall and care provided prior to the fall. Documentation located in R24's EMR noted that the intervention was to adjust prompted toileting assistance between 4-5AM. Surveyor noted that R24's care plan does not document that an intervention was implemented for toileting at this time. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	(7.) [DATE] Unwitnessed fall at 7:30 AM. R24 was observed laying on the floor in R24's room. It was determined the brakes were not working on R24's wheelchair. No staff statements were obtained to describe R24 at the time of the fall and care provided prior to the fall. R24 stated that R24 had attempted to get to the bathroom. Surveyor noted that no care plan intervention were reviewed and/or revised at this time. (8.) [DATE] Unwitnessed fall at 8:10 AM. R24 told writer that R24 fell from recliner in the middle of the night when R24 got up to use the bathroom and got dizzy and fell to floor on R24's bottom from recliner and did not tell anyone at the time of instance. No staff statements were obtained to describe R24 at the time of the fall and care provided prior to the fall. Surveyor noted that no care plan intervention was added to R24's fall or toileting care plan regarding toileting. Care plan intervention implemented on [DATE]: -Staff to offer assistance to transfer resident (R24) to recliner or bed around HS (bedtime) (9.) [DATE] Unwitnessed fall at 7:00 AM. CNA found R24 sitting on the bathroom floor. Found sitting in front of toilet. Was trying to transfer from toilet to wheelchair when R24 slid down from toilet and slid to floor. No staff statements were obtained to describe R24 at the time of the fall and care provided prior to the fall. R24 informed staff that R24's last 2 toes on R24 right foot were hurting but refused an x-ray. Care plan intervention implemented on [DATE]: -Gripper strips placed on the bathroom floor in front of the toilet On [DATE] it is documented that R24 went to a follow-up orthopedic appointment related to an old closed fracture. During the appointment a follow-up x-ray was performed showing a nondisplaced fracture of proximal phalanx of right lesser toe(s), initial encounter for closed fracture. Comments showed 4th and 5th toes. On [DATE], (R24) sustained a fall and per nursing assessment. (R24) complained that (R24's) last two toes on (R24's) right foot were hurting after the fall (no noticeable injuries, redness,or swelling noted). (R24) refused to go to the ED (emergency department). Nurse Practitioner aware and agrees that 4th and 5th toe fracture occurred during fall. (10.) [DATE] Unwitnessed fall at 10:30 PM. R24 called using call button, CNA went in room and found R24 sitting on R24's buttocks between recliner and wheelchair stating R24 needed to go to bathroom. Both staff statements documented that neither CNA provided cares to R24 and did not observe R24. Care plan intervention implemented on [DATE]: -Intervention for staff to toilet between shift change around 9:00 PM and 11:00 PM On [DATE], at 10:41 AM, Surveyor discussed each of R24's 10 falls with Nursing Home Administrator (NHA)-A. NHA-A had informed Surveyor that NHA-A would be the best person to discuss R24's falls as multiple staff are no longer working at the facility. NHA-A understood the following concerns that Surveyor shared about R24's falls.- The facility did not complete a thorough investigation of R24's [DATE] fall.- There is no investigation of R24 slipping from wheelchair to pick up a marker. NHA-A recalls the fall and stated Dycem was added to the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	wheelchair.- The facility did not complete a thorough investigation of R24's [DATE] fall.- The facility did not complete a thorough investigation of R24's [DATE] fall. Surveyor further shared that the intervention to use the call light and wear gripper socks should have already been used as they were recommended on [DATE].- The facility did not complete a thorough investigation of R24's [DATE] fall.- The facility did not complete a thorough investigation of R24's [DATE] fall. NHA-A agreed that R24's toileting plan was not documented on R24's care plan for falls.-The facility did not complete a thorough investigation of R24's [DATE] fall. Surveyor discussed that R24 was attempting to get to the bathroom.-The facility did not complete a thorough investigation of R24's [DATE] fall. Surveyor discussed that R24 was attempting to get to the bathroom.-The facility did not complete a thorough investigation of R24's [DATE] fall. Surveyor discussed that R24 was toileting self at the time of the fall.Surveyor discussed with NHA-A that R24 sustained right 4th and 5th nondisplaced fractures of proximal phalanx which is a concern. NHA-A understood the concerns.- The facility did not complete a thorough investigation of R24's [DATE] fall. Surveyor discussed that R24 was attempting to get to the bathroom. NHA-A agreed that several of R24's falls were related to R24 attempting to get to the bathroom and the pattern was mostly attempts to self-toilet that occurred on nights or at bedtime. Surveyor discussed that R24 was a fall risk based on documentation from R24's admission hospital record. Surveyor discussed with NHA-A and Director of Nursing (DON)-B the concern that R24's fall investigations were not thorough. Staff statements were either not obtained or staff statements were not detailed to indicate what R24 was doing prior to the fall including last time observed or cared for by staff. DON-B informed Surveyor that DON-B was doing a revamp of education with staff focusing on completing a thorough investigations when a resident falls. DON-B stated the expectation is that staff statements should always be obtained. DON-B stated DON-B initiated completing risk management packets about 2 weeks ago. *Suicidal Ideation On [DATE], at 2:20 PM in R24's EMR the following was documented: .Writer heard resident (R24) talking about wanting to schedule a doctors appointment. Writer approached resident (R24) and asked what doctors appointment she (R24) was trying to schedule and if she (R24) would like the facility to assist in scheduling that for her (R24). Resident (R24) became agitated and stated, (I want to see) a doctor that will give me a gun so I can shoot myself in the head. Resident (R24) was in the presence of another staff member when this comment was made and the writer went to get social worker for immediate follow up and intervention. On [DATE], at 4:43 PM, Social Service Coordinator (SSC)-D documented: .Approximately at 10:45 AM, SSC-D followed up with resident (R24) after DON updated her on what had happened. Resident (R24) stated she (R24) did tell the nurse that she (R24) was looking to set up an appointment with her PCP (primary care physician) and that she (R24) said something she (R24) should not have said. Surveyor noted that based on SSC-D documentation the incident occurred prior to 10:45 AM. There was no documentation in R24's EMR that R24's physician was notified of the incident. There was no documentation that measures were implemented to maintain R24's safety during the time of the incident. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On [DATE], at 1:13 PM, Surveyor interviewed SSC-D regarding R24's suicidal ideation on [DATE]. SSC-D stated that R24 was tired of going through things, frustrated with not being able to see. SSC-D is aware of R24's depression and definitely can tell R24 is depressed. SSC-D confirmed that the facility did not initiate any measures to maintain R24's safety during the time of R24's suicidal ideation. Surveyor shared with SSC-D that there was no documentation R24 was further assessed following the statement regarding wanting to get a gun and shoot themselves, increased supervision of R24 or development of a care plan to ensure R24's safety. On [DATE], Psychologist (Psych PhD)-S evaluated R24 for suicidal ideation at 9:05 PM. Psych PhD-S documented that (R24) denied current suicidal ideation. However, was making statements of not wanting to wake up, which represents passive suicidal ideation requiring careful assessments. (R24) stated that someone had given (R24) a gun, however, (R24) could not be more specific with regard to that claim, raising additional safety concerns. Previously spoke of (R24's) future funeral but had historically denied explicit suicidal ideation with no intent or plan. Immediate risk required ongoing monitoring with continued boundary setting and close observation given passive suicidal statements and gun-related concerns. Staff to monitor closely for any escalation of suicidal ideation or behavioral changes given passive statements made during today's visit. Facility to maintain safe environment with continued close supervision. Surveyor noted the facility did not implement any interventions with close supervision of R24 due to R24's expression of suicidal ideation including not implementing Psych PhD-S's recommendations. On [DATE], at 3:01 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A and Director of Nursing (DON-B) that a care plan with interventions had not been implemented for R24's suicidal ideation. Surveyor shared that Psych PhD-S recommended that the facility maintain a safe environment with continued close supervision for R24. There was no documentation that the facility implemented safety measures for R24. The facility provided no additional information as to why the facility did not implement safety measures due to R24's suicidal ideation and did not initiate a care plan with interventions.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and interview, the facility did not ensure that food was prepared, distributed, and served in accordance with professional standards for food service safety (Wisconsin Food Code) in the main kitchen. This deficient practice has the potential to affect all 33 residents who receive food from the main kitchen. *Three opened cardboard boxes containing cookie dough, turkey breast, and orange juice were observed resting directly on the floor in the walk-in freezer in the main kitchen. Findings include:The Wisconsin Food Code documents to prevent contamination from the premises, food shall be protected from contamination by storing the food in a clean, dry location, where it is not exposed to splash, dust, or other contamination; and at least 6 inches above the floor. On 5/19/26 at 8:09 AM, Surveyor conducted an initial tour of the facility's main kitchen. Surveyor observed three opened cardboard boxes resting directly on the floor of the walk-in freezer. One cardboard box contained cookie dough, one cardboard box contained turkey breast, and one cardboard box contained containers of orange juice. Surveyor interviewed Dietary Manager (DM)-J, who stated the facility follows Wisconsin Food Code for safe food practices. In an interview on 5/20/26 at 12:59 PM, DM-J stated DM-J was not sure why there were opened boxes resting directly on the floor in the freezer on 5/19/26, but they have since been removed from the floor. DM-J stated the box of orange juice was to be returned to the supplier since it was the wrong type of juice, but DM-J did not know why the other 2 boxes were on the floor. On 5/20/26 at 3:24 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B that three opened cardboard boxes were observed resting directly on the floor in the walk-in freezer in the main kitchen, leaving the potential for contamination exposure. No additional information was provided.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and record review, the facility did not implement policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring to develop activities to prevent adverse events potentially affecting 33 of 33 residents in the facility. The facility did not develop written documentation of performance improvement activities to facilitate the identification of facility-wide problems, devise plans to address the identified issues, and have a system to monitor the effectiveness of those plans and revise as needed. Findings include: The facility policy and procedure titled Quality Assurance Performance Improvement (QAPI) dated 7/11/2022 documents: QAPI (Quality Assurance Performance Improvement) is the coordinated application of two mutually reinforcing aspects of a quality management system: Quality Assurance (QA) and Performance Improvement (PI). QAPI takes a systematic, comprehensive, and data-driven approach to maintaining and improving safety and quality in nursing homes while involving residents, families, and all nursing home caregivers in practical and creative problem-solving. -QA Is the specification of standards for quality of care, service and outcomes, and systems throughout the facility for assuring that care is maintained at acceptable levels in relation to those standards. QA is ongoing, both anticipatory and retrospective in its efforts to identify how the organization is performing, including where and why facility performance is at risk or has failed to meet standards.-PI (also called quality improvement or QI) is the continuous study and improvement of processes with the intent to improve services or outcomes and prevent or decrease the likelihood of problems, by identifying opportunities for improvement and testing new approaches to fix underlying causes of persistent/systemic problems or barriers to improvement. PI in nursing homes aims to improve facility processes involved in care delivery and enhanced resident quality of life. PI can make good quality even better.QAPI represents an ongoing, organized method of doing business to achieve optimum results, involving all levels of an organization. QAPI is a data-driven, proactive approach to improving the quality of life, care, and services in nursing homes. The activities of QAPI involve members at all levels of the organization to identify opportunities for improvement, address gaps in systems or processes, develop and implement an improvement or corrective plan, and continuously monitor effectiveness of interventions. A Performance Improvement Project (PIP) typically is the concentrated effort on a particular problem in one area of the center or center wide; it involves gathering information systematically to clarify issues or problems using root cause analysis and intervening for improvements. PIPs are selected in areas important and meaningful for this specific type and scope of services unique to each center. An action plan is a document that is used to clarify resources required to reach a goal, list steps to be taken to achieve a goal and formulate a timeline for when tasks are to be complete. Task-oriented/action plan teams may be specially formed to investigate a particular problem and their work may be limited and focused. Action plans are typically created for isolated incidents such as survey citations. PIP teams are formed to investigate and resolve systemic problems using an interdisciplinary/inter-departmental approach for longer-term work on an issue.Element 1 Design and Scope . The QAPI program at our center and in our organization encompasses all systems of care and management practices including services provided for post-acute care and long-term care. The QAPI committee consists of representatives from all departments including nursing, dietary, life enrichment, social services, environmental services, maintenance, therapy, human resources, business office and administration. Our center utilizes the best available evidence to define and measure indicators of clinical care, quality of life and resident choice. Performance Improvement Projects (PIPs) will be implemented when an opportunity for improvement is identified through probable root case [sic] analysis processes. PIPs will be ongoing and will be revised as new data emerges. PIPs may apply to processes or systems at all levels of our organization.Element 2 Governance and Leadership - The Executive Director and the Director of (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Nursing (DON) are responsible and accountable for the development, implementation, monitoring and leadership of the center's QAPI program. A core team of individuals will be appointed to spearhead the QAPI program and will engage in monthly QAPI meetings which will include the creation/modification of performance improvement plans (PIPs).Element 3 Feedback, Data Systems and Monitoring . Data may be collected and reviewed weekly, monthly, or quarterly depending on frequency of data updates from each source. The Executive Director or designee oversees the maintenance of the QAPI Plan, the QAPI monthly reports, QAPI minutes of all meetings and the center's PIP Inventory form.Element 4 Performance Improvement Projects (PIPs) . Our center may utilize a Prioritization Worksheet for Performance Improvement Projects to organize, prioritize and plan the PIPs. Our center's services and resources will be considered when determining how many PIPs to support at one time. A minimum of one PIP and a maximum of four PIPs may occur simultaneously. The PIP Team will be designed by the QAPI Steering Committee and will establish the goals, scope, timing, and team roles for each PIP. The team will utilize root cause analysis to identify the cause of the problem and any contributing factors. The PIP team will develop an action plan with identified problem statement, causes, goals, interventions, staff responsible and due dates. In an interview on 5/26/2026 at 11:18 AM, Surveyor asked Nursing Home Administrator (NHA)-A what their process for QAPI was. NHA-A stated the department heads meet monthly and the Medical Director attends at least quarterly but may not be at every monthly meeting. Surveyor asked NHA-A how they become aware of areas that need improvement. NHA-A stated staff will bring forward suggestions for improvement as well as residents and visitors. Surveyor asked NHA-A if there were currently any PIPs they were working on. NHA-A stated they did not have any PIPs at that time. Surveyor asked NHA-A if there were any PIPs that were completed recently. NHA-A stated their PIPs were not a formal process and did not have anything in writing but have been looking at changing some processes such as immunizations being included in the admission packet. NHA-A stated a while back they looked at wound management but not recently. Surveyor shared with NHA-A the survey team had identified multiple areas of concern with immediate jeopardy being cited for pressure injuries and significant medication errors along with harm level citations for quality of care and accidents and QAPI had not identified the concerns. NHA-A did not have any further information at that time.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on interview and record review the facility did not ensure 8 of 8 direct & non-direct staff chosen at random received behavioral health training.Licensed Practical Nurse (LPN)-OO, Housekeeper-PP, Cook-QQ, Certified Nursing Assistant (CNA)-RR, CNA-SS, CNA-TT, CNA-MM, and CNA-UU did not receive behavioral health training.Findings include:On 6/3/26, at 9:30 a.m., Surveyor requested training for CNA-RR, CNA-SS, CNA-TT, CNA-MM, & CNA-UU.On 6/3/26, at 10:19 a.m., Surveyor requested training for LPN-OO, Housekeeper-PP and Cook-QQOn 6/3/26, at 11:30 a.m., Surveyor reviewed LPN-OO's training. LPN-OO has a hire date of 10/13/23. Surveyor noted LPN-OO has received required training for communication; residents rights & facility's responsibility; abuse, neglect, exploitation; infection control; QAPI (quality assurance performance improvement); and compliance & ethics. Surveyor was unable to locate behavioral health training for LPN-OO.On 6/3/26, at 11:40 a.m., Surveyor reviewed Houskeeper-PP's training. Housekeeper-PP has a hire date of 3/28/25. Surveyor noted Housekeeper-PP received required training for resident rights & responsibility; abuse, neglect, exploitation; infection control, and compliance & ethics. Surveyor was unable to locate behavioral health training for Housekeeper-PP.On 6/3/26, at 11:44 a.m., Surveyor reviewed Cook-QQ's training. Cook-QQ has a hire date of 4/27/21. Surveyor noted that Cook-QQ received required training for resident rights & responsibility; abuse, neglect, exploitation; infection control, and compliance & ethics. Surveyor was unable to locate behavioral health training for Cook-QQ.On 6/3/26, at 12:00 p.m., Surveyor reviewed CNA-RR's training. CNA-RR has a hire date of 1/28/25. Surveyor noted CNA-RR has received required training for communication; residents rights & facility's responsibility; abuse, neglect, exploitation; dementia; infection control; QAPI; and compliance & ethics. Surveyor was unable to locate behavioral health training for CNA-RR.On 6/3/26, at 12:10 p.m., Surveyor reviewed CNA-SS's training. CNA-SS has a hire date of 3/11/25. Surveyor noted CNA-SS has received required training for communication; residents rights & facility's responsibility; abuse, neglect, exploitation; dementia; infection control; QAPI; and compliance & ethics. Surveyor was unable to locate behavioral health training for CNA-SS.On 6/3/26, at 12:20 p.m., Surveyor reviewed CNA-TT's training. CNA-TT has a hire date of 5/26/20. Surveyor noted CNA-TT has received required training for communication; residents rights & facility's responsibility; abuse, neglect, exploitation; dementia; infection control; QAPI; and compliance & ethics. Surveyor was unable to locate behavioral health training for CNA-TT.On 6/3/26, at 12:30 p.m., Surveyor reviewed CNA-MM's training. CNA-MM has a hire date of 4/17/24. Surveyor noted CNA-MM has received required training for communication; residents rights & facility's responsibility; abuse, neglect, exploitation; dementia; infection control; QAPI; and compliance & ethics. Surveyor was unable to locate behavioral health training for CNA-MM.On 6/3/26, at 12:40 p.m., Surveyor reviewed CNA-UU's training. CNA-UU has a hire date of 5/13/25. Surveyor noted CNA-UU has received required training for communication; residents rights & facility's responsibility; abuse, neglect, exploitation; dementia; infection control; QAPI; and compliance & ethics. Surveyor was unable to locate behavioral health training for CNA-UU.On 6/3/26, at 1:27 p.m., Surveyor met with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B and Senior VP (Vice President) of Clinical Compliance & Quality-VV. Surveyor asked facility staff to explain the process for providing training to staff. DON-B informed Surveyor she is on the floor a lot, does staff training and is more hands on. They use [name of training system] which their staff is pretty good at completing. Surveyor inquired how in-services are assigned. NHA-A informed Surveyor in-services are assigned monthly and if needed there are additional training assigned. Surveyor inquired about who is responsible for in-servicing non nursing staff. NHA-A informed Surveyor she does one on one or shift to shift with other departments along with the department heads. Senior VP of Clinical Compliance & Quality-VV informed Surveyor employee training plan is through their support center which is from their compliance department for (continued on next page)

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	required training. Surveyor informed facility staff Surveyor was unable to locate behavioral health training for LPN-OO, Housekeeper-PP, Cook-QQ, CNA-RR, CNA-SS, CNA-TT, CNA-MM, and CNA-UU.On 6/3/26, at 1:52 p.m., Surveyor asked NHA-A for the facility's training policy.On 6/3/26, at 2:07 p.m., NHA-A informed Surveyor they do not have a policy.Surveyor was not provided with behavioral health training for LPN-OO, Housekeeper-PP, Cook-QQ, CNA-RR, CNA-SS, CNA-TT, CNA-MM, and CNA-UU.

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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 interview and record review, the facility did not ensure implementation of their policies and procedures to prevent abuse. The facility failed to ensure the criminal background checks were completed prior to employment for 4 of 8 employees reviewed potentially affecting a pattern of the 33 facility residents at the time of the survey. *Registered Nurse (RN)-K was hired on 12/1/2019 and the criminal background check was completed 3/2018, 21 months prior to the hire date and not just prior to employment. A second criminal background check was completed 3/2025, 5 years after the hire date. *Life Enrichment (LE)-L was hired on 8/24/2023 and the criminal background check was completed 1/2024, 4 months after the hire date, and the out-of-state background check was completed 11/2024, 15 months after the hire date. *Certified Nursing Assistant (CNA)-M was hired on 3/14/2024 and the criminal background check was completed 6/2024 and 7/2025, 3-4 months after the hire date. *CNA-N was hired on 7/16/2024 and the criminal background check was completed 10/2025, 15 months after the hire date. Findings include: The facility policy and procedure titled Abuse, Neglect and Exploitation dated 7/15/2022 documents: 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. Background checks, including re-checks, will be completed consistent with applicable state laws and regulation. Responsibility of performance of compliance checks on contracted temporary staff will be established via contractual agreement. 2. Screenings may be conducted by the facility itself, third-party agency or academic institution. 3. The facility will maintain documentation of proof that the screening occurred. On 5/19/2026 at 11:10 AM, Surveyor requested the criminal background checks consisting of the Background Information Disclosure (BID), Department of Justice (DOJ) letter, and the Integrated Background Information System (IBIS) for eight employees. 1.) RN-K was hired on 12/1/2019. The facility provided a BID dated 3/23/2025, a DOJ letter dated 3/24/2025, and an IBIS dated 3/24/2025. All forms were five years and three months after the date of hire. Surveyor requested the background checks that were completed prior to RN-K's hire date. The facility provided RN-K's BID dated 3/23/2018, the DOJ letter dated 3/28/2018, and the IBIS dated 3/28/2018. These forms were completed 21 months before RN-K was hired. The facility was not able to provide any background forms when RN-K was hired or within the required 4 years following the first background check. In an interview on 5/21/2026 at 9:42 AM, Surveyor shared with Nursing Home Administrator (NHA)-A the concern RN-K did not have a background check completed prior to starting employment other than the forms dated 21 months before RN-K started working for the facility. NHA-A stated NHA-A saw the dates when they were provided to Surveyor and was able to find the receipt dated 2019 for the required background checks but was not able to produce the actual documents. NHA-A had no idea why the background check was completed 21 months before the hire date. NHA-A stated NHA-A started working for the facility on 6/2024 and discovered background checks were not being done for new employees prior to NHA-A being employed at the facility so NHA-A started getting the background checks for new employees as well as those employees that were hired with no background checks completed. NHA-A stated not having the background checks completed timely was a problem and agreed with Surveyor's concerns. 2.) LE-L was hired on 8/24/2023. The facility provided a BID dated 1/29/2025, a DOJ letter dated 1/30/2025, and an IBIS dated 1/30/2025. All forms were one year and five months after the date of hire. Surveyor requested the background checks that were completed prior to LE-L's hire date as well as a background check for another state that LE-L had resided in within the last 3 years. The facility provided LE-L's BID dated 8/22/2023, the DOJ letter dated 1/4/2024, and the IBIS dated 1/4/2024. The DOJ letter and the IBIS were completed 4 months after LE-L was hired. The facility provided LE-L's out of state background check dated 11/2024, 15 months after the hire date. The facility was not able to provide a DOJ letter or IBIS (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	form when LE-L was hired. In an interview on 5/21/2026 at 9:42 AM, Surveyor shared with Nursing Home Administrator (NHA)-A the concern LE-L did not have a DOJ letter or IBIS form before LE-L was hired. NHA-A stated NHA-A started working for the facility on 6/2024 and discovered background checks were not being done for new employees prior to NHA-A being employed at the facility so NHA-A started getting the background checks for new employees as well as those employees that were hired with no background checks completed. NHA-A stated not having the background checks completed timely was a problem and agreed with Surveyor's concerns. 3.) CNA-M was hired on 3/14/2024. The facility provided DOJ letters dated 6/10/2024 and 7/17/2025 and an IBIS dated 7/17/2025, 3-4 months after CNA-M was hired. Surveyor requested the background checks that were completed prior to CNA-M's hire date. The facility was not able to provide a DOJ letter, IBIS form, or out of state background check when CNA-M was hired. In an interview on 5/21/2026 at 9:42 AM, Surveyor shared with Nursing Home Administrator (NHA)-A the concern CNA-M did not have a DOJ letter or IBIS form before CNA-M was hired. NHA-A stated NHA-A started working for the facility on 6/2024 and discovered background checks were not being done for new employees prior to NHA-A being employed at the facility so NHA-A started getting the background checks for new employees as well as those employees that were hired with no background checks completed. NHA-A stated not having the background checks completed timely was a problem and agreed with Surveyor's concerns. 4.) CNA-N was hired on 7/16/2024. The facility provided a DOJ letter dated 10/27/2025 and an IBIS dated 10/27/2025. The forms were completed 15 months after the date of hire. Surveyor requested the background checks that were completed prior to CNA-N's hire date. The facility was not able to provide a DOJ letter or IBIS form when CNA-N was hired. In an interview on 5/21/2026 at 9:42 AM, Surveyor shared with Nursing Home Administrator (NHA)-A the concern CNA-N did not have a DOJ letter or IBIS form before CNA-N was hired. NHA-A stated NHA-A started working for the facility on 6/2024 and discovered background checks were not being done for new employees prior to NHA-A being employed at the facility so NHA-A started getting the background checks for new employees as well as those employees that were hired with no background checks completed. NHA-A stated not having the background checks completed timely was a problem and agreed with Surveyor's concerns.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on observation, interview, and record review, the facility did not ensure licensed nurses had competencies and skill sets necessary to care for diabetic residents requiring insulin was identified with 1 (R30) of 4 sampled residents. *R30 was administered insulin from an insulin pen. Registered Nurse (RN)-P did not administer the insulin as instructed by the manufacturer or to professional standards. Findings include: The Facility Assessment, last reviewed on 4/27/2026, documents: Prospective Admissions:-When a prospective resident has a diagnosis or condition not recently or previously managed by the facility, a comprehensive evaluation will be conducted.-The facility will educate staff on the new condition and validate that their competencies align with the necessary care requirements.-Training will be provided to ensure staff can effectively manage the conditions within their licensed scope of practice.Current Residents:-If a current resident presents with a new diagnosis or condition that the facility has not recently or previously supported, the same process of staff education and competency validation will apply.-The facility will promptly educate the relevant staff and validate their competencies. 1.)The facility policy and procedure titled Medication Administration Subcutaneous Insulin dated 1/2023 documents: . PROCEDURES . 9. Prepare injection. a. Determine correct amount of insulin to be withdrawn. b. Prepare syringe/pen and safety needle. (See pen example) c. Swab rubber cap of vial with antimicrobial agent. Line up the needle with the pen, and keep it straight as you attach it (screw or push on, depending on the needle type). If the needle is not kept straight while you attach it, it can damage the rubber seal and cause leakage, or break the needle. Always perform the safety test before each injection. Performing the safety test ensures that you get an accurate dose by: ensuring that pen and needle work properly; removing air bubbles. A. Select the dose of units by turning the dosage selector. You can set the dose in steps of 1 unit, from a minimum of 1 unit to maximum of 80 units. If you need a dose greater than 80 units, you should give it as two or more injections. A. Check that the dose window shows 0 following the safety test. B. Select your required dose (in the example below, the selected dose is 30 units). If you turn past your dose, you can turn back down. C. Take off the outer needle cap and keep it to remove the used needle after injection. Take off the inner needle cap and discard it. D. Hold the pen with the needle pointing upwards. E. Tap the insulin reservoir so that any air bubbles rise up towards the needle. F. Press the injection button all the way in. Check if insulin comes out of the needle tip. You may have to perform the safety test several times before insulin is seen.-If no insulin comes out, check for air bubbles and repeat the safety test two more times to remove them.-I still no insulin comes out, the needle may be blocked. Change the needle and try again.-If no insulin comes out after changing the needle, the pen may be damaged. Do not use this pen.-Do not push the injection button while turning, as insulin will come out.-You cannot turn the dosage selector past the number of units left in the pen. Do not force the dosage selector to turn.A. Insert the needle into the skin at a 90 degree angle. B. Deliver the dose by pressing the injection button in all the way. The number in the dose window will return to 0 as you inject. C. Keep the injection button pressed all the way in. Slowly count to 10 before you withdraw the needle from the skin. This ensures that the full dose will be delivered. On 5/20/2026 at 12:20 PM, Surveyor observed Registered Nurse (RN)-P prepare to give R30 12 units of Humalog insulin from a Kwik insulin pen. RN-P screwed the needle onto the pen; RN-P did not clean off the rubber seal with an alcohol pad prior to putting the needle on. RN-P dialed up 12 units on the pen and was prepared to enter R30's room. Surveyor asked RN-P if RN-P was going to prime the insulin pen. RN-P did not know what Surveyor meant. Surveyor described to RN-P the process of making sure insulin was in the needle prior to injecting R30: dial 2 units on the insulin pen and then expel that amount watching the end of the needle to make sure there was no air left in the needle. RN-P stated they had never heard of priming an insulin pen before. Surveyor observed RN-P prime the insulin pen. Surveyor observed RN-P inject R30 with the insulin by pressing the plunger and letting go (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of the plunger after the initial press. RN-P held the pen to R30's abdomen for 10 seconds but did not hold the plunger for a count of 10 seconds. Surveyor shared the concern with RN-P that the plunger was not held down for 10 seconds. Surveyor asked RN-P if RN-P had any training on the use of insulin pens. RN-P stated RN-P had worked at the facility for two years and maybe had training using the pens when first hired but could not recall any specific training that was provided. On 5/20/2026 at 3:24 PM, Surveyor shared with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B the concern RN-P did not clean off the rubber seal on the insulin pen prior to putting the needle on, did not prime the insulin pen prior to administration of the insulin until instructed by Surveyor, and did not hold the plunger down for the 10 seconds required to administer the insulin. DON-B stated there will be education provided to nursing staff.

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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, interview, and record review, the facility did not ensure a sanitary environment for 3 (R4, R14, and R28) of 13 sampled residents and potentially affecting any resident eating in the dining room. *R4 was administered oral medications by Registered Nurse (RN)-P. RN-P touched every pill with bare hands before putting them in the medicine cup. *R14 had a dressing change done to a wound by RN-O where hand hygiene was not performed during the treatment and RN-P provided incontinence care to R14 without performing hand hygiene between dirty and clean areas and touched items in R14's room without performing hand hygiene. *R28 was in enhanced barrier precautions and staff did not don gowns prior to performing cares on R28 and no hand hygiene was performed after incontinence care. *An uncovered rack of unclaimed clothing was observed in the dining room throughout the survey. Findings include: 1.)The facility policy and procedure titled Medication Administration Orals dated 1/2023 documents: 7. Pour the correct number of tablets or capsules into the medication cup, taking care to avoid touching any of the medication unless wearing gloves. On 5/20/2026 at 8:43 AM, Surveyor observed RN-P prepare to give R4 their morning medications. RN-P took R4's medication cards and punched each individual medication into RN-P's bare hand and then put the pill into the medication cup. For stock medication, RN-P took off the cap of the pill bottle and poured the pills into RN-P's bare hand and took the ordered dose from the pills in the hand and returned the remaining pills into the pill bottle. Surveyor asked RN-P if RN-P always puts the medications into RN-P's hand before putting the pill into the medication cup. RN-P said yes because a lot of the time the pills bounce out of the cup. On 5/20/2026 at 3:24 PM, Surveyor shared with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B the concern RN-P touched every medication in their bare hands during medication pass. DON-B agreed that the medications should not be touched. 2.) R14 was admitted to the facility on [DATE] with diagnoses of cerebral palsy, deaf and quadriplegia. The quarterly Minimum Data Set (MDS) dated [DATE] documents R14 is cognitively intact and is dependent on staff assistance for all activities of daily living (ADL), transfers and bed mobility; and is also documents R14 is incontinent of bladder and bowel. On 2/20/26, a stage 4 pressure ulcer of the right ischium/buttock care plan was initiated with the following interventions: administer treatments as ordered and monitor for effectiveness, assess/record/monitor wound healing every 7 days. Measure length, width, and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD (Medical Doctor), avoid positioning the resident on right side, follow facility policies/protocols for the prevention/treatment of skin breakdown, monitor dressing to coccyx to ensure it is intact and adhering. Report loose dressing to treatment nurse, monitor (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nutritional status, obtain and monitor lab work. On 5/20/26 at 10:25 a.m., Surveyor observed R14's pressure injury treatment to the right buttock. Registered Nurse (RN)-O performed the treatment while RN-P assisted with holding R14 on her left side. Surveyor observed RN-O prepared the overbed table for supplies by disinfecting it and placing a clean towel on it. RN-O placed the clean supplies still in the wrapper on the towel along with the disinfected scissors. With gloves on RN-O and RN-P repositioned R14 on her left side and RN-O removed the dressing on R14 right buttock. RN-O removed his gloves, and hand sanitized his hands then place clean gloves on to cleanse the wound. RN-O cleaned the wound bed then discarded the gauzed soaked with 1/2 dakins solution and with the same gloved reached to open the clean wound vac sponge packaging. RN-O opened the packaging halfway then stopped and removed the gloves; he used to clean the wound and used hand sanitizer. With clean gloves on RN-O continued to open the wound vac sponge packaging and cut the wound vac sponge to fit R14's wound with the clean scissors. RN-O continued with treatment by cutting the sponge to fit inside the wound and sponge to fit the wound vac tubing and cut the tape that goes over the sponge. RN-O then placed the clean scissors on R14's bed that was not clean. RN-O then reached down towards the bottom of the bed where a three-tiered cart was standing to pull it towards him so that he could reach for a swab stick. RN-O pulled out a swab stick from the cart and proceeded to continue with R14 treatment. RN-O placed the sponge inside of R14 wound bed and started to place the tape over part of the sponge and R14's gloves broke. RN-O then removed his gloves and hand sanitized his hands to place a new glove on. The rest of the treatment RN-O continued to struggle with placing the tape on the wound and had RN-P, who was assisting by holding R14 on her side, to assist with placing the tape correctly on the wound. At no point when RN-P, went from the task of holding R14 on her side, to assisting during the wound treatment when RN-P would assist RN-O with the tape then go back to assisting R14 on her side, did RN-P remove her gloves and perform hand hygiene. RN-O continued to use the same gloves even when struggling with the wound tape. At one point during the treatment the wound tape stuck to RN-O's gloves and to remove the tape, RN-O brought his gloves up to his mouth and removed the tape from his gloves with his mouth. RN-O continued to use the unclean scissors that RN-O had placed on R14's bed to cut tape and the sponge. At the end of the treatment, RN-O threw away the used supplies and moved the 3-tiered cart back against the wall at the foot of R14's bed, RN-O then removed his gloves and used hand sanitizer. During the treatment, CNA-U knocked on the door and came in to see if RN-O and RN-P needed assistance. RN-P stated to CNA-U that R14 is wet and to get a clean draw sheet and brief. After the treatment was completed, CNA-U and RN-P removed the wet brief and draw sheet. RN-P still had on the gloves she had when she was assisting RN-O with R14's treatment. CNA-U and RN-P placed the clean draw sheet and brief on R14. RN-P was closing the brief and placing the tabs on R14's brief to secure it when Surveyor asked RN-P if R14 had been incontinent. RN-P stated yes R14 was incontinent. After a few seconds RN-P opened R14's brief and performed incontinence care on R14 then with the same gloves closed the clean brief. With the same gloves, RN-P proceeded to touch R14's call light, bed controller and bedding before removing her gloves and used hand sanitizer that was in the hall outside R14's room. On 5/21/26 at 3:00 p.m., during the daily exit meeting with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B Surveyor explained the observed concerns with infection control during R14's wound treatment and incontinence care. DON-B understood the concern and had no additional (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	information. 3) The Facility's policy, titled Enhanced Barrier Precautions, with a last reviewed/revised date of 8/8/2024, documents . 4. High-contact resident care activities include: a. Dresing b. Bathing c.Transferring d. Providing hygiene e. Changing linens f. Changing briefs or assisting with toileting . R28 was admitted to the facility on [DATE] for therapy services for strengthening following a hospital stay with influenza. R8 was admitted with diagnoses including weakness, multiple sclerosis (a chronic, unpredictable autoimmune disorder of the central nervous system), urinary tract infection, dementia (a decline in mental abilities severe enough to interfere with daily life) and acquired absence of other parts of the urinary tract. R8's admission Minimum Data Set, dated [DATE] indicates R28 has a Brief Interview for Mental Status score of 9 indicating moderate cognitive impairment, has no Range of Motion impairment in upper or lower extremities, is dependent on staff for transfers, has an indwelling catheter and has an ostomy (urostomy). On 05/19/2026, at 8:53 AM, Surveyor observed R28 in bed. Certified Nursing Assistant (CNA)-DD and CNA-EE came into R28's room with a full body lift and informed Surveyor they are going to get R28 cleaned and out of bed. Surveyor noted R28 is on Enhanced Barrier Precautions (EBP) and neither CNA were wearing Personal Protective Equipment (PPE) for EBP while caring for R28 and only wearing gloves. Surveyor observed CNA-EE clean R28 after having a bowel movement and noted CNA-EE did not change gloves or perform hand hygiene after completing the task. CNA-EE then began touching R28's sling for the full body lift and assisting R28 to move in the bed. Once R28 was transferred from bed into R28's wheelchair, CNA-EE then disposed of CNA-EE's soiled gloves and did not perform hand hygiene. On 05/26/2026, at 9:05 AM, Surveyor informed Director of Nursing (DON)-B and Nursing Home Administrator (NHA)-A of the observation. DON-B informed Surveyor R28 is on Enhanced Barrier precautions and requires PPE when performing high contact care activities, as well as proper hand hygiene. 4) On 05/19/2026, at 3:21 PM, Surveyor observed a rack of clothes in the dining room, with a sign attached indicating, Please mark with Resident's name after they claim it. On 05/27/2026, at 11:17 AM, Surveyor noted the clothes rack still in dining room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/27/2026, at 11:33 AM, Surveyor interviewed Account Manager-BB, who informed Surveyor when a resident is discharged or pass, clothes can be left behind or donated from families. Due to having an abundance of clothes, the facility wants to offer the residents to go through. Account Manager-BB indicated the clothing rack should not be in the dining room and will move it now. On 05/27/2026, at 11:46 AM, Surveyor informed the Facility of the above concern. No further information provided at time of write up.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review, the facility did not ensure pneumonia immunizations were offered to residents affecting 4 (R4, R17, R20, And R22) of 5 sampled residents reviewed for pneumonia immunizations. *R4 was not current in their pneumococcal vaccination, and no vaccine was offered. *R17 was not current in their pneumococcal vaccination, and no vaccine was offered. *R20 was not current in their pneumococcal vaccination, and no vaccine was offered. *R22 was not current in their pneumococcal vaccination, and no vaccine was offered. Findings include: The facility policy and procedure titled Pneumococcal Vaccine (Series) dated 3/25/2025 documents: 1. Each resident will be assessed for pneumococcal immunization upon admission. Self-report of immunization shall be accepted. Any additional efforts to obtain information shall be documented, including efforts to determine date of immunization or type of vaccine received. 2. Each resident will be offered a pneumococcal immunization unless it is medically contraindicated or the resident has already been immunized. Following assessment for any medical contraindications, the immunization may be administered in accordance with physician-approved standing orders. 3. Prior to offering the pneumococcal immunization, each resident or the residence representative will receive education regarding the benefits and potential side effects of the immunization with the education documented in the clinical record. a. The individual receiving the immunization, or the resident's representative, will be provided with a copy of CDC's current vaccine information statement (VIS) relative to that vaccine. 4. The resident/representative retains the right to refuse the immunization. The facility will document in the clinical record the reason for refusal or the medical contraindication of the immunization. 5. A consent form shall be signed prior to the administration of the vaccine and filed in the individual's medical record, along with what education was provided and a risk vs benefit discussion. Notify MD if immunization is declined. 6. The type of pneumococcal vaccine (PCV15, PCV20, PCV 21 or PPSV 23) offered will depend upon the recipient's age, having certain risk conditions, and previously received pneumococcal vaccines, in accordance with current CDC guidelines and recommendations. 1.)R4 was due to receive either the PCV20 or the PCV21. No documentation was found indicating R4 received the immunization, or information was provided and R4 declined the immunization. In an interview on 5/20/2026 at 1:43 PM, Surveyor asked Director of Nursing (DON)-B and Registered Nurse (RN)-O, the facility Infection Preventionist, how immunizations were tracked. RN-O stated the information should be in the resident's medical record. Surveyor shared with DON-B and RN-O the concern R4 was not offered or provided information for the current pneumococcal vaccination. DON-B stated the facility was working on a process for the immunizations to be offered on admission by updating the admission packet so all the consents for immunizations would be in it. 2.)R17 was due to receive either the PCV20 or the PCV21. No documentation was found indicating R17 received the immunization, or information was provided and R17 declined the immunization. In an interview on 5/20/2026 at 1:43 PM, Surveyor asked Director of Nursing (DON)-B and Registered Nurse (RN)-O, the facility Infection Preventionist, how immunizations were tracked. RN-O stated the information should be in the resident's medical record. Surveyor shared with DON-B and RN-O the concern R17 was not offered or provided information for the current pneumococcal vaccination. DON-B stated R17 had a care conference where the immunization was declined but there was no documentation of the conversation. DON-B stated the facility was working on a process for the immunizations to be offered on admission by updating the admission packet so all the consents for immunizations would be in it. 3.)R20 had no documentation of ever receiving a pneumococcal vaccination or that information was provided and R4 declined the immunization. In an interview on 5/20/2026 at 1:43 PM, Surveyor asked Director of Nursing (DON)-B and Registered Nurse (RN)-O, the facility Infection Preventionist, how immunizations were tracked. RN-O stated the information should be in the resident's medical record. Surveyor shared with DON-B and RN-O the concern R20 was not offered or provided information for the current pneumococcal vaccination. DON-B stated the facility (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was working on a process for the immunizations to be offered on admission by updating the admission packet so all the consents for immunizations would be in it. 4.)R22 was due to receive either the PCV20 or the PCV21. No documentation was found indicating R22 received the immunization, or information was provided and R22 declined the immunization. In an interview on 5/20/2026 at 1:43 PM, Surveyor asked Director of Nursing (DON)-B and Registered Nurse (RN)-O, the facility Infection Preventionist, how immunizations were tracked. RN-O stated the information should be in the resident's medical record. Surveyor shared with DON-B and RN-O the concern R22 was not offered or provided information for the current pneumococcal vaccination. DON-B stated the facility was working on a process for the immunizations to be offered on admission by updating the admission packet so all the consents for immunizations would be in it.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure a resident's physician was consulted with for 1 (R28) of 13 residents reviewed. *The Facility did not ensure the physician was notified/consulted after R28 reported mild knee pain to Physical Therapy on 1/29/2026. R28 continued to experience left knee swelling and the physician was not notified until 2/12/2026. Findings include: The Facility policy, titled Change in Condition of the Resident, last review/revised on 9/20/2022, indicates . a.Immediate notification: Immediate notification for any symptom, sign or apparent discomfort that is:i. Acute or sudden onset, and:ii. A marked change (i.e., more severe in relation to usual symptoms and signs, . b. Non-immediate notification R28 was admitted to the facility on [DATE] for therapy services focused on strengthening following a hospital stay with influenza. R28 was a stand to pivot assistance at home prior to hospitalization. R8 was admitted with diagnoses including weakness, multiple sclerosis (a chronic, unpredictable autoimmune disorder of the central nervous system) and dementia (a decline in mental abilities severe enough to interfere with daily life). R28's admission Minimum Data Set, dated [DATE] indicates R28 has a Brief Interview for Mental Status score of 9 indicating moderate cognitive impairment, has no impairment in upper or lower extremities, is dependent on staff for transfers and has no pain. R28's electronic health record (EHR) progress note, dated 1/22/2026, written by Registered Nurse (RN)-E, indicated R28 was in R28's wheelchair and R28's family member was assisting R28 to the dining room, R28's left leg got stuck under the wheelchair causing R28 pain but R28 denied wanting anything for pain. Staff to monitor for swelling or an increase in pain for R28's left foot and ankle. Surveyor noted, R28's EHR did not indicate any further monitoring relating to this event. On 05/21/2026, at 9:18 AM, Surveyor interviewed RN-E regarding RN-E's progress note in R28's EHR. RN-E informed Surveyor that RN-E recalled the incident occurring with R28 and believed the Nurse Practitioner was notified and the previous Director of Nursing (DON). RN-E shared the provider is usually notified, and an order is put in for nursing staff to monitor for any redness, swelling or increased pain to the area. Once an order goes in, it pops up on the Medication Administration Record (MAR) and/or Treatment Administration Record (TAR) to monitor for increase swelling, redness and/or pain. RN-E also indicated there is a binder for the 24-hour status report sheets. The 24-hour status report sheets are for any notifications to monitor or any appointments, etc . RN-E looked through R28's electronic health record and informed Surveyor that there was no order or documented monitoring of R28's left lower extremity after the incident. Surveyor asked RN-E if monitoring would be documented anywhere else. Surveyor was informed that RN-E does not believe monitoring would be documented anywhere else and indicated the provider will give guidelines on how long to monitor, if only for 24 hours may not be an actual order and if the provider was notified in person, RN-E may have forgot to put the notification in the note and would have gotten a verbal order to monitor. The 24-hour status report sheets, from 1/21/2026 through 1/30/2026 indicated that on 1/22/2026 R28 was on the sheet to monitor left foot and ankle for swelling and increased pain. Surveyor noted there is no evidence of provider notification and no monitoring of R28's left lower extremity following the incident on 1/22/2026. A physical therapy note by Lead Physical Therapy Assistant (PTA)-W, dated 1/29/2026, indicated R28 reported mild left knee pain with observed swelling. On 05/21/2026, at 11:05 AM, Surveyor interviewed PTA-W who indicated being familiar with R28. PTA-W recalled speaking with R28's family member early on around the beginning of R28's arrival and it was brought up by R28's family member that there was redness and swelling to R28's left knee. PTA-W indicated it was brought up to the nurse for monitoring. PTA-W informed Surveyor that typically PTA-W will go directly to the nurse and verbally communicate findings. If there was documentation on who was notified it would be in R28's EHR. Surveyor noted there is no documented evidence that therapy made nursing staff aware of R28's concerns. On (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/21/2026, at 3:12 PM, Surveyor informed the Facility of the above concerns regarding provider notification of R28's left knee pain and requested any additional information the Facility has. On 05/26/2026, at 9:05 AM, Surveyor interviewed Director of Nursing (DON)-B and Nursing Home Administrator (NHA)-A. DON-B informed Surveyor there was no provider notification or monitoring of R28's left lower extremity after the incident on 1/22/2026. DON-B informed Surveyor that DON-B expected immediate interventions to be done, provider to be updated and obtain any new orders or diagnostics. DON-B expected monitoring to be documented on every shift in the electronic health record and to include an assessment. NHA-A indicated Physical Therapy needed to let the nurse know immediately when a resident was having pain, to ensure the resident is properly assessed and expected it to be documented in the residents' chart regarding the notification and assessment of pain. NHA-A indicated that staff were documenting about R28's left lower extremity based on what they believed at the time was edema, which was better some days and worse other days, but the provider should have been notified, and an online form should have been done immediately.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and record review the facility did not ensure 1 (R14) of 15 sampled residents were provided with privacy during treatments/cares. On 5/20/26 at 10:25 a.m. Surveyor observed R14 receive wound treatment to the right buttock. During the treatment, R14's window blinds were not closed and the window faced the outside where people could possibly walk by and observe R14 receiving care. Findings include: R14 was admitted to the facility on [DATE] with diagnoses of cerebral palsy, deaf and quadriplegia. The quarterly Minimum Data Set (MDS) dated [DATE] documents R14 is cognitively intact and is dependent for all activities of daily living (ADL), transfers and bed mobility. It also documents R14 is incontinent of bladder and bowel. On 5/20/26 at 10:25 a.m. Surveyor observed R14's pressure injury treatment being completed to their right buttock. Registered Nurse (RN)-O performed the treatment while RN-P assisted with holding R14 on her left side. R14's window blinds were not closed prior to or during the treatment to R14s right buttock pressure injury. RN-O and RN-P did not ask R14 if she wanted to have blinds closed. The window shade remained open throughout the wound treatment, including incontinence care. On 5/21/26 at 3:00 p.m. during the daily exit meeting with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B, Surveyor explained the concern of the lack of privacy for R14 during wound treatment. DON-B stated she understood the concern and agreed R14 didn't have privacy.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility did not ensure a safe, clean, comfortable, and homelike environment for 2 (R4, and R30) of 13 sampled residents. *R4 had a large hole in R4's wall in R4's room on the right side.*R30 had a large amount of paint missing on R30's wall on the right side. Findings include: 1) R4 was admitted to the facility on [DATE] with diagnoses of Chronic Obstructive Pulmonary Disease(lung disease that block airflow and make it difficult to breathe), Type 2 Diabetes Mellitus(adult onset of trouble controlling blood sugar), Anxiety Disorder(mental health disorder characterized by feelings of worry, fear that interfere with daily activities), and Schizophrenia(chronic brain disorder characterized by distortions in thinking, perception, emotions, and behavior).R4's Quarterly Minimum Data Set (MDS) assessment, dated 3/12/26, indicated that R4's Brief Interview for Mental Status (BIMS) score was 11, which indicated that R4 demonstrated moderately impaired skills for daily decision making.On 5/19/2026, at 10:07 AM, Surveyor observed a large hole with plaster pushed in on the right side of R4's wall in R4's room.On 5/26/2026, at 8:28 AM, Surveyor observed the large hole with plaster pushed in R4's room had not been repaired. R4 informed Surveyor the hole had been there like that for over a year. R4 informed Surveyor that R4 was aware of the large hole and it bothers R4 that it is still there. On 5/26/2026, at 8:31 AM, Surveyor interviewed Maintenance Director (MD)-H. MD-H informed Surveyor that MD-H had been employed at the facility for about 7 months. MD-H had known about the large hole in R4's wall and when asked how long MD-H had known about the large hole, MD-H replied, longer than I want to admit. MD-H stated that it is one of the projects coming up and had been working on getting things caught up. MD-H informed Surveyor that MD-H had been in every resident room but does not complete an organized audit on a routine basis of room conditions. On 5/26/2026, at 9:12 AM, Surveyor observed MD-H with a pail of plaster repair. Surveyor observed R4's wall. R4 informed Surveyor that MD-H had just repaired the hole in the wall and R4 stated R4 was told by MD-H that the wall repair would be done by the end of the week and then MD-H would paint R4's wall. R4 thanked Surveyor very much for getting the wall repaired. 2) R30 was admitted to the facility on [DATE] with diagnoses of Chronic Kidney Disease(progressive damage and loss of function in the kidneys), Type 2 Diabetes Mellitus(adult onset of trouble controlling blood sugar), Post-Traumatic Stress Disorder(PTSD)(a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event), Bipolar(episodes of mood swings ranging from depressive lows to manic highs), and Schizophrenia(chronic brain disorder characterized by distortions in thinking, perception, emotions, and behavior).R30's Minimum Data Set (MDS) assessment, dated 4/2/26, indicated that R30's Brief Interview for Mental Status (BIMS) score was 15, which indicated that R30 was cognitively intact for daily decision making.On 5/20/2026, at 12:30 PM, Surveyor observed R30's wall on the right side. R30's wall was missing a large amount of paint. R30 informed Surveyor that R30 had informed maintenance about the wall that needed to be painted about a year ago. R30 informed Surveyor that is hard to look at and bothered R30. On 5/26/2026, at 8:31 AM, Surveyor interviewed Maintenance Director (MD)-H. MD-H informed Surveyor that MD-H had been employed at the facility for about 7 months. MD-H had known about large amount of paint missing on R30's wall and when asked how long MD-H had known about the paint missing, MD-H replied, longer than I want to admit. MD-H stated that it is one of the projects coming up and had been working on getting things caught up. MD-H informed Surveyor that MD-H had been in every resident room but does not complete an organized audit on a routine basis of room conditions. On 5/26/2026, at 1:46 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A that R4's large hole in the wall and R30's large amount of paint had not been repaired for over a year and both R4 and R30 indicated to Surveyor that it bothered them to have the condition of their room like this. NHA-A understood the concern and had no further information to provide at this time.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure 1 (R32) of 3 sampled residents reviewed for potential abuse concerns had their allegations reported to the state agency. On 5/1/26 a bump with bruising was discovered on R32's right forehead. The area measured 1.9 centimeters (cm) by 4.0 cm. R32 was unable to state what happened so an investigation was initiated. This potential allegation was not reported to the state agency. Findings include: The facility's Abuse, Neglect and Exploitation dated 7/15/22 documents: Reporting/Response1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g law enforcement when applicable) within specified timeframes: Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involved abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. R32 was admitted to the facility on [DATE] with diagnoses that include Alzheimer's disease and paranoid personality disorder . The quarterly Minimum Data Set (MDS) dated [DATE] documents R32 has severe cognitive impairment. A nurses note dated 5/1/26 documented a bruise to R32's forehead was discovered. The facility investigation dated 5/1/26 at 4:09 p.m. documented R32 was noted to have a bruise on the right forehead just below R32's hairline. The bruise was light blue measuring 1.0 cm by 3.7 cm bruise; surrounding the bruise was a bump measuring 1.9 cm by 4 cm. Due to R32's cognitive status R32 was unable to state what happened to her forehead. The investigation documented interviews conducted with staff from various shifts. The investigation revealed R32 is combative during cares and was swinging her arms and struck herself while swinging out. The investigation also documented the facility ruling out possible bruise from the mechanical lift bar. On 5/26/26 at 8:49 a.m. Surveyor interviewed Nursing Home Administrator (NHA)-A. Surveyor asked NHA-A if this investigation was reported to the state agency as an injury of unknown source. NHA-A stated they did not report it because she talked with her corporate colleagues and they stated because the CNAs were able to describe the actions R32 was exhibiting by flailing her arms around and it was easily explained they did not feel it was necessary to self report this to the state agency.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure written notice of the facility bed hold policy was provided to the resident and/or the resident's representative. Proper transfer/discharge information was also not sent to the State Long-Term Care Ombudsman for 3 (R7, R8, & R22) of 7 residents reviewed for transfers or discharges. *R7 was hospitalized on [DATE]. A written copy of R7's bed hold notice was not sent to R7's representative, and the facility did not notify the State Long-Term Care Ombudsman of R7's transfer to the hospital. *R8 was hospitalized on [DATE] and 3/21/26. A written copy of R8's bed hold notice was not sent to R8's representative, and the facility did not notify the State Long-Term Care Ombudsman of R8's transfer to the hospital on 3/21/26.*R22 was hospitalized on [DATE]. The facility did not notify the State Long-Term Care Ombudsman of R22's transfer to the hospital. Findings include: The facility policy titled Transfer and Discharge (including AMA) (against medical advice) dated 7/15/2022 documents: .It is the policy of this facility to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility except as initiated by resident, necessary for the health and safety of resident or other individuals are endangered, or as otherwise permitted by applicable law. emergency transfers/discharges – initiated by the facility for medical reasons, or for the immediate safety and welfare of a resident. provide a notice of the resident's bed hold policy to the resident and representative at the time of transfer, as possible, but no later than 24 hours of the transfer. social services director, or designee, shall provide notice of transfer to a representative of the State Long-Term Care Ombudsman via monthly list. 1.) R7 was admitted to the facility on [DATE]. R7's Minimum Data Set (MDS) dated [DATE] documented R7 has a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. R7 had an activated power of attorney (POA) for healthcare decisions. Surveyor reviewed R7's electronic health record (EHR), which documented R7 was hospitalized on [DATE] for blood in stool. R7's progress notes documented R7 was admitted to the hospital with anemia and thrombocytopenia and returned to the facility 3/5/26. Surveyor reviewed R7's bed hold request form dated 3/2/26 which documents phone confirmation was obtained by R7's POA to hold R7's bed. On 5/21/26 at 8:28 AM, Surveyor interviewed Social Services Coordinator (SSC)-D who confirmed SSC-D notifies the State Long-Term Care Ombudsman of resident hospitalizations and discharges on a monthly basis. Surveyor asked SSC-D if SSC-D notified the Ombudsman of R7's hospitalization on 3/2/26. SSC-D was unable to provide evidence that the Ombudsman was notified of R7's hospitalization. SSC-D stated SSC-D forgot to send the March 2026 and April 2026 monthly email to the Ombudsman. No additional information was provided. On 5/21/26 at 1:07 PM, Surveyor interviewed Business Office Manager (BOM)-I who confirmed BOM-I assists with completing the bed hold notice when residents go out to the hospital. BOM-I stated the facility does not provide a written copy of the bed hold notice to a resident's representative and only (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	verbal consent is obtained to hold the resident's bed. On 5/21/26 at 1:10 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B that the State Long-Term Care Ombudsman was not notified of R7's hospitalization on 3/2/26, and R7's representative was not provided a written copy of the bed hold notice for R7's hospitalization on 3/2/26. NHA-A and DON-B stated they were not aware the bed hold notice should be sent to the resident representative in writing. No additional information was provided. 2.) R8 was admitted to the facility 1/6/26. R8's admission Minimum Data Set (MDS) dated [DATE] documented R8 has a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. R8 had an activated Power of Attorney (POA) for healthcare decisions. Surveyor reviewed R8's Electronic Health Record (EHR), which documented R8 was hospitalized on [DATE] due to shaking and tremors. R8's progress notes documented R8 was admitted to the hospital with COVID and returned to the facility 1/18/26. Surveyor reviewed R8's bed hold request form dated 1/17/26 which documents phone confirmation was obtained by R8's POA to hold R8's bed. Surveyor reviewed R8's EHR, which documented R8 was hospitalized on [DATE] due to back pain. R8's progress notes documented R8 was admitted to the hospital with urinary stones and returned to the facility on 3/24/26. Surveyor reviewed R8's bed hold request form dated 3/21/26 which documents phone confirmation was obtained by R8's POA to hold R8's bed. On 5/21/26 at 8:28 AM, Surveyor interviewed Social Services Coordinator (SSC)-D who confirmed SSC-D notifies the State Long-Term Care Ombudsman of resident hospitalizations and discharges on a monthly basis. Surveyor asked SSC-D if SSC-D notified the Ombudsman of R8's hospitalizations on 1/17/26 and 3/21/26. SSC-D provided evidence that the Ombudsman was notified of R8's hospitalization on 1/17/26 but was unable to provide evidence that the Ombudsman was notified of R8's hospitalization on 3/21/26. SSC-D stated SSC-D forgot to send the March 2026 and April 2026 monthly email to the Ombudsman. No additional information was provided. On 5/21/26 at 1:07 PM, Surveyor interviewed Business Office Manager (BOM)-I who confirmed BOM-I assists with completing the bed hold notice when residents go out to the hospital. BOM-I stated the facility does not provide a written copy of the bed hold notice to a resident's representative and only verbal consent is obtained to hold the resident's bed. On 5/21/26 at 1:10 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B that the State Long-Term Care Ombudsman was not notified of R8's hospitalization on 3/21/26, and R8's representative was not provided a written copy of the bed hold notice for R8's hospitalizations on 1/17/26 or 3/21/26. NHA-A and DON-B stated they were not aware the bed hold notice should be sent to the resident representative in writing. No additional information was provided. 3.) R22 was admitted to the facility on [DATE]. R22's Significant Change Minimum Data Set (MDS) assessment, dated 4/1/26, indicated that R22's Brief Interview for Mental Status (BIMS) score was (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	13, indicating R22 was cognitively intact for daily decision-making skills. R22's electronic medical record documented that on 4/5/26, R22 was sent to the hospital for R22 complaining of their head feeling like it could explode along with neck pain. R22 returned from the hospital on 4/8/26. On 5/19/2026, at 1:15 PM, R22 informed Surveyor that R22 had been out to the hospital and did not recall receiving a bed-hold and transfer notice. R22 did not recall the bed-hold policy being explained to R22 at the time of going out to the hospital. Surveyor reviewed R22's Bed-Hold and Transfer Notice that R22 signed on 4/5/26. According to the form, it is marked for hand delivering to R22. On 5/20/2026, at 9:43 AM, Surveyor interviewed Social Services Coordinator (SSC)-D in regard to the bed-hold and transfer notice policy and procedure. SSC-D confirmed that SSC-D does notify the ombudsman of monthly discharges. SSC-D provided a binder of email notifications with a list of residents discharged since the last facility survey. Surveyor noted that September 2025, March and April 2026 are not in the binder. SSC-D stated that SSC-D will need to look for the emails confirming the ombudsman was notified of Resident discharges for the above months. On 5/21/2026, at 8:29 AM, SSC-D notified Surveyor that SSC-D missed sending in September 2025, March and April 2026 discharges to the ombudsman and did send an email yesterday (5/20/26) once Surveyor brought it to SSC-D's attention. On 5/21/2026, at 3:01 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, and Senior [NAME] President of Success (VPS)-C that the ombudsman was not notified for the month of April 2026 which is the month that R22 was discharged to the hospital. No further information has been provided by the facility as to why the ombudsman was not notified on a consistent monthly basis.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not develop a comprehensive care plan based upon an assessment for 1 (R14) of 15 sampled residents.*R14's was assessed as needing side rails on their bed. R14's care plan did not include R14's use of side rails as part of their care plan.Findings include:The Facility's policy, titled Comprehensive Care Plan, with a last review/revised date of 9/23/2022, indicates . 2. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment . 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. f. Resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity, as indicated. R14 was admitted to the facility on [DATE] with diagnoses that included cerebral palsy and quadriplegia. The quarterly Minimum Data Set (MDS) dated [DATE] documents R14 is cognitively intact and is dependent for all activities of daily living (ADL), transfers and bed mobility. The MDS also documents R14 has bed rails that are used daily.Surveyor reviewed R14's care plan and the use of bed rails was not included on R14's care plans.On 5/19/26 at 10:10 a.m. Surveyor interviewed R14. Surveyor asked R14 if she uses the bed rails when she is being assisted with cares to roll from side to side. R14 stated yes, she uses them.On 5/20/26 at 10:25 a.m. Surveyor observed R14's wound treatment. Surveyor observed RN-O and RN-P reposition R14 on her left side. Surveyor observed that R14 did not use the bed rail.On 5/26/26 at 8:37 a.m. Surveyor interviewed Director of Nursing (DON)-B about R14's bed rails and care plan. Surveyor shared with DON-B R14 was assessed for the use of bed rails and R14 states she uses them during cares. Surveyor asked DON-B what the expectations are for the care plans when a resident uses siderails and has an assessment to use siderails. DON-B stated that the siderails should be included in the resident's care plan.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure sufficient nursing staff was provided for 1 (R37) of 13 residents observed for call light wait times in order to allow residents to maintain or attain their highest practicable physical, mental, and psychosocial well-being. *On 5/20/26, Surveyor observed R37's call light go unanswered for 35 minutes when R37 needed assistance with toileting. Findings include:The facility policy titled . Call lights: Accessibility and Timey Response dated 7/26/22 documents: . The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. all staff who see or hear an activated call light are responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified. Process for responding to call lights: . listen to the resident's request and respond accordingly. Inform the resident if you cannot meet the need and assure him/her that you will notify the appropriate personnel. inform the appropriate personnel of the resident's need. R37 was admitted to the facility 5/15/26 with diagnoses including displaced intertrochanteric fracture of right femur (the right thigh bone is broken in the upper section) and displaced subtrochanteric fracture of right femur (the right thigh bone is broken in at least two pieces just below the hip joint). R37's admission Minimum Data Set (MDS) assessment dated [DATE] documented R37 requires assistance of one staff member for transfers and toileting, and R37 is continent of bowel and bladder. R37's Brief Interview for Mental Status (BIMS) assessment dated [DATE] documented a score of 15, indicating intact cognition. On 5/20/26 at 8:05 AM, Surveyor entered the D hallway at the facility and observed the call light activated above R37's door. On 5/20/26 at 8:20 AM, Surveyor heard R37 state I am going to s*** the bed, oh f***. On 5/20/26 at 8:25 AM, Surveyor observed a staff member walk past R37's room and did not respond to R37's call light. On 5/20/26 at 8:36 AM, Surveyor observed a staff member walk past 37's room and go into a different resident's room whose call light was not activated, and the staff member did not respond to R37's call light. On 5/20/26 at 8:40 AM, Surveyor observed two certified nursing assistants (CNAs) deliver meal trays to the D hallway and one CNA responded to R37's call light. R37's care plan documents ADL (Activities of Daily Living) self-care deficit as evidenced by difficulty walking, weakness, right femur fracture (post-surgical intervention). Interventions include toe touch weight bearing to right lower extremity; . mobility assist of 1; . toileting assist of 1; . Assist of 1 with gait belt and walker (toe touch weight bearing to RLE) .On 5/20/26 at 10:19 AM, Surveyor interviewed R37 who stated R37 had to have a bowel movement earlier in the morning, but staff did not answer the call light in time, so R37 had to go in R37's brief. R37 stated R37 usually uses a commode to toilet and staff need to use a lift to get R37 out of bed onto the commode. On 5/21/26 at 1:10 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B. NHA-A stated if staff are passing by a room with the call light on, they are encouraged to let the resident know someone will be in to help. DON-B stated call lights are expected to be answered in 10 to 15 minutes. Surveyor shared the concern with NHA-A and DON-B that Surveyor observed R37's call light activated for 35 minutes before staff responded, and R37's toileting needs were not met timely. No additional information was provided.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure 1 (R28) of 13 residents (R) received necessary care and treatment.* R28 experienced changes in their left lower extremity that included, swelling, pain, and decrease in strength. The facility staff documented about R28 having increased swelling but a thorough assessment was not completed. Consistent monitoring did not occur. On 2/12/26 a doppler ultrasound was ordered which ruled out a possible blood clot. An x-ray of the knee was not ordered until 2/20/26 which indicated a possible fracture of the knee. This was confirmed by a second x-ray. Findings include: 1.) R28 was admitted to the facility on [DATE] for therapy services for strengthening following a hospital stay with influenza. R28 was a stand to pivot assistance at home prior to hospitalization. R28 was admitted with diagnoses including weakness, multiple sclerosis (a chronic, unpredictable autoimmune disorder of the central nervous system,) and dementia (a decline in mental abilities severe enough to interfere with daily life.) R28's admission Minimum Data Set (MDS) dated [DATE] indicates: R28 has a Brief Interview for Mental Status score of 9 indicating moderate cognitive impairment, has no impairment in upper or lower extremities, is dependent on staff for transfers, and has no pain. Surveyor reviewed R28's Electronic Health Record (EHR) and noted a progress note, dated 1/22/2026, written by Registered Nurse (RN)-E which indicates R28 was in their wheelchair and R28's family member was assisting R28 to the dining room, R28's left leg got stuck under the wheelchair causing R28 some pain in the moment but resident denied wanting anything for pain and staff to monitor for swelling or an increase in pain for R28's left foot and ankle. On 05/21/2026, at 9:18 AM, Surveyor interviewed RN-E. RN-E informed Surveyor that RN-E believes the Nurse Practitioner was notified as well as the previous Director of Nursing (DON.) RN-E indicated that the provider is usually notified and an order is put in for nursing staff to monitor for any redness, swelling, or increased pain to the area. Once an order goes in, it pops up on the Medication Administration Record (MAR) and/or Treatment Administration Record (TAR) to monitor for increase swelling, redness and/or pain. RN-E also indicated there is a binder for the 24-hour status report sheets. The 24-hour status report sheets are for any notifications to monitor or any appointments, etc RN-E looked through R28's electronic health record and informed Surveyor that there was no order or documented monitoring of R28's left lower extremity after the incident. Surveyor asked RN-E if monitoring would be documented anywhere else. Surveyor was informed that RN-E does not believe monitoring would be documented anywhere else and indicated the provider will give guidelines on how long to monitor, if only for 24 hours may not be an actual order and if the provider was notified in person, RN-E may have forgot to put the notification in the note and would have got a verbal order to monitor. The 24-hour status report sheets from 1/21/2026 through 1/30/2026 indicates that only on 1/22/2026 R8 was on the sheet to monitor left foot and ankle for swelling and increased pain. Surveyor notes a Physical Therapy note by Lead Physical Therapy Assistant (PTA)-W, dated 1/29/2026, indicating R28 reported mild left knee pain with observed swelling. On 05/21/2026, at 11:05 AM, Surveyor interviewed PTA-W who indicated being familiar with R28. PTA-W recalls speaking with R28's family member early on toward beginning of R28's arrival and it was brought up by R28's family member that there was redness and swelling to R28's left knee. PTA-W indicated it was brought up to the nurse and monitoring. PTA-W informed Surveyor that typically PTA-W will go directly to the nurse and verbally communicate findings. If there were documentation on who was notified it would be in notes, otherwise it just wasn't documented, per PTA-W. Surveyor notes there is no documented evidence that therapy made nursing staff aware of R28's concerns. A progress note dated 1/31/2026, by RN-X, indicated R28 has edema and swelling to the left knee and left lower extremity with no pain. R28's family member reported left knee swelling to physical therapy and asked if the Facility would be doing an x-ray of R28's left knee. On 5/21/2026, at 9:15 AM, Surveyor attempted to contact RN-X but was unsuccessful. Surveyor notes no further (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	information or follow up regarding the above information was found in R28's medical record. Surveyor reviewed R28's Physical Therapy notes and Nursing notes in R28's electronic health record and found the following:2/1/2029- Nursing note indicated left knee swelling2/2/2026- Nursing note indicated left knee swelling2/2/2026- Physical Therapy documents- heavy queues for Lower Left Extremity (LLE)2/3/2026- Nursing note indicated left knee swelling2/4/2026- Nursing note indicated left knee swelling2/5/2026- Nursing note indicated left knee swelling2/6/2026- Nursing note indicated required a lot of encouragement when it came to propelling self in wheelchair.2/9/2026- Nursing note indicated left knee swelling Surveyor noted R17 continued to have left knee swelling and not making progress in therapy for multiple weeks since first identified. A progress note, by Advanced Nurse Practitioner (APNP)-Y, dated 2/12/2026, indicated the provider was notified on 2/12/2026 regarding R28 experiencing lower left extremity swelling, pain and immobility. Assessment and plan indicated left knee swelling, warm, shiny and increased pain with nursing documentation showing progressive left lower extremity edema with acute worsening on 2/12/2026. A doppler ultrasound was ordered along with lab results to rule out a deep vein thrombosis (DVT) (blood clot). On 2/16/2026, the results indicated R28 was negative for a DVT and no new orders at that time. Surveyor noted R28 continued to experience left knee swelling and was re-evaluated by the provider on 2/20/2026. On 2/20/2026, a progress note by APNP-Y, indicated R28 was re-evaluated and R28's family member requested an x-ray. An x-ray was then ordered for R28. A progress note, dated 2/21/2026, indicated R28's x-ray resulted with a suspicious fracture of R28's left tibial plateau. A repeat x-ray was recommended and ordered. On 2/22/2026, R28's second x-ray confirmed a fracture of the left tibial plateau and R28 was sent out to the emergency room for further evaluation and returned to the Facility the same day with instructions to follow up with Orthopedics. On 3/18/2026, R28 was seen by Orthopedics, R28 was instructed to be non-weight bearing, therapy as tolerated and was unable to wear a brace due to being unable to straighten R28's leg. No invasive interventions required. On 05/26/2026, at 9:05 AM, Surveyor interviewed Director of Nursing (DON)-B and Nursing Home Administrator (NHA)-A. DON-B informed Surveyor that there was no provider notification or monitoring of R28's left lower extremity after the incident on 1/22/2026. DON-B informed Surveyor that DON-B expects immediate interventions to be done, provider to be updated and obtain any new orders or diagnostics. DON-B expects monitoring to be documented on every shift in the electronic health record and to include an assessment. NHA-A indicated Physical Therapy needs to let the nurse know immediately when a resident is having pain, to ensure the resident is properly assessed and expect it to be documented in the residents' chart regarding the notification and assessment of pain. NHA-A indicated that staff were documenting about R28's left lower extremity (LLE) based on what they believed at the time was R28 having edema, which was better some days and worse other days but the provider should have been notified and an online form should have been done immediately.

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility did not ensure 1 (R28) of 2 residents with a urostomy received appropriate treatment & care.*R28 was admitted to the Facility with a urostomy (a surgical procedure that creates an alternate route for urine to leave your body when the bladder is removed or malfunctioning). The Facility did not have the proper supplies to care for R28's urostomy needs.Findings include:R28 was admitted to the facility on [DATE] for therapy services and strengthening following a hospital stay with influenza. R28 was admitted with diagnoses including weakness, multiple sclerosis (a chronic, unpredictable autoimmune disorder of the central nervous system), urinary tract infection, dementia (a decline in mental abilities severe enough to interfere with daily life) and acquired absence of other parts of the urinary tract.R28's admission Minimum Data Set, dated [DATE] indicated R28 had an indwelling catheter and an ostomy (urostomy).Surveyor reviewed R28's electronic health record and noted a progress note dated 1/22/2026, that indicated R28's family member would be bringing temporary urostomy supplies for R28.Surveyor reviewed the 24-hour Status Report for 1/21/2026 through 1/30/2026 and noted on 1/23/2026 R28 still was in need of urostomy supplies.On 05/21/2026, at 10:43 AM, Surveyor interviewed Medical Records-F, who also orders supplies for the facility. Medical Records-F indicated they ordered a box of 10 urostomy pouches on 1/20/26, which shipped on 1/26/2026. Medical Records-F did not know when the supplies were received. Medical Records-F stated their process is for Medical Records-F to go through supplies and see what is needed. If staff know something is out before Medical Records-F can get to it then staff are supposed to write it on the sheet in the medication room. Medical Records-F then stated urostomy supplies are kept in the med cart, which Medical Records-F does not have access to and indicated nursing is responsible for notifying Medical Records-F of the supplies needed in the medication cart.On 05/21/2026, at 3:18 PM, Surveyor interviewed Director of Nursing (DON)-B. DON-B informed Surveyor she was unsure of the process for ordering supplies and encouraged Surveyor to speak with Medical Records-F. On 05/21/2026, at 3:24 PM, Surveyor interviewed Agency Licensed Practical Nurse (LPN)-FF who indicated being unsure of the ordering process but indicated that the facility does not always have the rubber wafer for R28's urostomy but R28's wife is very good about bringing them in when the facility does not have them.On 05/26/2026, at 9:05 AM, Surveyor interviewed DON-B and Nursing Home Administrator (NHA)-A. DON-B indicated that urostomy supplies are not part of the typical supplies and the facility worked closely with the family on the care of R28's urostomy. Pictures were provided by R28's family and hung in R28's room for reference on care of R28's urostomy. NHA-A indicated that prior to a resident coming into the Facility, if they have a specialty need, staff should be trained prior to residents walking through the door and have available supplies. NHA-A indicated central intake, who work outside of the Facility, are supposed to notify the Facility of what a resident needed prior to being admitted to facility but sometimes they do not relay that information and indicated the process will be improving.

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	525346	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Williams Bay Health Services	146 Clover St Williams Bay, WI 53191

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the Facility did not comprehensively assess 3 (R22, R24, and R30) of 3 sampled Residents for traumas and develop care plan approaches ensure provision of trauma informed care to mitigate any triggers to prevent re-traumatization.* R22's psychology progress note dated [DATE] identify' s R22 as having military service with deployment. The facility did not complete a comprehensive trauma assessment to develop and implement an individualized trauma informed plan of care.*R24's trauma informed care assessment dated [DATE] was incomplete with 8 questions not answered. The facility did not complete a comprehensive trauma assessment to develop and implement an individualized trauma informed plan of care.*R30 was admitted on [DATE] with a diagnosis of Post Traumatic Stress Disorder (PTSD). The facility did not complete a comprehensive trauma assessment to develop and implement an individualized trauma informed plan of care.Findings include:The facility's Trauma Informed Care policy & procedure last reviewed/revised [DATE] documents:Policy:.It is the policy of this facility to provided care and services which, in addition to meeting professional standards, are delivered using approaches which are culturally competent, account for experiences and preferences, and address the needs of trauma survivors by minimizing triggers and/or re-traumatization.'".Definitions: Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and had lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. Common sources of trauma may include, but are not limited to:a. Natural and human caused disastersb. Accidentsc. Ward. Physical, sexual, mental, and/or emotional abuse (past or present)e. Rapef. Violent crimeg. History of imprisonmenth. History of homelessnessi. Traumatic life events (death of a loved one, personal illness, etc.) Traumatic-Informed Care is an approach to delivering care that involves understanding, recognizing, and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, and procedures and practices to avoid re-traumatization.Policy Explanation and Compliance Guidelines:1.The facility will work to facilitate the principles of trauma informed care which include:a. Safety-Ensuring residents have a sense of emotional and physical safety.b. Trustworthiness and transparency-Efforts to establish a relationship based on trust, and clear and open communication between the staff and the resident.c. Peer support and mutual self-help-If practicable, assist the resident in locating and arranging to attend support groups (potentially hosted by the facility) which are organized by qualified professionals.d. Collaboration-an emphasis on partnering between residents and/or his or her representative, and all staff and disciplines involved in the resident's care in developing the plan of care.e. Empowerment, voice, and choice-Ensuring that resident's choice and preferences are honored and that residents are empowered to be active participants in their care and decision-making, including recognition of, and building on resident's strengths.2. The facility will use a multi-pronged approach to identifying a resident's history of trauma. This will include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event, as well as reviewing documentation such as the history and physical, consultation notes, or information received from family/responsible party.4. The facility will collaborate with resident trauma survivors, and as appropriate, the resident's family, friends, the primary care physician, and any other health care professionals (such as psychologists and mental health professionals) to develop and implement individualized care plan interventions.5. The facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger-specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident and will be added to the resident's care plan. While most triggers are (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	highly individualized, some common triggers may include, but are not limited to:a. Experiencing a lack of privacy or confinement in a crowded or small spaceb. Exposure to loud noises, or bright/flashing lightsc. Certain sights, such as objects that are associated with their abuserd. Sounds, smells, and physical touch6. Trauma-specific care plan interventions will recognize the interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, depression, and anxiety. These interventions will also recognize the survivor's need to be respected, informed, connected, and hopeful regarding their own recovery.7. The facility will evaluate whether the interventions have been able to mitigate (or reduce) the impact of identified triggers on the resident that may cause re-traumatization. The resident and/or his or her family or representative will be included in this evaluation to ensure clear and open discussion and better understand if interventions must be modified.8. In situations where a trauma survivor is reluctant to share their history, the facility will still try to identify triggers which may re-traumatize the resident and develop care plan interventions which minimize or eliminate the effect of the trigger on the resident.1.) R22 was admitted to the facility on [DATE] with diagnoses that included Major Depressive Disorder (persistent feelings of sadness, hopelessness, and a loss of interest or pleasure in activities), Anxiety Disorder (mental health disorder characterized by feelings of worry, fear that interfere with daily activities), and Dementia (loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life).R22's Significant Change Minimum Data Set (MDS) assessment, dated [DATE], indicated that R22's Brief Interview for Mental Status (BIMS) score was 13, indicating R22 was cognitively intact for daily decision-making skills. R22's Patient Health Questionnaire (PHQ-9) score is 0 however; R22's MDS documented R22 feels down, depressed, and with little interest or pleasure for 1-2 days. R22 had no documented behaviors. R22's psychology progress note dated [DATE], written by Psychology PhD (Psych)-S documented the following: .On [DATE], (R22) described himself as having severe depression and anxiety, stating I am surviving day-to-day. On [DATE], when evaluated by psychiatry, (R22) was noted to be grieving over (R22's) loss of independence. (R22) has a history of psychiatric hospitalizations related to meltdowns within the last 5 years and was displaying significant adjustment issues related to (R22's) placement.(R22) had former heavy severe alcohol use for approximately 15 years; abstinent since 1995.(R22's) paternal grandmother reportedly left suicide notes. Brother died by suicide. Broader family history of mental illness.Past suicidal ideation with contemplated firearm use.Military deployment during Navy service noted as potential trauma history factor.The facility did not have documentation that an assessment of R22's trauma was completed to ensure R22 received trauma-informed care based upon individual needs and standards of practice.Surveyor reviewed R22's comprehensive care plan.Surveyor noted there is no documented focused problem with person centered interventions for the traumatic events referenced in the [DATE] psychology progress note.On [DATE], at 10:04 AM, Surveyor interviewed Social Services Coordinator (SSC)-D regarding SSC-D initiating care plan focused problems. SSC-D stated that SSC-D is responsible for C (cognitive patterns), D (mood), E (behaviors), and Q (participation in assessment and goal setting) sections of the MDS. SSC-D stated they are responsible for identifying focused problems with interventions within the comprehensive care plan. SSC-D develops a care plan based on a Resident's MDS documentation or if assessments generate focused care plan problems.On [DATE], at 9:20 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-G regarding R22. CNA-G confirmed that CNA-G is familiar with R22. CNA-G is not aware of R22 having a history of any traumatic experiences or what to do to prevent any triggers for R22.On [DATE], at 9:29 AM, Surveyor interviewed SSC-D regarding R22. SSC-D stated they were not aware of R22 having a history of possible traumatic events or experience. SSC-D stated, I have to figure out how to get people to talk to me. SSC-D confirmed that SSC-D is far behind in reviewing psychology notes. SSC-D stated, I have a couple of months to get through. SSC-D stated that SSC-D will need to have psychology services work with SSC-D to develop focused problems within the care plan for the more difficult Residents.On [DATE], at 3:01 PM, Surveyor shared the concern with Nursing Home (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator (NHA)-A, Director of Nursing (DON)-B, and [NAME] President of Success (VP)-C that R22 was identified as having possible traumatic events or experiences in their life, including military service with deployment. The facility did not complete an assessment of R22's trauma and develop a trauma informed care plan with person centered interventions to prevent triggering traumatic responses for R22.No further information has been provided by the facility at this time as to why R22 was not comprehensively assessed to facilitate the development of a person-centered care plan for R22's potential for trauma experience or event with identified individualized triggers. 2.) R24 was admitted to the facility on [DATE] with diagnoses that included Anxiety Disorder (mental health disorder characterized by feelings of worry, fear that interfere with daily activities), and Depression (mood disorder that causes persistent feelings of sadness and loss of interest).R24's Annual Minimum Data Set (MDS) dated [DATE], indicated that R24's Brief Interview for Mental Status (BIMS) score was 15, indicating R24 was cognitively intact for daily decision-making skills. R24's Patient Health Questionnaire (PHQ-9) score is 1 however, however; R24's MDS documented R24 feels down, depressed, and with little interest or pleasure for 1-2 days. R24 had no documented behaviors. R24's Trauma-Informed Care Observation assessment dated [DATE] had 8 questions that were not answered as part of the assessment. The assessment documented that R24 believed R24's sister was evil, and an old friend stole from R24. The assessment indicated that R24 is reminded of this experience when R24's things are misplaced. The assessment is documented to proceed with an individualized care plan, determine individualized triggers, and to determine individualized de-escalation preferences.Surveyor reviewed R24's comprehensive care plan.Surveyor noted that R24's focused problem: at risk for traumatization of past events or experience where reminders/trigger of even or experience may cause behavioral changes and/or emotional distress initiated [DATE] does not document what the specific past event(s) or experience(s) that R24 experienced. Surveyor also noted that an intervention to determine as able, the triggers of traumatic event or experience, such as sights, smells, sounds and touch, which may lead to a set of emotional, physiological and behavioral responses that arise in service of survival and safety initiated [DATE] did not include person centered interventions to help de-escalate R24 in the event R24's past traumatic experience triggered negative responses.R24's care plan was not individualized, did not determine individualized triggers, and does not determine individualized de-escalation preferences.On [DATE], at 10:04 AM, Surveyor interviewed Social Services Coordinator (SSC)-D regarding SSC-D initiating care plan focused problems. SSC-D stated that SSC-D is responsible for C (cognitive patterns), D (mood), E (behaviors), and Q (participation in assessment and goal setting) sections of the MDS. SSC-D stated they are responsible for identifying focused problems with interventions within the comprehensive care plan. SSC-D develops a care plan based on a Resident's MDS documentation or if assessments generate focused care plan problems.On [DATE], at 1:13 PM, Surveyor interviewed Social Services Coordinator (SSC)-D again regarding R24's trauma-informed care assessment not being completed thoroughly and R24's care plan was not individualized with a specific traumatic triggers and interventions to prevent triggering trauma and how to respond to R24's trauma. events or experience with person-centered triggers. Surveyor shared the concern that staff and visitors would not know what to avoid doing and/or say in order to not trigger any potential re-traumatization of R24. SSC-D agreed and understood that R24 was not comprehensively assessed to help facilitate a person-centered care plan with individualized potential triggers.On [DATE], at 9:20 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-G regarding R24. CNA-G confirmed that CNA-G was familiar with R24. CNA-G stated that CNA-G was to watch out for comments of not wanting to live but is not aware of any past trauma or what triggers R24 may have had.On [DATE], at 9:29 AM, Surveyor interviewed SSC-D again regarding R24. SSC-D stated SSC-D was not completely aware of R24's trauma history and SSC-D confirmed that SSC-D is far behind in reviewing psychology notes. SSC-D stated, I have a couple of months to get through. SSC-D stated that SSC-D will need to have psychology services work with SSC-D to develop focused problems within the care plan for the (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	more difficult Residents.On [DATE], at 3:01 PM, Surveyor shared the concerns regarding R24 with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, and [NAME] President of Success (VPS)-C.3.) R30 was admitted to the facility on [DATE] with diagnoses that included Post-Traumatic Stress Disorder (PTSD) (a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event), Bipolar disorder (episodes of mood swings ranging from depressive lows to manic highs), and Schizophrenia (chronic brain disorder characterized by distortions in thinking, perception, emotions, and behavior).R30's Minimum Data Set (MDS) assessment, dated [DATE], indicated that R30's Brief Interview for Mental Status (BIMS) score was 15, indicating that R30 was cognitively intact for daily decision making. R30's MDS documented R30's Patient Health Questionnaire (PHQ)-9 score of 0 indicating R30 had no depressive symptoms. R30 had no behaviors.R30's Psychiatric Follow Up visit dated [DATE] documented by Psychology Nurse Practitioner (Psych)-NP stated that R30 had past psychiatric hospitalizations and significant trauma from discovering son-in-law after his suicide with also reported Post Traumatic Stress Disorder (PTSD) related to an extensive history of trauma.Surveyor noted there is no documented assessment beyond the [DATE] psychiatric follow up visit to determine the extent of the trauma experienced by R30 to develop a comprehensive care plan for R30.On [DATE], at 11:29 AM, Surveyor interviewed R30. R30 shared that they had PTSD from witnessing their son-in-law commit suicide using a gun outside R30's home. On [DATE], at 10:04 AM, Surveyor interviewed Social Services Coordinator (SSC)-D regarding SSC-D initiating care plan focused problems. SSC-D stated that SSC-D is responsible for C (cognitive patterns), D (mood), E (behaviors), and Q (participation in assessment and goal setting) sections of the MDS. SSC-D stated they are responsible for identifying focused problems with interventions within the comprehensive care plan. SSC-D develops a care plan based on a Resident's MDS documentation or if assessments generate focused care plan problems. SSC-D stated that trauma assessments are completed at admission. Surveyor shared the concern with SSC-D that R30 did not have a trauma assessment completed.Surveyor noted on [DATE], at 2:52 PM, SSC-D completed a trauma assessment which documented that R30 experienced a number of traumatic events/experiences in their life. Surveyor noted that the assessment did capture that R30 witnessed a suicide.On [DATE] a care plan for being at risk for traumatization of past events or experience where reminders/triggers of event or experience may cause behavioral changes and/or emotional distress PTSD was initiated.The intervention was not individualized for R30 and stated to determine as able, the triggers of traumatic events or experience, such as sights, smells, sounds and touch, which may lead to a set of emotional, physiological and behavioral responses that arise in service of survival and safety.On [DATE], at 9:20 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-G who stated they were familiar with R30. CNA-G stated when asked, that CNA-G was not aware of any past trauma or triggers for R30. On [DATE], at 9:29 AM, Surveyor interviewed SSC-D regarding R30. SSC-D stated SSC-D was not aware of R30 having a diagnosis of PTSD and what the traumatic event or experience was. SSC-D stated that SSC-D was far behind in reviewing psychology notes. SSC-D stated, I have a couple of months to get through. SSC-D stated that SSC-D will need to have psychology services work with SSC-D to develop focused problems within the care plan for the more difficult Residents.On [DATE], at 3:01 PM, Surveyor shared the concern regarding R30 with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, and [NAME] President of Success (VP)-C.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure Residents received the necessary behavioral health care and services to maintain the highest practicable mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care for 3 (R2, R24, and R30) of 5 sampled Residents reviewed for mood concerns.*R2 expressed the need to receive in-person psychotherapy and psychotherapy was not initiated by the facility.*R24 expressed suicidal ideation on 2/2/26. No documentation was found that a suicidal evaluation was completed. The physician was not notified, or a Care Plan was not developed to address R24's suicidal ideation.*R30 expressed the need to receive in-person psychotherapy and psychotherapy was not initiated by the facility.Findings include:On 5/26/2026, at 1:31 PM, Surveyor was informed by Nursing Home Administrator (NHA)-A that the facility does not have a policy and procedure for initiating behavioral health care and services.1.R2 was admitted to the facility on [DATE] with diagnoses of Post-Traumatic Stress Disorder(PTSD)(a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event), Major Depressive Disorder(persistent feelings of sadness, hopelessness, and a loss of interest or pleasure in activities), Paraplegia(paralysis of lower half of body), End Stage Renal Disease(permanent stage of chronic kidney disease), Morbid Obesity(too much body fat), Type 2 Diabetes Mellitus(adult onset of trouble controlling blood sugar), and Chronic Obstructive Pulmonary Disease(lung disease that block airflow and make it difficult to breathe).R2's Quarterly Minimum Data Set (MDS) assessment, dated 2/2/26, documented R2's Brief Interview for Mental Status (BIMS) score to be 14 which indicated that R2 is cognitively intact for daily decision making. R2 had no depressive symptoms and behaviors.On 5/20/2026, at 11:07 AM, Surveyor interviewed R2. R2 shared with Surveyor that R2 was struggling with multiple issues which are impacting R2's mood/behavioral healthcare and services. R2 shared that at one-point R2 was offered psychology services but informed the facility R2 only wanted to participate in psychology services in person. R2 shared with Surveyor that R2 was more than willing to participate in psychotherapy if the services could be in person. On 5/21/2026 1:07 PM, Surveyor asked Social Service Coordinator (SSC)-D about R2 receiving psychotherapy services. SSC-D informed Surveyor that R2 had been going through a lot with transportation to and from dialysis and the possibility of having to transfer to another facility. SSC-D had been trying to get R2 to receive psychotherapy services, but R2 only wants talk therapy here at the facility and will not do zoom psychotherapy. On 5/21/2026, at 3:01 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, and Senior [NAME] President of Success (VPS)-C that R2 had requested to participate in psychotherapy in person vs zoom psychotherapy and the facility did not facilitate this. No further information was provided by the facility at this time as to why R2 was not provided with psychotherapy services per request and preference. On 5/26/2026, at 9:29 AM, Surveyor interviewed Social Services Coordinator (SSC)-D again in regard to R2. SSC-D acknowledged that R2 wanted and needed psychology services. SSC-D confirmed that the facility only offered R2 the ability to receive psychology services via zoom. SSC-D confirmed that the facility made no attempt to provide R2 psychology services in person. SSC-D informed Surveyor that there may have been a miscommunication between the facility and the psychology services. SSC-D believed the psychology service may have thought there was only one person who needed psychology services. SSC-D shared with Surveyor that Sr. [NAME] President (VPC)-C asked SSC-D why the facility did not have in-person psychology services available at the facility and would be working on providing in-person services. 2) R24 was admitted to the facility on [DATE] with diagnoses of Type 2 Diabetes Mellitus(adult onset of trouble controlling blood sugar), Essential Hypertension(chronic condition of persistently high blood pressure), Anxiety Disorder(mental health disorder characterized by feelings (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of worry, fear that interfere with daily activities), and Depression(mood disorder that causes persistent feelings of sadness and loss of interest).R24's Annual Minimum Data Set (MDS) dated [DATE], indicated that R24's Brief Interview for Mental Status (BIMS) score was 15, indicating R24 was cognitively intact for daily decision-making skills. R24's Patient Health Questionnaire (PHQ-9) score is 1 however, R24's MDS documented R24 feels down, depressed, little interest or pleasure for 2-6 days. R24 had no documented behaviors. On 2/2/2026, a progress note located in R24's Electronic Medical Record (EMR) documented: .Writer heard resident (R24) talking about wanting to schedule a doctor's appointment. Writer approached resident(R24) and asked what doctors' appointment she (R24) was trying to schedule and if she (R24) would like the facility to assist in that for her (R24). Resident (R24) became agitated and stated, A doctor that will give me (R240 a gun so I (R24) can shoot myself (R24) in the head. Resident (R24) was in the presence of another staff member when this comment was made, and the writer went to get social worker for immediate follow up and intervention.On 2/3/26, Psychologist PhD (Psych)-S documented that R24 had a history of suicidal ideation.Surveyor noted that R24's history of suicidal ideation and the expression of suicidal ideation on 2/2/26 was not initiated as a focused problem within R24's comprehensive care plan.R24 expressed suicidal ideation on 2/2/26. No documentation was found that a suicidal evaluation was completed or that the physician was notified of R24's suicidal ideation.On 5/20/2026, at 10:04 AM, Surveyor interviewed Social Services Coordinator (SSC)-D in regard to SSC-D initiating care plan focused problems. SSC-D stated that SSC-D was responsible for C, D, E, Q sections of the MDS and is responsible for implementing focused problems with interventions within the comprehensive care plan. SSC-D develops a care plan based on a Resident's MDS documentation or if assessments generate focused care plan problems.On 5/21/26, at 1:13 PM, Surveyor interviewed Social Services Coordinator (SSC)-D again in regard to R24's suicidal ideation and the expression on 2/2/26. SSC-D only recalls talking with R24 in regard to the expression and was aware of R24's depression. Surveyor shared that there is no care plan focused problem addressing R24's suicidal ideation expressions. SSC-D does not know why there are no care plans in place. Surveyor also expressed concern that an assessment was not completed for R24's expression of suicidal ideation.On 5/26/2026, at 9:20 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-G in regard to R24. CNA-G confirmed that CNA-G is familiar with R24. CNA-G confirmed that CNA-G is to watch out for comments of not wanting to live but was not aware of any past trauma or what triggers R24 may have had.On 5/26/2026, at 9:29 AM, Surveyor interviewed SSC-D again in regard to R24. SSC-D stated SSC-D was not aware of R24 having a history of suicidal ideation and SSC-D confirmed that SSC-D was far behind in reviewing psychology notes. I have a couple of months to get through. SSC-D stated that SSC-D will need to have psychology services work with SSC-D to develop focused problems within the care plan for the more difficult Residents. On 5/21/2026, at 3:01 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, and Senior [NAME] President of Success (VPS)-C that the facility did not notify R24's physician of R24's suicidal ideation, a suicidal evaluation was not completed, and a care plan with person centered interventions was not implemented. The facility has not provided additional information as to why R24's suicidal ideation was not assessed and interventions implemented and documented within R24's comprehensive care plan. 3) R30 was admitted to the facility on [DATE] with diagnoses of Chronic Kidney Disease(progressive damage and loss of function in the kidneys), Type 2 Diabetes Mellitus(adult onset of trouble controlling blood sugar), Post-Traumatic Stress Disorder(PTSD)(a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event), Bipolar(episodes of mood swings ranging from depressive lows to manic highs), and Schizophrenia(chronic brain disorder characterized by distortions in thinking, perception, emotions, and behavior).R30's Minimum Data Set (MDS) assessment, dated 4/2/26, indicated that R30's Brief Interview for Mental Status (BIMS) score was 15, indicating that R30 was cognitively intact for daily decision making. R30's MDS documented R30's Patient Health Questionnaire (PHQ)-9 score of 0 indicating R30 had no depressive symptoms. R30 had (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	no behaviors. R30's Psychiatric Follow Up visit dated 10/31/25 documented by Psychology Nurse Practitioner (Psych)-NP stated that R30 had past psychiatric hospitalizations and significant trauma from discovering son-n-law after his suicide with also reported Post Traumatic Stress Disorder (PTSD) related to an extensive history of trauma. On 5/20/2026, at 10:04 AM, Surveyor interviewed Social Services Coordinator (SCC)-D in regard to R30. SSC-D informed Surveyor that SSC-D was unaware that R30 still wanted to see a psychotherapist in person. SSC-D was aware that R30 did not want to utilize the only way to receive psychotherapy zoom service provided by the facility. SSC-D acknowledged that the facility was not providing in person psychotherapy services to Residents. SSC-D informed Surveyor that SSC-D knew that R30 did not like receiving psychotherapy services on zoom, did not like it and preferred to not receive psychotherapy services on zoom. SSC-D stated R30, and SSC-D talked about it awhile ago, but never re-approached R30 about setting up psychotherapy services in the community and never approached R30's community case manager. On 5/20/2026, at 1:52 PM, Surveyor interviewed R30 in regard to psychotherapy service. R30 informed Surveyor that R30 requested to go see a therapist but stated the facility did not do anything about it. On 5/21/2026, at 3:01 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, and Senior [NAME] President of Success (VPS)-C that R30 had requested to participate in psychotherapy in person vs zoom psychotherapy and the facility did not facilitate this. No further information was provided by the facility at this time as to why R30 was not provided with psychotherapy services per request and preference.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon observation, interview and record review, the facility did not ensure 1 (R2) of 13 sampled residents reviewed received medically related social services to address individual Resident needs in order to maintain the highest practicable physical, mental, and psychosocial well-being.*Therapy assessed R2 as needing a bigger wheelchair 10/24/25. R2 attends dialysis 3 times a week and the transportation company stated they would no longer be able to transport R2 to and from dialysis with a bigger wheelchair. R2 has not received the replacement wheelchair and continues to use a wheelchair that is too small and is broken because the facility informed R2 that R2 would need to seek alternative placement to get a bigger chair and continue dialysis. R2 does not want to leave the facility. The facility hasn't actively sought alternatives either for equipment or transportation options to assist R2 to remain in the facility.Findings include:The facility's Medically Related Social Services policy & procedure last reviewed/revised 7/22 documents:Procedure:.The facility must provide medically related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Medically related social services may include:1.Making arrangements for obtaining needed adaptive equipment, clothing and personal items.4.Making referrals and obtaining services from outside entities (e.g., talking books, absentee ballots, community wheelchair transportation).7.Providing or arranging provision of needed counseling services.8.Through the assessment and care planning process, identifying and seeking ways to support resident's individual needs.9.Promoting actions by staff that maintain or enhance each resident's dignity in full recognition of each resident's individuality.11.Finding options that most meet the physical and emotional needs of each resident.R2 was admitted to the facility on [DATE] with diagnoses that included Post-Traumatic Stress Disorder (PTSD) (a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event), Major Depressive Disorder (persistent feelings of sadness, hopelessness, and a loss of interest or pleasure in activities), Paraplegia (paralysis of lower half of body), End Stage Renal Disease (permanent stage of chronic kidney disease).R2's Quarterly Minimum Data Set (MDS) assessment, dated 2/2/26, documented R2's Brief Interview for Mental Status (BIMS) score to be 14 which indicated that R2 is cognitively intact for daily decision making. R2 had no depressive symptoms and behaviors. R2 had lower extremity impairment on both sides. R2 required partial/moderate assistance for both upper and lower dressing. R2 required substantial/maximum assistance for mobility and dependent for showers and transfers.On 5/20/2026, at 11:07 AM, Surveyor interviewed R2. R2 shared with Surveyor that R2 is struggling with multiple issues which are impacting R2's mood/behavioral healthcare. R2 informed Surveyor that R2 has been fighting since October 2025 to resolve a transportation issue so R2 can remain in the facility and continue to attend the same dialysis center 3 times a week. The specific transportation company R2 uses will no longer be able to transport due to a wider wheelchair not fitting on the transportation ramp. R2 explained that R2 had been the second longest resident in the facility since 2019 and had been attending the same dialysis center 3 times a week since 2019. R2 stated the facility informed R2 that R2 would need to transfer to a new facility that has in-house dialysis. R2 did not know what to do and would love to stay. R2 informed Surveyor that R2's husband has liver cancer and is on death door. R2 stated, I am going to be without my support system, it affects me greatly, it's breaking my heart. R2 informed Surveyor that the facility had known about the transportation issue since October. R2 stated that R2 had tried calling places on R2's own. R2 had a fear of having to go live in Illinois, which is where the facility stated there was an in-house dialysis facility that may admit R2. R2 explained that the social worker from dialysis had been helping and was a great support system for R2. R2 informed Surveyor that the facility social worker had not been helping R2 at all and R2 barely sees the social worker from the facility. I have yet to see what the social worker here has done anything. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor noted R2 was crying during the interview and expressed how sad R2 was to have to leave the facility.Surveyor reviewed R2's electronic medical record (EMR)and noted that the R2's EMR had no documentation from social services, specifically addressing R2's struggles with dialysis transportation, referrals to other facilities and addressing R2's emotional well-being. One progress note dated 5/12/26 written by Social Services Coordinator (SSC)-D that stated R2 was fine with referrals being sent to two facilities. No follow-up note had been written.Surveyor noted that R2's discharge care plan documented that R2 was a long-term resident of the facility initiated on 11/5/21. R2's discharge care plan had not been updated with the possibility of being transferred to another facility.On 5/20/2026, at 1:01 PM, Surveyor interviewed Medical Records Coordinator (MRC)-F who confirmed that MRC-F makes the appointments and transportation arrangements for Residents. MRC-F confirmed that MRC-F was working on alternative transportation arrangements. MRC-F stated that as soon as alternative transportation could be found, then R2 could switch to the bigger chair. MRC-F stated that the bigger, more appropriate chair for R2 would not fit on the current transportation's ramp into the vehicle. MRC-F confirmed the facility had known about the chair since October. MRC-F stated the current chair had been breaking because R2 was too large for the chair, MRC-F stated the sides are popping out of it (sides are breaking) and MRC-F understood that the social worker had given R2 an option of going to a place with in-house dialysis. I believe (Social Service Coordinator (SSC)-D) is working on that; putting out referrals.On 5/20/2026, at 1:38 PM, Surveyor interviewed Rehabilitation Director (RD)-GG regarding R2. RD-GG stated that therapy will screen Residents on admission and as needed. RD-G recalled having screened R2 and discussed what size chair would have been appropriate for R2. RD-GG will provide documentation of the screen to Surveyor.On 5/20/2026, at 3:24 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A regarding R2. NHA-A confirmed that R2 did not receive a new wheelchair, and R2 was offered alternate placements, and the facility made a few referrals. NHA-A understood that alternative transportation has to be found.On 5/21/2026, at 6:05 AM, Surveyor received from therapy R2 had been screened on 10/24/25 for a larger wheelchair and it was determined that R2 needed a 24-inch-wide seat instead of a 22 inch-wide seat.On 5/21/2026, at 6:29 AM, Surveyor interviewed Registered Nurse (RN)-E who was familiar with R2. RN-E informed Surveyor that R2's mood had been up and down recently. RN-E has observed R2 to be very teary eyed. RN-E explained R2's chair is breaking, but if the facility put R2 in a bigger chair it would not fit on the van. RN-E stated, I know she is very worried and upset about having to leave as this has been her home for so long. RN-E described R2's mood as sad and teary.On 5/21/2026, at 11:02 AM, Surveyor observed R2 in R2's wheelchair right after R2 returned from dialysis. Surveyor observed the sides of R2's wheelchair were busted off. R2's chair had no sides, only arm rests. R2 stated that the right side was busted off many months ago and the left side busted off about two weeks ago. R2 explained to Surveyor that R2 has two large growths on either side, and the physician would not do surgery because of the risk. Surveyor observed as R2 was propelled to R2's room, the sides of R2's hips ride on the wheels of the wheelchair. R2 informed Surveyor that the wheelchair R2 was currently using was uncomfortable and painful.On 5/21/2026, at 1:07 PM, Surveyor interviewed SSC-D. SSC-D confirmed that R2's new chair had not been ordered because then R2 would not fit on the transportation vehicle. SSC-D stated SSC-D had sent referrals to in-house dialysis facilities. SSC-D stated the facility is looking for transportation that could accommodate R2 but had not received phone calls back. SSC-D stated, I know it is very hard on her to have to leave, I don't want anything to happen to her with the wheelchair she is in with the transportation van.On 5/21/2026, at 3:01 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, and [NAME] President of Success (VP)-C that R2 had not received medically related social services regarding assisting R2 to have proper, working equipment, the ability to receive necessary medical services and reside where R2 prefers to reside On 5/26/2026, at 7:43 AM, Surveyor interviewed Dialysis Masters Social Worker (MSW)-HH via telephone. MSW-HH confirmed that MSW-HH had been R2's dialysis social worker for a long time. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MSW-HH informed Surveyor that the facility had informed MSW-HH that R2 needed a bariatric wheelchair for transportation and would need to go to another facility. MSW-HH informed Surveyor that this had been going on since the past fall. MSW-HH explained it has been hard to get updates from the facility and stating it feels like they had been avoiding MSW-HH. MSW-HH stated the facility did not provide updates on R2's situation. MSW-HH had reached out several times to the facility, calling every week. MSW-HH stated MSW-HH had to do hand holding of SSC-D. MSW-HH stated that R2's Medicaid was due for renewal 2/10/26 and the facility did not even know that. MSW-HH stated SSC-D was not doing anything about the transportation issue, so MSW-HH was helping with it. MSW-HH relayed what needed to be done for the transportation and still nothing had been done. MSW-HH stated that on 5/12/26 MSW-HH sent an email to SSC-D and informed SSC-D the name of a company that could transport R2 and the transportation ombudsman has followed up on the case. MSW-HH had also been helping SSC-D to find another facility because SSC-D was not sending referrals. MSW-HH provided R2 with the ombudsman phone number. MSW-HH stated, it was ridiculous how long it has been taking; I would have expected the facility to take care of this. MSW-HH stated that R2 was very anxious and R2 did not want to leave and was in distress about the thought of leaving the facility.On 5/26/2026, at 9:20 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-G. CNA-G stated that R2 could be tearful and emotional and had been more tearful in the past month or so. CNA-G stated that R2 had been talking about the thought of having to leave and this was when we noticed her becoming more tearful.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not maintain procedures for acting upon the monthly drug regimen review recommendations for 1 (R7) of 5 residents reviewed.R7's Pharmacy Medication Regimen Review, dated 1/21/26, recommended discontinuing scheduled Benzonatate 100 milligrams (mg) daily and changing it to PRN (as needed). R7's physician approved this recommendation on 2/11/26. R7 continued to receive scheduled Benzonatate 100 mg daily until it was discontinued on 3/4/26.Findings include:The facility policy titled Medication Monitoring . Medication Regimen Review and Reporting dated January 2023 documents: . Medication Regimen Review (MRR) or Drug Regimen Review is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with mediation. The MRR includes review of the medical record in order to prevent, identify, report, and resolve medication-related problems, medication errors, or other irregularities. For . MRRs: . the findings are communicated to the director of nursing or designee and the medical director. These findings are documented and filed with other consultant pharmacist recommendations in the resident's chart. resident-specific MRR recommendations and findings are documented and acted upon by the nursing care center and/or physician. the nursing care center follows up on the recommendations to verify that appropriate action has been taken. Recommendations shall be acted upon within 30 calendar days. for those issues that require physician intervention, the attending physician either accepts and acts upon the report and recommendations or rejects all or some of the report and should document his or her rationale of why the recommendation is rejected in the resident's medical record.R7 admitted to the facility on [DATE] with diagnoses including hypertensive heart and chronic kidney disease (long-term high blood pressure leading to heart and kidney damage), anxiety, and chronic diastolic (congestive) heart failure (a heart condition causing the heart to work harder leading to fluid back up into the lungs and body). R7's pharmacy medication regimen review dated 1/21/26 documented current order: Benzonatate 100 mg QD (daily) since 8/22/25 for cough. Benzonatate is generally only used for short term treatment of cough. It has a narrow therapeutic window and has a high risk of adverse effects when used long term. Adverse effects include nausea, dizziness, headache, sedation, somnolence and, in some cases, numbness of the tongue. Recommendation: consider discontinuing schedule and change to PRN if started for acute condition to decrease risk of adverse effects. R7's ordering practitioner response documented OK PRN dated 2/11/26. Surveyor was unable to locate evidence R7's order for Benzonatate was changed to PRN as recommended on R7's 1/21/26 pharmacy medication regimen review and approved by R7's physician on 2/11/26. Surveyor notes R7's received scheduled Benzonatate 100 MG QD until it was discontinued on 3/4/26. On 5/26/26 at 9:42 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B. NHA-A stated the previous DON left the facility at the beginning of February and there were two interim DONs before DON-B started at the facility at the end of April 2026. NHA-A stated normally the DON would be responsible for following up on the physician response to pharmacy MRRs, but this process got lost with the interim DONs. NHA-A stated the DON or assistant DON (ADON) would be responsible for updating the resident's orders after physician recommendations. Surveyor shared the concern with NHA-A and DON-B that R7's pharmacy MRR dated 1/21/26 recommended Benzonatate be discontinued or changed to PRN and R7's practitioner responded to change Benzonatate to PRN on 2/11/26, but the facility did not follow up on this recommendation. DON-B stated DON-B was aware the order was missed, but DON-B was not yet working at the facility in March 2026. NHA-A and DON-B did not provide any additional information.

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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 interview and record review, the facility did not ensure each resident's drug regimen was free from unnecessary drugs for 1 (R7) of 5 residents reviewed.R7's pharmacy medication regimen review dated 1/21/26 recommended R7's order for Benzonatate 100 milligrams (mg) daily be discontinued or changed to as needed (PRN). R7's ordering practitioner response documented OK PRN dated 2/11/26, but R7 continued to receive Benzonatate 100 mg daily until 3/1/26. Findings include:The facility policy titled Medication Monitoring . Medication Regimen Review and Reporting dated January 2023 documents: . Medication Regimen Review (MRR) or Drug Regimen Review is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with mediation. The MRR includes review of the medical record in order to prevent, identify, report, and resolve medication-related problems, medication errors, or other irregularities. For . MRRs: . the findings are communicated to the director of nursing or designee and the medical director. These findings are documented and filed with other consultant pharmacist recommendations in the resident's chart. resident-specific MRR recommendations and findings are documented and acted upon by the nursing care center and/or physician. the nursing care center follows up on the recommendations to verify that appropriate action has been taken. Recommendations shall be acted upon within 30 calendar days. for those issues that require physician intervention, the attending physician either accepts and acts upon the report and recommendations or rejects all or some of the report and should document his or her rationale of why the recommendation is rejected in the resident's medical record. R7 admitted to the facility on [DATE] with diagnoses including hypertensive heart and chronic kidney disease (long-term high blood pressure leading to heart and kidney damage), and chronic diastolic (congestive) heart failure (a heart condition causing the heart to work harder leading to fluid back up into the lungs and body).R7's pharmacy medication regimen review dated 1/21/26 documented current order: Benzonatate 100 mg QD (daily) since 8/22/25 for cough. Benzonatate is generally only used for short term treatment of cough. It has a narrow therapeutic window and has a high risk of adverse effects when used long term. Adverse effects include nausea, dizziness, headache, sedation, somnolence and, in some cases, numbness of the tongue. Recommendation: consider discontinuing schedule and change to PRN if started for acute condition to decrease risk of adverse effects. R7's ordering practitioner response documented OK PRN dated 2/11/26. R7's physician orders documented the following order: Tessalon Perles oral capsule 100 mg (Benzonatate), give 1 capsule by mouth one time a day for cough, start date 8/22/25, discontinuation date 3/4/26. R7's February 2026 Medication Administration Report (MAR) documented R7 received Benzonatate 100 mg daily 2/11/26 - 2/28/26. R7's March 2026 MAR documented R7 received Benzonatate 100 mg daily on 3/1/26. R7 was hospitalized on [DATE] and the order for Benzonatate 100 mg daily was discontinued on 3/4/26. On 5/26/26 at 9:42 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B. NHA-A stated the previous DON left the facility at the beginning of February and there were two interim DONs before DON-B started at the facility at the end of April 2026. NHA-A stated normally the DON would be responsible for following up on the physician response to pharmacy MRRs, but this process got lost with the interim DONs. NHA-A stated the DON or assistant DON (ADON) would be responsible for updating the resident's orders after physician recommendations. Surveyor shared the concern with NHA-A and DON-B that R7's pharmacy MRR dated 1/21/26 recommended Benzonatate be discontinued or changed to PRN and R7's practitioner responded to change Benzonatate to PRN on 2/11/26, but R7 continued to receive Benzonatate daily through 3/1/26. DON-B stated DON-B was aware the order was missed, but DON-B was not yet working at the facility in March 2026. NHA-A and DON-B did not provide any additional information.

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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 interview and record review the facility did not ensure 1 (R34) of 6 residents reviewed for medications were free from significant medication errors.On 3/17/26 between 7:50 p.m. and 10:00 p.m., R34 received a combination of narcotics, benzodiazepine and muscle relaxers in a short time span and not according to physician orders for the amount and frequency.Findings include:R34 was admitted to the facility on [DATE] with diagnoses of COPD, bipolar disorder and dependent on supplemental oxygen. The significant change Minimum Data Set (MDS) dated [DATE] documents R34 had moderate cognitive impairment, needed supervision with dressing, independent with transfers and hygiene. It also documents R34 was independent to walk 10 feet with a walker and 50 feet with supervision. R34 was always continent of bowel and occasionally incontinent of bladder.On 3/3/26, R34 was admitted to hospice services due to COPD.On 3/18/26, at 13:16 (1:16 PM) (late entry), R34's medical record documents, Writer walked by room and saw resident on floor with head by bed and legs toward recliner, CNA (Certified Nursing Assistant) called to room and vitals equipment brought to room. [NAME] was over by recliner, so it was not within her reach.Surveyor reviewed F34's fall report dated 3/18/26, at 12:45 AM. The fall report documents Licensed Practical Nurse (LPN)-V found R34 on the floor with her head by the bed and legs towards the recliner. LPN-V asked (Certified Nursing Assistant) CNA-N to bring the vitals equipment. The report documents: R34 was by her recliner, and the call light was attached to the recliner. R34 stated she fell backwards but did not hit her head .On 3/18/26 at 1:08 a.m., a nurse's note documents R34 was sent to the hospital.On 4/3/26, at 11:42 AM, R34's medical record documents IDT (Interdisciplinary Team) members reviewed medication error from 3/17 on PM shift. Reason for Review: It was identified by the interim DON (Director of Nursing) that a medication error had occurred. Upon MAR (Medication Administration Record) review following [R34's] fall it was discovered that [R34] received two doses of lorazepam 0.5 mg (milligrams) approx (approximately) 2 hours and 15 mins (minutes) apart which is not within the order for lorazepam which was 0.5 mg every 4 hours. Background: . Prior to her fall [R34] was frequently asking and receiving pain medication oxycodone and methocarbamol for pain. [R34] was asking for these medications consistently when she was able to receive them. On 3/13 a progress note indicated that [R34] was requesting medication for pain not even an hour after writer had administered pain medications. Hospice was contacted to see if additional PRN morphine could be obtained for comfort rather than PRN every 12 hours however the hospice provider refused at the time due to [R34's] history. [R34] also received an order for morphine 3/13 for .25 ml by mouth two time a day for hospice order SOB (shortness of breath), air hunger, pain and also received orders for PRN .24 ml (sic) by mouth every 4 hours as needed for SOB, pain, restlessness. The nurse that had the medication error was spoken to on accuracy of documentation and stated that [R34] seemed like she really needed it and continuously kept asking for another pain medication. On 3/19/26 a nurse's note documents a review of R34's medications discovered a medication error which documented R34 received lorazepam 0.5 mg (milligrams) too close together. Surveyor reviewed the facility's medication error report dated 3/17/26. The report documents R34's medications were reviewed post fall, and it was discovered R34 received two doses of lorazepam 0.5 mg approximately 2 hours and 15 minutes apart which was too frequent compared to the resident's current physician order for lorazepam 0.5mg every 4 hours.The medication error report documents an interview with Licensed Practical Nurse (LPN)-Z, who administered the lorazepam, was conducted. LPN-Z stated R34 was continuously asking for the lorazepam and LPN-Z felt like she needed it, so she gave it to R34.Surveyor notes R34's physician orders document R34's scheduled and as needed (PRN) pain and anxiety medication as the following: -Morphine (narcotic pain medication) 0.25 ml twice a day (BID) at 10:00 a.m. and 10:00 p.m. for shortness of breath, air hunger and pain-Oxycontin (opioid pain medication) 10 mg BID at 6:00 a.m. and 3:00 p.m. for pain-Lorazepam (anti anxiety medication) 0.5 mg (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	every 4 hours PRN for anxiety-Morphine 0.25 ml every 4 hours PRN for shortness of breath, air hunger and pain-Oxycodone 5 mg every 6 hours PRN for pain-Methocarbamol 500 mg every 6 hours PRN for painSurveyor notes a severe interaction can occur when mixing lorazepam with opioids (painkillers), and other sedatives can cause severe, life-threatening breathing issues, extreme drowsiness, or coma. (MedlinePlus (.gov) https://medlineplus.gov)Surveyor reviewed the medication administration record (MAR) for R34 on 3/17/26, prior to the fall documents R34 received the following medications:At 7:50 p.m. Methocarbamol 500 mg (muscle relaxer)At 7:51 p.m. Oxycodone 5 mg (narcotic)At 7:51 p.m. Morphine 0.25 ml (narcotic) (PRN)At 8:23 p.m. Lorazepam 0.5 mg (benzodiazepine) (PRN)At 9:21 p.m. Lorazepam 0.5 mg (PRN)At 10:00 p.m. Morphine 0.25 ml (scheduled)Surveyor reviewed R34's Controlled Substance Record for Lorazepam 0.5 mg every 4 hours PRN. The facility received 30 tablets that are half tablets which is 0.5 mg. R34's record documents on 3/17/26 at 7:30 p.m., Lorazepam 0.5 mg 2 tablets were removed from the medication pack instead of the prescribed 1 tablet. Then another 2 tablets removed at 9:45 p.m.According to R34's MAR the Lorazepam was administered to R34 at 8:23 p.m. and 9:21 p.m. In a span of about an hour R34 received a total of 2 mg of Lorazepam. Surveyor notes R34 received 1.0 mg of Lorazepam for each of these med administrations vs the prescribed 0.5 mg. Surveyor notes R34 received double the dose of Lorazepam 2 times within an hour of each other prior to the fall. Surveyor also notes R34 received Morphine 0.25 ml at 7:51 PM and a scheduled Morphine 0.25 ml at 10:00 PM. R34's physician order was for PRN Morphine q (every) 4 hours PRN and R34 received the scheduled Morphine 2 hours and 9 minutes after the PRN dose. The facility did not clarify if R34 could receive the Morphine doses closer than the prescribed 4 hours.On 5/26/26, at 10:10 a.m., Surveyor interviewed Nursing Home Administrator (NHA)-A. Surveyor asked NHA-A if LPN-Z administered the lorazepam not according to physician orders. NHA-A explained LPN-Z stated R34 was feeling anxious and wanted more Lorazepam, so she gave her more. NHA-A stated LPN-Z no longer works at the facility. On 5/26/26 at 2:47 p.m., Surveyor interviewed Nurse Practitioner (NP)-AA. Surveyor asked NP-AA if she was made aware of R34's medication error and concerns with the combination of medications R34 received prior to the fall on 3/18/26. NP-AA stated she was made aware and was aware medications were being monitored by hospice. Surveyor asked NP-AA if the number of medications R34 received could contribute to R34 fall. NP-AA stated R34 was on hospice, elderly and had comorbidities that contributed to the fall. NP-AA did not answer the question if the medications R34 received contributed to R34's fall. On 5/26/26 at 3:00 p.m., during the daily exit meeting with NHA-A and Director of Nursing (DON), Surveyor explained the concern R34 received an unusual amount of pain and anti-anxiety medications in a short amount of time. Surveyor explained the lorazepam was not administered as ordered, by receiving a double dose two times within an hours' time. On 5/27/26 the facility provided Surveyor with an email response from a pharmacy consultant the facility receives their medication from. The email indicates with hospice patients particularly those with COPD, anxiety, chronic pain and oxygen dependence, as in this case, it is common for both lorazepam and opioids (e.g., morphine) to be used with some flexibility to manage distressing symptoms such as dyspnea (air hunger), anxiety and terminal discomfort.The email continues to explain from a clinical standpoint: Lorazepam: although the order was for 0.5 mg every 4 hours PRN, hospice and palliative care guidelines commonly allow for lorazepam administration as frequently as every 2-4 hours PRN, and in some actively symptomatic or dying patients, even more frequent dosing may be clinically appropriate to relieve acute distress or agitation. Morphine: dosing in hospice care is often individualized and titrated based on symptom burden rather than rigid timing, particularly for dyspnea and pain. It is not uncommon for PRN and scheduled doses to occur in relatively close proximity when a patient is symptomatic, provided the patient is monitored for tolerance and adverse effects. Importantly, documentation indicates that respiratory rate was 24 (not depressed), blood pressure was stable (152/76) and no evidence of oversedation or respiratory compromise was noted.Surveyor notes facility documentation does not indicate R34 was exhibiting distressing symptoms such as (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dyspnea or terminal discomfort prior to the medication error and fall with major injury. Surveyor also notes the facility does not document an assessment by licensed staff and consultation with R34's physician to administer R34's medications outside of prescribed parameters.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program. Based on interview and record review the facility did not ensure 2 of 2 non-direct staff chosen at random received QAPI (Quality Assurance Performance Improvement) training on the elements and goals of the facility's QAPI program.Housekeeper-PP and Cook-QQ did not receive QAPI training.Findings include:On 6/3/26, at 10:19 a.m. surveyor requested training for Housekeeper-PP with a hire date of 3/28/25 and Cook-QQ with a hire date of 4/27/21.On 6/3/26, at 11:40 a.m., Surveyor reviewed Houskeeper-PP's training received from date of hire. Surveyor noted Housekeeper-PP received required training for resident rights & responsibility; abuse, neglect, exploitation; infection control, and compliance & ethics. Surveyor was unable to locate when Housekeeper-PP received QAPI training.On 6/3/26, at 11:44 a.m., Surveyor reviewed Cook-QQ's training received during 2025-2026. Surveyor noted that Cook-QQ received required training for resident rights & responsibility; abuse, neglect, exploitation; infection control, and compliance & ethics. Surveyor was unable to locate when Cook-QQ received QAPI training.On 6/3/26, at 1:27 p.m., Surveyor met with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B and Senior VP (Vice President) of Clinical Compliance & Quality-VV. Surveyor inquired how in-services are assigned. NHA-A informed Surveyor in-services are assigned monthly and if needed there is additional training assigned. Surveyor inquired about who is responsible for in-servicing non nursing staff. NHA-A informed Surveyor she does one on one or shift to shift with other departments along with the department heads. Senior VP of Clinical Compliance & Quality-VV informed Surveyor employee training plan is through their support center which is from their compliance department for required trainings. Surveyor informed facility staff Surveyor was unable to locate QAPI training for Housekeeper-PP and Cook-QQ.On 6/3/26, at 1:48 p.m., Senior VP of Clinical Compliance & Quality-VV informed Surveyor they do not have QAPI training for Housekeeper-PP and Cook-QQ.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review the facility did not ensure 1 of 5 randomly sampled Certified Nursing Assistant (CNA) had a current CNA Skills Competency Checklist completed to address areas of weakness.CNA-TT's last CNA Skills Competency Checklist was completed on 1/1/24.Findings include:On 6/3/26, at 9:30 a.m., Surveyor requested competencies for five randomly selected Certified Nursing Assistants (CNAs) including CNA-TT from Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B.CNA-TT date of hire is 5/26/20. On 6/3/26, at 9:42 a.m., Surveyor was provided with CNA-TT's CNA Skills Competency Checklist. Surveyor noted this skills competency was completed on 1/1/24. CNA-TT and Prior DON-JJ signed the CNA skills competency checklist on 1/4/24.On 6/3/26, at 1:33 p.m., Surveyor informed Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B and Senior VP (Vice President) of Clinical Compliance & Quality-VV the CNA skills competency checklist for CNA-TT was signed as complete by CNA-TT & Prior DON-JJ on 1/4/24 and asked if there is a current competency.On 6/3/26, at 1:52 p.m. NHA-A informed Surveyor they cannot locate another competency. Surveyor asked NHA-A if there is a policy for competencies.On 6/3/27, at 2:07 p.m., NHA-A informed Surveyor they don't have a competency policy.

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F 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. Based on observation, staff interview, and record review the facility did not ensure contact information for all pertinent State agencies and advocacy groups, was posted. Further, a statement that the Resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to Resident abuse or neglect, and non-compliance with the advanced directives requirements, Medicaid Fraud Control Unit and requests for information regarding returning to the community was not posted. This practice had the potential to affect all 33 residents of the facility at the time of the survey. * The facility did not have posted list of names, addresses (mailing and emailing), and telephone numbers for all pertinent State agencies and advocacy groups such as adult protective services where state law provides for jurisdiction in long term care facilities, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit, and a statement that the Resident may file a complaint with the State Survey Agency. The State Survey Agency, Ombudsman and Adult Protective Services did not have the email address listed for each of the agencies. Findings Include: The facility's undated Facility Required Postings documents:Policy:.The facility will post required postings in an area that is accessible to all staff and residents.Policy Explanation and Compliance Guidelines:.1.Facility postings include the following:a.A list of names, addresses(mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups to include but not limited to:i.State Survey agencyii.State Licensure Officeiii.Adult Protective Servicesiv.Office of the State of Long-Term Care Ombudsmanv.Protection and Advocacy Networkvi.Home and Community Based Service Programsvii.Family and Medical Leave Actviii.Medicaid Fraud Control Act Unitix.Applying for Medicare and Medicaid. On 5/20/2026, at 11:40 AM, Surveyor conducted the Quality-of-Life Assessment Group Interview. All 6 Residents in attendance (R7, R11, R16, R23, R26, and R30) informed Surveyor they were not aware of the location of facility required information for Residents was posted. On 5/20/2026, at 2:13 PM, Surveyor conducted a tour of the facility. Surveyor observed the facility's postings located behind a glass cabinet on the left wall when entering the facility. Surveyor noted the postings were not located in any other location within the facility. Surveyor noted the Ombudsman, State Survey Agency, and Adult Protective Services information did not contain the email for each of the agencies. Surveyor noted the information regarding the following required agencies was not posted:-Protection and Advocacy Network-Home and Community Based Service Programs-Family and Medical Leave Act-Medicaid Fraud Control Act Unit-Applying for Medicare and Medicaid Surveyor also noted during the tour of the facility a statement that the Resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to Resident abuse or neglect, non-compliance with the advanced directives requirements, and requests for information regarding returning to the community were not posted. On 5/20/2026, at 11:40 AM, during the Quality-of-Life Assessment Group Interview Surveyor asked all 6 Residents in attendance (R7, R11, R16, R23, R26, and R30) if the Residents knew where the State survey results were located. All 6 Residents were not aware there was State survey results or where they may be located.On 5/20/26, at 11:40 AM, Surveyor also asked the 6 Residents if they had been informed of their right to contact the Office of the State Long-Term Care Ombudsman. 5 (R7, R11, R16, R23, R26) Residents did not know what an Ombudsman was or what an Ombudsman does. Further, 5 (R7, R11, R16, R23, R26) Residents did not know where the Ombudsman information was located.On 5/26/2026, at 12:41 PM, Surveyor interviewed Nursing Home Administrator (NHA-A) and asked NHA-A who is responsible for posting the required regulatory information within the facility for the Residents. NHA-A stated, I guess I am responsible for the postings. Surveyor shared the concern that the Ombudsman, State Survey Agency, and Adult Protective Services information did not contain the email for each of the agencies. Surveyor shared (continued on next page)

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F 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	that the contact information including telephone number, mailing address, and email was not posted for the Protection and Advocacy Network, Home and Community Based Service Programs, Family and Medical Leave Act, Medicaid Fraud Control Act Unit, and Applying for Medicare and Medicaid. Surveyor shared with NHA-A the statement that a Resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to Resident abuse or neglect, non-compliance with the advanced directives requirements, and requests for information regarding returning to the community were not posted. NHA-A had no further information as to why the required information was not posted at a location within the facility that was easily accessible to Residents.