STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525358	A. Building B. Wing	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Florence Health Services	5778 Chapin St Florence, WI 54121

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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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on staff interview and record review, the facility did not designate a person to serve as the director of food and nutrition services who is a certified dietary manager, a certified food service manager, has a national certification for food service management and safety from a national certifying body, or who has an associate's or higher level degree in food service management or hospitality. This practice had the potential to affect all 49 residents residing in the facility. Findings include: During an initial kitchen tour that began at 9:12 AM on 4/6/26, Account Manager (AM)-K indicated AM-K was not certified as a dietary manager. On 4/7/26 at 7:46 AM, Surveyor interviewed District Manager (DM)-H who indicated DM-H was the regional manager and oversaw several facilities. DM-H did not work at the facility regularly and stated AM-K oversaw the day-to-day kitchen and staff management. On 4/7/26 at 9:45 AM, Surveyor requested the required certification for AM-K. On 4/7/26 at 11:27 AM, Nursing Home Administrator (NHA)-A shared a Long Term Care Food Service Manager certification for DM-H. At 11:31 AM, NHA-A shared a word document that indicated AM-K did not have any certification. On 4/8/26 at 8:33 AM, Surveyor interviewed DM-H who indicated DM-H took over regional management of the facility in early March (2026). DM-H stated DM-H tried to be at the facility once or twice weekly, however, it was difficult because DM-H's assigned facilities were spread out. On 4/8/26 at 10:26 AM, Surveyor requested any dietary waivers in place for the facility. Surveyor did not receive a waiver from the facility. On 4/8/26 at 11:42 AM, NHA-A shared an email chain from 3/31/26 that indicated AM-K was enrolled in a dietary manager certification course and was instructed via email to take the course and exam by 4/21/26. On 4/8/26 at 12:52 PM, Surveyor contacted Division of Quality Assurance (DQA) Dietary Services Consultant (DSC)-AA to check if the facility submitted a waiver for the dietary manager position. DSC-AA indicated the facility did not submit a waiver for the position. On 4/8/26 at 3:08 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated the facility should have a waiver in place until AM-K is certified.

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

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and record review, the facility did not ensure food was stored and served in a safe and sanitary manner. This practice had the potential to affect 48 of 49 residents residing in the facility (1 resident received nutrition via tube feeding.) The facility did not store food in a manner to ensure food safety, including proper food dating. Staff did not test or document parts per million (PPM) of the sanitizing solution. Findings include: On 4/6/26 at 9:12 AM, Surveyor and Account Manager (AM)-K began an initial kitchen tour. AM-K indicated the facility follows the Food and Drug Administration (FDA) Food Code. Food Labeling/Storage: The 2022 FDA Food Code documents at 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food (TCS), Date Marking: (A) Except when packaging food using a reduced oxygen packaging method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5 Celsius (C) (41 Fahrenheit (F)) or less for a maximum of 7 days. The day of preparation shall be counted as day 1. The 2022 FDA Food Code documents at 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food (TCS), Disposition: (A) A food specified in 3-501.17(A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3-501.17(A), except time that the product is frozen; (2) Is in a container or package that does not bear a date or day; or (3) Is inappropriately marked with a date or day that exceeds a temperature and time combination as specified in 3-501.17(A). The facility's Food Storage policy, dated 8/16/22, indicates: .b. Food should be dated as it is placed on the shelves. c. Date marking will be visible on all high-risk foods to indicate the date by which ready to eat, TCS food should be consumed, sold, or discarded .All containers must be allegedly and accurately labeled and dated. 9. Scoops must be provided for bulk foods such as sugar, flour, and spices. Scoops are not to be stored in food or ice containers but are kept covered in a protected area near the containers. Scoops are washed and sanitized on a regular basis .Refrigerated food storage: .f. All foods should be covered, labeled, and dated. All foods will be checked to assure that foods (including leftovers) will be consumed by their safe use-by dates, or frozen, or discarded .Frozen Foods: .13. c. All foods should be covered, labeled, and dated. All foods will be checked to assure that foods will be consumed by their safe use-by dates or discarded. During the initial tour with AM-K, Surveyor observed the following food storage concerns: Dry Storage:~ An open and unsealed bag of elbow pasta. There were no open or use-by dates. ~ An open bag of potato chips. There were no open or use-by dates.~ An unlabeled bulk container of flour (per AM-K). A scoop was left in the flour.~ An unlabeled container of [NAME] Krispies cereal (per AM-K). There were no open or use-by dates.~ An open and unsealed carton of Goldfish Crackers. There were no open or use-by dates. Coolers:~ An open, unsealed, and undated box of sausage links~ An unlabeled package of Swiss cheese (per AM-K) dated 3/19/26~ A package labeled cheese 4/3/26 without a use-by date~ A package of butter dated 3/25/26~ An unlabeled package of parmesan cheese (per AM-K) dated 3/31/26 that had a hole which left the cheese open to air~ An unlabeled package of onions (per AM-K) dated 3/25/26~ An open and undated container of cottage cheese~ An open, unlabeled, and undated container of tomato soup (per AM-K)~ A shallow steam table pan of red Jell-O with fruit (per AM-K) dated 4/4/26. A scoop was in the Jell-O. Freezers:~ An open, unsealed, and undated box of folded cheese omlettes that were open to air~ An open, unsealed, and undated box of hamburger patties that were open to air~ An open, unsealed, and undated box of fried eggs that was open to air~ An open, unsealed, and undated box of sugar cookie dough that was open to air~ An open, unsealed, and undated box of cinnamon rolls that were open to air~ An open, unsealed, and undated bag of pizzas (per AM-K) that were open to air ~ An open, unsealed, and undated bag of donuts (per AM-K) that were open to air~ An open, unsealed, and (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	undated bag of French toast (per AM-K) that was open to air ~ An open, unsealed, and undated bag of pancakes (per AM-K) that were open to air Surveyor interviewed AM-K who indicated all food products should be sealed, labeled, and dated with open, made, and use-by dates. AM-K indicated food that is past the use-by date should be discarded. AM-K was unsure of the use-by dates for the potato chips, cottage cheese, omlettes, hamburgers, and fried eggs. Sanitizing Solution: The 2022 FDA Food Code documents at 4-501.114 Manual and Mechanical Warewashing Equipment, Chemical Sanitization - Temperature, pH, Concentration, and Hardness: A chemical sanitizer used in a sanitizing solution for a manual or mechanical operation at contact times specified under 4-703.11(C) shall meet the criteria specified under 7-204.11 Sanitizers, Criteria, shall be used in accordance with the Environmental Protection Agency (EPA)-registered label use instructions. The 2022 FDA Food Code documents at 4-501.116 Warewashing Equipment, Determining Chemical Sanitizer Concentration: Concentration of the sanitizing solution shall be accurately determined by using a test kit or other device. The Ecolab Oasis 146 Multi-Quat Sanitizer data sheet indicates the sanitizing solution should be tested for effectiveness by measuring the parts per million (PPM) dilution range. Hydrion Quat test strips are the appropriate testing strips. The sanitizing solution temperature needs to be tested and within 65 to 75 degrees Fahrenheit. The effective PPM range is 150-400 PPM. The facility's Manual Warewashing (three-compartment sink) policy, revised 1/2024, indicates: .Remember to check the water temperature and concentration of the sanitizer (if using chemical sanitization) in the sink compartments .Chemical sanitizer testing and concentrations used according to manufacturer's guidelines (water temperature for chemical sanitizing must be a minimum of 75 degrees Fahrenheit if using Quaternary ammonia compound solution). Appropriate test strips will be used to measure the concentration of the sanitizing solution for the chemical being used. Results will be recorded on the Three-compartment Sink Log. Change the solution when the temperature or sanitizer concentration falls out of range or as directed by manufacturer's instructions . During an initial kitchen tour that began at 9:12 AM on 4/6/26, Surveyor observed a container of Ecolab Oasis 146 Multi-Quat Sanitizer in the kitchen and an Ecolab Oasis 146 Multi-Quat Sanitizer data sheet posted above the three-compartment sink. Surveyor noted the first compartment of the three-compartment sink contained water, dish soap, and dishes. The second compartment contained water. The third compartment was labeled sanitizer, but did not contain any liquid. There were dishes and utensils in the sink and a sanitizer testing log posted above the sink. The log did not contain a month. Surveyor noted the log was filled out 3 times daily from the 1st through the 20th with the temperature, PPM of the sanitizing solution, and staffs' initials. There were no entries after the 20th. Surveyor noted every PPM entry was 300. Surveyor observed Hydrion test strips on the sink. Surveyor interviewed AM-K who was not sure which month the testing log was from. AM-K indicated even if the log was from the previous month, there were no entries since the 20th. AM-K indicated the sanitizing solution should be tested and documented every shift. AM-K indicated the third compartment of the sink contained sanitizing solution which must have drained out. On 4/7/26 at 8:27 AM, Surveyor interviewed District Manager (DM)-H who indicated the sanitizer testing log was from March (2026). DM-H identified the month based on DM-H's initials on two days at the beginning of the month. DM-H indicated sanitizer testing and documentation should be completed every shift. On 4/7/26 at 9:08 AM, Surveyor noted the third compartment of the three-compartment sink contained sanitizing solution. Surveyor asked Dietary Aide (DA)-W to test the sanitizing solution. DA-W dipped a Hydrion test strip into the third compartment of the sink and let it soak for 10 seconds. DA-W withdrew the strip and matched it to the Hydrion label at 500 PPM. DA-W did not document the PPM on the log. When Surveyor asked DA-W to read the Ecolab Oasis 146 Multi-Quat Sanitizer data sheet posted above the sink, DA-W stated DA-W should have temped the water. DA-W used a thermometer and tested the water at 129.4 degrees F. When asked if the temperature and PPM were okay, DA-W indicated they were. DA-W was not aware the temperature of the sanitizing solution was too high for an accurate PPM reading and that the PPM was outside of the effective range. On 4/8/26 at 8:33 AM, Surveyor interviewed DM-H who was (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	aware the sanitizing soluton wasn't tested correctly. DM-H indicated if the PPM are not appropriate, there is potential to not sanitize effectively and put residents at risk. DM-H was aware AM-K and kitchen staff needed training on food storage and preparation. On 4/8/26 at 12:11 PM, Surveyor interviewed Registered Dietitian (RD)-C who indicated staff should be aware of and follow the facility's food storage, preparation, and serving policies. On 4/8/26 at 3:04 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated kitchen staff should be aware of and follow the facility's food storage, preparation, and serving policies.

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident has the right to receive notices in a format and a language he or she understands. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff and resident interview, the facility did not ensure residents were given the information to file a complaint, including the name and contact information for the State Survey Agency and a list of names/addresses/telephone numbers of other pertinent state agencies. In addition, the facility did not ensure information regarding resident's rights and how to file a grievance was posted in the facility. This had the potential to affect more than 4 of the 49 residents residing in the facility.During a Resident Council meeting on 4/7/26, R39, R55, R18, R45, and R46 indicated they did not know how to file a complaint with the State Agency. In addition, the residents did not know how to access a list of state agencies, did not know how to file a grievance with the facility, and stated they did not have access to information regarding residents' rights.Findings include:During an environmental tour of the facility on 4/6/26 at 10:05 AM, Surveyor could not locate required posted information for residents on how to file a complaint with the State Agency, access to a list of State agencies, how to file a grievance with the facility, or information regarding residents' rights.On 4/7/26 at 1:06 PM, Surveyor conducted a Resident Council meeting. During the meeting, R39, R55, R18, R45, and R46 indicated they did not know how to file a complaint with the State Agency and were not aware of posted information on how to file a grievance. R45 indicated at one time the information was posted on the wall across from the nurses' station but had been removed. The residents indicated they wanted the information but did not have access to it. On 4/7/26, Surveyor reviewed the medical records of R39, R55, R18, R45, and R46 and noted the following:~ R39 was admitted to the facility on [DATE]. R39's Minimum Data Set (MDS) assessment, dated 1/23/26, indicated R39 had moderately impaired cognition.~ R55 was admitted to the facility on [DATE]. R55's medical record did not contain information related to R55's cognition.~ R18 was admitted to the faclity on 12/8/22. R18's MDS assessment, dated 3/23/26, indicated R18 had moderately impaired cognition.~ R45 was admitted to the facility on [DATE]. R45's MDS assessment, dated 4/7/26, indicated R45 had intact cognition.~ R46 was admitted to the facility on [DATE]. R46's MDS assessment, dated 4/13/26, indicated R46 had intact cognition.On 4/7/26 at 2:17 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated the required postings were on the wall across from the nurses' station and on Social Services Coordinator (SSC)-D's door. NHA-A indicated if the postings were removed, SSC-D would have information.On 4/7/26 at 2:30 PM, Surveyor did not observe the required postings on the wall across from the nurses' station. Surveyor observed an Ombudsman positing on SSC-D's door. At that time, SSC-D indicated SSC-D was not aware of the required postings and did not know if the postings were somewhere in the facility. SSC-D indicated Surveyor should speak to NHA-A regarding the required postings.On 4/8/26 at 7:46 AM, Surveyor again interviewed NHA-A who indicated the required postings were on the wall across from the nurses' station where residents frequently travel. NHA-A indicated the map of the state agencies was posted. Surveyor observed the map; however, it did not contain information on how to contact the agencies. At that time, NHA-A indicated NHA-A was unsure what information was required to be posted. NHA-A indicated NHA-A recently removed and replaced some postings that were outdated and confirmed the required postings must have been removed. NHA-A could not locate the required postings that contained contact information for the State Agency, contact information for grievances, and information on residents' rights.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, staff and resident interview, and record review, the facility did not provide a safe, clean, comfortable, and home-like environment for 6 residents (R) (R4, R7, R23, R43, R16, and R55) of 16 sampled residents.The facility did not ensure R4, R7, R23, and R43's rooms and/or bathrooms were in clean condition and were cleaned daily.R16's bed did not have a bariatric fitted sheet which caused R16 discomfort.Residents who ate in the dining room at the same table were not served meals together which caused residents (including R55) to watch others eat as they waited for their food. Findings include: Cleanliness: The facility's undated 7-Step Daily Washroom Cleaning policy indicates: The proper method to sanitize a washroom or bathroom in a long-term care and hospital facility .Clean and sanitize commode. The commode includes the tank, the seat, the bowl, and the base.Using a separate rag and a germicide solution, wipe every area of the commode. Use a [NAME] mop or toilet brush to disinfect the bowl.Spot clean walls and/or partitions .Damp mop the floor.Be sure to run the mop along the corners and edges. When damp mopping floors, pay close attention to any possible build-up along corners and edges. Use your disinfectant and scraper to remove any potential build-up in these areas to maintain a clean/sanitary surface. 1. On 4/6/26, Surveyor reviewed R4's medical record. R4 had diagnoses including infection of amputation stump lower left extremity, hypertensive heart disease with heart failure, and dysphagia (difficulty swallowing). R4's Minimum Data Set (MDS) assessment, dated 2/16/26, indicated R4 had intact cognition. On 4/6/26 at 8:02 AM, Surveyor interviewed R4 who indicated housekeeping does not clean R4's room daily. R4 indicated Certified Nursing Assistants (CNAs) remove garbage from the room, however, it had been over a week since housekeeping staff cleaned R4's room. Surveyor noted R4's floor contained dirt and debris and observed dust, hair, and garbage under the bed the spanned the length and width of the bed. On 4/6/26 at 10:34 AM, 2:00 PM, and 4:15 PM, Surveyor noted R4's room was in the same unclean condition. On 4/7/26, Surveyor conducted environmental tours beginning at 8:10 AM, 11:45 AM, and 3:05 PM and noted R4's room contained dirt and debris on the floor and dust, hair, and garbage under the bed that covered the length and width of the bed. On 4/8/26 at 7:32 AM and 12:31 PM, Surveyor noted R4's floor contained dirt and debris. There was dust, hair, and garbage under R4's bed that covered the length and width of the bed. R4 indicated no one had cleaned the room. 2. On 4/6/26, Surveyor reviewed R7's medical record. R7 had diagnoses including cancer and dementia. R7's MDS assessment, dated 2/23/26, indicated R7 had moderately impaired cognition. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/6/26 at 8:33 AM, Surveyor observed R7's room and noted the area underneath and around R7's recliner contained food debris, dust, hair, and paper particles. The area where R7 was sitting in front of the television contained dust, hair, and food particles as well as paper debris that extended to the corner of the room near R7's recliner. Clumps of dust and hair extended from the left side of the room to the middle of the room. The area underneath the bed contained dust and debris. On 4/6/26 at 10:38 AM, 2:08 PM, and 4:18 PM, Surveyor noted R7's room was in the same unclean condition. On 4/7/26 at 8:05 AM, Surveyor noted R7's room was in the same unclean condition as observed on 4/6/26 at 4:18 PM. At that time, Surveyor interviewed R7 and Unnamed Family Member (UFM)-I who indicated housekeeping staff did not clean daily. R7 and UFM-I stated R7's floor was dirty and neither knew when it was last cleaned. On 4/7/26, Surveyor conducted environmental tours beginning at 8:10 AM, 11:45 AM, and 3:05 PM and noted the area underneath and around R7's recliner contained food debris, dust, hair, and paper particles. The area where R7 was sitting in front of the television contained dust, hair, and food particles as well as paper debris that extended to the corner of the room near R7's recliner. Clumps of dust and hair extended from the left side of the room to the middle of the room. On 4/8/26 at 7:32 AM and 12:31 PM, Surveyor noted the area underneath and around R7's recliner contained food debris, dust, hair, and paper particles. The area where R7 was sitting in front of the television contained dust, hair, and food particles as well as paper debris that extended to the corner of the room near R7's recliner. Clumps of dust and hair extended from the left side of the room to the middle of the room. There were brown, sticky spots on the floor in the middle of the room. R7's sink contained white water stains and hair. R7 indicated housekeeping did not clean the room. 3. On 4/6/26, Surveyor reviewed R23's medical record. R23 had a diagnosis of severe dementia without behavioral disturbance. R23's MDS assessment, dated 3/12/26, indicated R23 had severely impaired cognition. On 4/6/26 at 8:41 AM, Surveyor observed R23's shared room. The curtain from R23's side of the room to the wall and under the bed contained dust. An area in the middle of R23's side of the room contained a black sticky substance on the floor. On 4/6/26 at 10:35 AM, 2:05 PM, and 4:17 PM, Surveyor noted R23's room was in the same unclean condition. On 4/7/26, Surveyor conducted environmental tours beginning at 8:10 AM, 11:45 AM, and 3:05 PM and noted the curtain from R23's side of the room to the wall and the area under R23's bed contained dust. An area extending to the middle of R23's side of the room contained a black sticky substance on the floor. On 4/8/26 at 7:32 AM and 12:31 PM, Surveyor noted the curtain from R23's side of the room to the wall and the area under R23's bed contained dust. An area extending to the middle of R23's side of the room contained a black sticky substance on the floor. On 4/7/26 at 8:09 AM, Surveyor interviewed Housekeeping Manager (HSKM)-F who indicated rooms are cleaned daily including all horizontal surfaces, sinks, toilets, dusting the floors, and mopping with (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a wet mop. HSKM-F indicated there are typically two housekeepers with one on each wing. HSKM-F indicated HSKM-F was the only housekeeper currently working and was trying to clean every room. HSKM-F verified sweeping and mopping included each room floor and under the bed as well as monthly deep cleans which involved moving furniture and cleaning underneath. HSKM-F indicated all cleaning was documented. Surveyor requested the last 30 days of cleaning documentation from HSKM-F. On 4/7/26, Surveyor reviewed cleaning documentation from HSKM-F and noted the following: ~ Handwritten sheets indicated housekeeping staff did not complete daily room cleans or deep cleans from 3/1/26 to 3/23/26. ~ On 3/24/26 and 3/25/26, documentation indicated R4, R7 and R23's rooms were cleaned. ~ There were no documented housekeeping sheets of daily room cleans or deep cleans from 3/26/26 to 3/31/26. ~ On 4/1/26, documentation indicated R4, R7, and R23's rooms were cleaned. ~ There was no documentation provided for 4/2/26 to 4/3/26. ~ On 4/4/26, 4/5/26, and 4/6/26, documentation indicated R4, R7, and R23's rooms were cleaned. In addition, R7's room was deep cleaned on 4/5/26 and R4's room was deep cleaned on 4/6/26. On 4/8/26 at 2:34 PM, Surveyor conducted an environmental tour with HSKM-F during which Surveyor and HSKM-F observed R4, R7, and R23's rooms. HSKM-F verified the unkept and unsanitary conditions noted above. HSKM-F indicated R23's floor was cleaned on 4/8/26 but may not have been cleaned previously because the black sticky substance did not come off. HSKM-F indicated the floor in R23's room is frequently unclean and a more thorough cleaning process is required for R23's room. HSKM-F indicated R23's room should be cleaned daily and rechecked. 4. From 4/6/26 to 4/8/26, Surveyor reviewed R43's medical record. R43 had a diagnosis of diabetes with neuropathy. R43's MDS assessment, dated 3/24/26, indicated R43 had intact cognition. On 4/6/26 at 10:18 AM, Surveyor interviewed R43 who indicated the facility was home but staff could make it nice. R43 indicated staff try to keep rooms clean but also do laundry which makes it difficult to keep up with cleaning. R43 stated R43's room hadn't been cleaned recently and doesn't get cleaned for days at a time. R43 also wished R43's room could be organized. Surveyor noted R43's garbage was three-quarters full and there were open and unorganized boxes on the floor behind R43. There were boxes along the wall behind R43's chair and dental hygiene supplies on top of a wall mounted sink below a soap dispenser. When Surveyor observed the bathroom, Surveyor's shoes stuck to the floor. A urine odor was present. There were dark pieces in the toilet and a dark substance on the front of the toilet rim. The floor contained a dark yellow stain in front of the handrail bar legs and a dark yellow spot behind the handrail bar legs. Three rolls of toilet paper lined the back of the toilet. A tube of hemorrhoid cream was inside one of the rolls. On 4/6/26 at 1:06 PM, Surveyor interviewed R43 who indicated R43's red and black nightgown had gone missing a couple weeks ago and laundry staff were looking for it. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/7/26 at 11:32 AM, Surveyor interviewed Social Services Coordinator (SSC)-D who indicated the nightgown was found that morning in a box behind R43's recliner. On 4/7/26 at 4:16 PM, Surveyor interviewed R43 who verified the nightgown was found. R43 indicated the nightgown was hanging on the back of the recliner the last time R43 it and must've fallen off the recliner into the box. R43 indicated it was difficult to find anything in the room due to the disorganization. On 4/8/26 at 2:34 PM, Surveyor conducted an environmental tour with HSKM-F and observed R43's bedroom and bathroom. Surveyor noted R43's toilet seat and riser contained urine stains which went down the toilet, down the back of the toilet near the toilet seat, and in between the toilet seat and riser. There was garbage and debris on the bathroom floor and brown smudges that appeared to be feces. The sink was dirty and contained hair. HSKM-F confirmed the unclean condition of R43's bathroom and indicated the toilet and sink were wiped down the day before. HSKM-F verified the floor had not been cleaned and was unsure when the floor was last cleaned. HSKM-F verified R43's bathroom should be cleaned daily. Bariatric Sheets: The facility's Facility Assessment, dated 10/23/25, indicates: .[NAME] Health Services provides care for bariatric residents based on assessment prior to admission. Bariatric lifts, mattresses, wheelchairs, and shower chairs are available .Non-Medical Supplies - Soaps, body cleansing products, incontinence supplies, waste baskets, bed and bath linens . On 4/6/26, Surveyor reviewed R16's medical record. R16 was readmitted to the facility on [DATE] and had diagnoses including Body Mass Index (BMI) of 70 or greater, pressure ulcer stage 4, unspecified open wound right lower leg, unspecified open wound left foot, cellulitis right lower limb, chronic pain syndrome, and diabetes with neuropathy. R16's MDS assessment, dated 3/20/26, indicated R16 had intact cognition. On 4/6/26 at 11:40 AM, Surveyor interviewed R16 who indicated the facility does not have bariatric sheets for R16's bed and staff try to put on sheets that do not fit. R16 indicated R16 is uncomfortable without a fitted sheet because R16 is in bed up to 24 hours per day and wears an open back hospital gown. R16 stated R16's bare skin sticks to the plastic mattress without a sheet which makes it hard to move and turn in bed. R16 stated staff often put a flat sheet for a regular bed on R16's bed which doesn't stay in place. R16 indicated the flat sheet slides down when R16 puts the head of the bed up which leaves R16's bare skin stuck to the mattress and makes R16 uncomfortable with the flat sheet under R16's lower back or buttocks. R16 stated R16 was stuck to the mattress for 18 hours on 4/5/26. Surveyor observed R16 in bed wearing an open back hospital gown and noted R16's bed did not contain a fitted sheet. The head of the bed was up and there was a sheet bunched up underneath R16's buttocks. The foot of the bed was uncovered and the mattress was exposed. On 4/7/26 at 12:28 PM, Surveyor observed R16 sitting up in bed for lunch. R16's mattress contained a flat sheet that was not secured to the top half of the mattress and was bunched up behind R16's lower back. A progress note indicated R16 was transferred to the hospital on 4/7/26 per R16's request. On 4/8/26 at 9:24 AM, Surveyor observed R16's room prior to R16's return from the hospital. R16's (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bed was in a flat position and contained linens. Surveyor noted the bottom sheet was a flat sheet for a regular sized mattress. On 4/8/26 at 9:28 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-R who indicated the facility has bariatric fitted sheets but it is hard to find them. CNA-R indicated staff put a flat sheet on R16's bed instead. CNA-R indicated the flat sheet doesn't always stay in place and staff have to adjust it because it falls off and gets tangled under R16. On 4/8/26 at 9:54 AM, Surveyor interviewed Housekeeper (HK)-S who was not aware where bariatric fitted sheets were stored or what they looked like. Surveyor and HK-S checked all 4 linen closets on one side of the facility and did not find any regular or bariatric fitted sheets. At 9:56 AM, Surveyor observed HK-S ask CNA-R where fitted sheets were located. CNA-R indicated the facility didn't have any fitted sheets. At 9:58 AM, Surveyor observed HK-S ask HSKM-F where bariatric fitted sheets were located. HSKM-F indicated they may be mixed in with other fitted sheets. When HK-S and Surveyor informed HSKM-F there were no fitted sheets on one side of the facility, HSKM-F stated Nursing Home Administrator (NHA)-A had ordered some that were white with yellow stitching. On 4/8/26 at 9:57 AM, Surveyor observed HK-S attempt to put a regular sized fitted sheet on R16's bariatric mattress. The sheet did not fit. On 4/8/26 at 10:00 AM, Surveyor and HK-S looked in 2 linen closets on the other side of the building but did not find any fitted sheets. HK-S asked another staff who directed HK-S to a white fitted sheet with yellow stitching at the end of the hall outside a resident's room. On the way back to R16's room, NHA-A approached Surveyor and HK-S and indicated NHA-A had ordered several blue bariatric fitted sheets. When HK-S and Surveyor indicated there were no fitted sheets in 6 linen closets or downstairs, NHA-A looked in the linen closets and found 4 blue bariatric fitted sheets and approximately 12 regular white fitted sheets in the last linen closet on the north side of the facility. HK-S and NHA-A put the bariatric fitted sheet on R16's bed. On 4/8/26 at 10:47 AM, NHA-A showed Surveyor that NHA-A had found 6 more bariatric fitted sheets. NHA-A indicated staff should use bariatric fitted sheets on bariatric beds. Dining: The facility's Dining Experience policy, revised 7/27/22, indicates: The dining experience will be person-centered with the purpose of enhancing each individual's quality of life and being supportive of each individual's needs during dining. Individuals will be provided with nourishing, palatable, attractive meals that meet daily nutritional, and/or special dietary needs and food preferences and are served at a safe and appetizing temperature .13. Individuals at the same table should be served and assisted at the same time. On 4/7/26 Surveyor observed lunch service beginning at 11:34 AM. Surveyor noted there were 23 residents in the dining room, including 9 tables of residents. Surveyor noted 4 of the tables had 1 resident each. The other 5 tables had between 2 and 6 residents. Surveyor labeled the tables 1 through 9 for documentation purposes. On 4/7/26 at 11:53 AM, Surveyor noted the first plate was brought to table 4 which had 2 residents. The resident ate their meal while their tablemate watched. The resident left the dining room at 12:05 PM. The second resident received their meal at 12:24 PM which was 31 minutes after the first (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident received their meal. On 4/7/26 at 12:18 PM, Surveyor observed 2 residents seated at table 2 who were a couple. The first resident received their meal at 12:18 PM. The second resident received their meal at 12:25 PM which was 7 minutes after the first resident received their meal. Surveyor interviewed the residents. The first resident indicated they wait for their partner to receive their meal before they eat so they can eat together. On 4/7/26 at 12:07 PM, Surveyor observed 6 residents seated at table 3. The first resident received their meal at 12:07 PM. Additional meals were brought for residents at 12:09 PM, 12:12 PM, and 12:13 PM. The last resident was served at 12:20 PM which was 13 minutes after the first resident received their meal. Surveyor noted the last resident to receive their meal at table 3 had become agitated while waiting. Staff indicated their meal would be brought soon and offered the resident another drink. On 4/7/26 at 12:06 PM, Surveyor observed 4 residents seated at table 7. The first resident received their meal at 12:06 PM. The resident ate their meal while their 3 tablemates watched. The first resident finished their meal and left the dining room at 12:15 PM. Additional meals were brought for residents at 12:16 PM and 12:18 PM. The last resident was served at 12:26 PM which was 20 minutes after the first resident received their meal. On 4/7/26 at 12:09 PM, Surveyor observed 6 residents at table 8. The first resident received their meal at 12:09 PM. The resident ate their food while their 5 tablemates watched. Additional meals were brought for residents at 12:17 PM and 12:19 PM. The last resident received their meal at 12:23 PM which was 14 minutes after the first resident received their meal. On 4/7/26 at 12:22 PM, Surveyor interviewed the last resident (R55) at table 8 to receive their meal who indicated R55 often waits to receive meals. R55 indicated R55 is not okay with waiting for food while others eat at the table. R55 indicated it is hard to watch others eat and not have food. (R55's medical record indicated R55 had intact cognition.) On 4/8/26 at 3:09 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated residents at the same table should be served their meals together. DON-B indicated dining room staff are supposed to submit table tickets together to the kitchen to ensure residents at the same table eat at the same time.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not follow ordered diets and menus to ensure nutritional needs were met for 11 residents (R) (R1, R47, R7, R27, R15, R41, R20, R11, R17, R14, and R4) of 11 sampled residents. Residents with pureed diets (R1 and R47) and mechanically-altered diets (R7, R27, R15, R41, R20, R11, R17, and R14) did not receive the ordered serving sizes for breakfast on 4/7/26 or breakfast and lunch on 4/8/26.Residents with pureed diets (R1 and R47) and mechanically-altered diets (R7, R27, R15, R41, R20, R11, R17, and R14) did not receive parslied noodles for lunch on 4/7/26. The residents received mashed potatoes instead.R7 did not receive mechanically-altered (L3/Advanced) meat for lunch on 4/6/26 and breakfast on 4/8/26. In addition, R7 did not receive Boost for lunch on 4/8/26.R14 did not receive a mechanically-altered diet (L2/Mech altered) for lunch on 4/6/26.R4's diet order included double portions of veggies and meat and half portions of starch. R4 did not receive a protein item for breakfast on 4/7/26. In addition, R4 did not receive a double portion of veggies for lunch on 4/6/26, 4/7/26, and 4/8/26.R1 did not receive a double portion of eggs for breakfast on 4/7/26 and did not receive a pureed dinner roll for lunch on 4/7/26.R15 did not receive a cookie for lunch on 4/7/26.R41 did not receive a double portion of eggs for breakfast on 4/7/26.R20 did not receive a mechanically-altered (L2) half cup of cottage cheese for lunch on 4/7/26.R17 did not receive a white bread slurry for lunch on 4/7/26.R47 did not receive a pureed dinner roll for lunch on 4/7/26.Findings include: The facility follows the National Dysphagia Diet as the standard of practice for all modified texture diets. The facility's Therapeutic Diets policy, revised 3/2026, indicates: All residents have a diet order, including regular, therapeutic, and texture modification that is prescribed by the attending physician, physician extender, or credentialed practitioner in accordance with applicable regulatory guidelines .Therapeutic diet is defined as a diet ordered by a physician, or delegated registered or licensed dietitian, as part of the treatment for a disease or clinical condition. The purpose of a therapeutic diet is to eliminate or decrease specific nutrients in the diet or to increase specific nutrients in the diet or to provide food that a resident can eat (mechanically-altered diet). Mechanically-altered diet means one in which the texture of the diet is altered. When the texture is modified, the type of texture must be specific and part of the physician's or delegated registered or licensed dietitian's order .Diets are prepared in accordance with the guidelines in the approved diet manual and the individualized plan of care . According to www.dysphagia-diet.com .Advanced level diets sometimes referred to as a mechanically-altered diet, require the modification of food textures to ensure safe swallowing. The goal is to modify the food's consistency to make it easier to manage in the mouth and swallow without causing choking or aspiration .a balance between safety and a palatable, varied diet. It's not simply about pureeing everything^ it's about carefully selecting and preparing foods to meet specific texture requirements .Level 2 Dysphagia Diet (L2) foods are not homogenous. They have texture to them. They may be finely minced or chopped, or soft, cooked and smashed through a fork. The food can be added to a food processor and pulsed until the pieces are very small .Level 3 Dysphagia Diet (L3) should be moist and easy to chew, with a consistency that allows for safe swallowing. The food should be small, bite-sized pieces to facilitate easier chewing and swallowing .This level food should be ground, moist, and in small pieces, these foods are easy to chew without much effort and are easier to move around with the tongue .Soft foods should always have extra moisture added to them (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	or on the side. This can be in the form of sauce (BBQ, dressing, marinara, etc.), gravy, butter, or any other option that tastes good with the food you are preparing. 1. On 4/6/26, Surveyor reviewed R1's medical record. R1 had diagnoses including dysphagia (difficulty swallowing) and type 2 diabetes. R1's Minimum Data Set (MDS) assessment, dated 3/9/26, had a Brief Interview for Mental Status (BIMS) score of 2 out of 15 which indicated R1 had severely impaired cognition. R1 had a court-ordered Guardian. A care plan, dated 1/30/26, indicated R1 was at risk for nutritional status change related to pressure wounds, noted confusion with variable intake, need for assistance with eating, and dysphagia requiring an altered textured diet. R1 was admitted to the facility on [DATE] and had had a 13.16% weight loss. The care plan contained the following interventions: provide diet as ordered; regular pureed texture with thin liquids with 2 servings of eggs in the AM, Greek yogurt at lunch, and cottage cheese at supper to supplement estimated protein needs; regular diet, L1/Puree texture, thin liquids in lidded cups; added calories at every meal to supplement: butter, 8 ounces (oz) juice, provide hot chocolate instead of coffee, extra Greek yogurt at breakfast, extra pudding at lunch, and extra fruit sauce at supper; will exhibit no weight loss; encourage food intake. 2. On 4/7/26, Surveyor reviewed R47's medical record. R47 had diagnoses including type 2 diabetes mellitus, severe protein-calorie malnutrition, and dementia. R47's MDS assessment, dated 2/25/26, had a BIMS score of 2 out of 15 which indicated R47 had severely impaired cognition. A care plan, dated 2/19/26, indicated R47 will exhibit no chewing or swallowing problems with current diet texture as evidenced by no signs/symptoms of aspiration, choking, or complaints of difficulty eating. 3. On 4/6/26, Surveyor reviewed R7's medical record. R7 had diagnoses including cancer and dementia. R7's MDS assessment, dated 2/23/26, had a BIMS score of 11 out of 15 which indicated R7 had moderately impaired cognition. R7's medical record included a physician order for a modified texture diet (L3/Advanced) with ground meats and Boost at every meal to assist in weight loss. A progress note, dated 3/17/26, indicated R7 received assistance from staff while eating cabbage and choking. The Heimlich Maneuver was performed and the cabbaged was dislodged. The note indicated Speech Therapy would evaluate R7's swallowing and diet recommendations. An investigation indicated R7's meal, including the cabbage, was cooked per R7's diet order. R7 had a physician order, dated 4/5/26, for an L3 diet with chopped meats and foods, extra gravy on the side at all meals, thin liquids, upright during meals, direct 1:1 supervision with all meals if family not present; assistance and cueing; may need to be fed; slow rate of intake; alternate between solid and liquids with meals (per Speech Therapy). On 4/6/26 at 10:18 AM, Surveyor interviewed R7 who indicated the food is not easy to chew at times. Surveyor noted R7 had several missing teeth. Unnamed Family Member (UFM)-I was present during the interview and indicated R7 had difficulty chewing and swallowing and required ground meats and soft food. UFM-I indicated R7 had recently worked with Speech Therapy on diet textures. R7 and UFM-I indicated R7 at times did not receive the correct diet texture for meals. R7 and UFM-I indicated R7 was given the wrong texture of foods and had a choking incident in which R7 received the Heimlich (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assessment, dated 3/4/26, had a BIMS score of 13 out of 15 which indicated R20 had intact cogntion. A care plan, dated 3/8/26, indicated R20 was at risk for nutritional status change related to anemia and recent chronic urinary tract infections (UTIs). The care plan indicated R20 had dental work in process and asked for a level 2 texture diet. The care plan contained interventions to honor food preferences - eggs with honey bun at breakfast is often R20's request; R20 is a cardiac regular diet but will request level 2 textured meals for lunch/supper with soup and cottage cheese for lunch; provide diet as ordered - cardiac with regular textures and thin liquids; family/R20 is asking for a temporary change of texture to level 2 due to dental work until May 2026. 8. On 4/7/26, Surveyor reviewed R11's medical record. R11 had diagnoses including Alzheimer's disease, dementia, and dysphagia. R11's MDS assessment, dated 4/4/26, had a BIMS score of 3 out of 15 which indicated R11 had severely impaired cognition. A care plan, dated 4/3/26, indicated R11 was at risk for nutritional status change related to Alzheimer's disease and dementia. The care plan contained interventions to provide additional calories/protein at meals per R11's preference; provide 2 tablespoons of peanut butter in hot cereal at breakfast, and one pad of butter to veggies at lunch; provide diet as ordered - Regular diet, L3/Advanced/chopped texture, regular/thin consistency. 9. On 4/7/26, Surveyor reviewed R17's medical record. R17 had a diagnosis of dysphagia. R17's MDS assessment, dated 1/14/26, had a BIMS score of 2 out of 15 which indicated R17 had severely impaired cognition. A care plan, dated 1/25/26, indicated R17 was at nutritional risk related to hypertensive heart disease with heart failure causing fluid shifts and dysphagia requiring altered texture diet and weight changes related to medication changes. The care plan indicated R17 would have no significant weight changes for 30 to 180 days and indicated R17 was on a Regular diet, L2/ Mechanical soft texture, regular/thin consistency. 10. On 4/6/26, Surveyor reviewed R4's medical record. R4 had a diagnosis of dysphagia. A care plan, dated 2/16/26, contained interventions to provide diet as ordered - cardiac, thin liquids; R4 wants double portions of veggies and meat; half portions of starch; Snack per R4's preference: high protein encouraged: Greek yogurt with fruit and sugar- free juice in the afternoons. On 4/6/26 at 10:34 AM, Surveyor interviewed R4 who indicated R4 does not receive the correct menu items or portion sizes and continues to receive incorrect items and portions sizes despite discussing the issue with staff. R4 indicated R4 doesn't know what R4 will receive and doesn't always eat what is served if it is not what R4 ordered. R4 indicated the food is either too much or not enough at times. 11. From 4/6/26 to 4/8/26, Surveyor reviewed R14's medical record. R14 had a diagnosis of pneumonia. R14's MDS assessment, dated 4/5/26, had a BIMS score of 14 out of 15 which indicated R14 had intact cognition. The assessment indicated R14 received a mechanically-altered diet. A care plan, dated 3/31/26, indicated R14 was on a consistent carbohydrate (CCHO) cardiac diet, had an L2/Mech altered texture and was able to have regular/thin liquids. A physician order, dated 3/31/26, indicated R14's diet was a CCHO cardiac diet, L2/Mech altered (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	texture with an 1800 ml fluid restriction. On 4/6/26 at 2:02 PM, Surveyor interviewed R14 who indicated the food was bad. R14's lunch ticket indicated R14 was on a fluid restriction of 1800 ml. The ticket indicated R14 should receive mashed potatoes with gravy, ground turkey with gravy, soft mixed vegetables, 8 oz of milk, 1 slurry piece of bread, and cherry pie filling. Surveyor noted R14's tray contained mashed potatoes with gravy, flaked turkey with gravy, mixed vegetables, milk, a red drink, and a red dessert R14 described as rhubarb/strawberry. During a continuous kitchen observation that began at 7:19 AM on 4/7/26, Surveyor observed [NAME] (CK)-G plate breakfast trays at the steam table. CK-G scooped two tablespoons of sausage, 2 oz (1/4 cup) of eggs, and 4 oz (1/2 cup) serving of oatmeal onto meal trays for R7, R27, R15, R41, R20, R11, R17, and R14 (who had L2/L3 textured diets). Surveyor noted R1 and R41 did not receive double portions of eggs. R4 received cereal and toast. Surveyor interviewed CK-G who indicated two tablespoons was the right serving size for L2, L3 and pureed diets and indicated the serving size looks like about one sausage patty on the plate. CK-G indicated Account Manager (AM)-K puts scoops in the steam table for serving eggs and oatmeal. Surveyor noted diet cards indicated the following serving sizes for residents with modified texture diets: ~ One ground sausage patty for L2/L3 modified texture diets ~ #16 (2 oz) scoop for sausage patty for pureed diets ~ #4 (8 oz) to equal a double portion of pureed eggs for R1 ~ #8 scoop (1/2 cup) eggs for L2/L3 modified texture diets ~ #6 (3/4 cup) oatmeal On 4/7/26 at 7:41 AM, Surveyor interviewed AM-K who stated CK-G put serving scoops in the breakfast items on the steam table. On 4/7/26 at 7:51 AM, Surveyor interviewed R4 who indicated R4 did not receive eggs for breakfast or a yogurt parfait as ordered. R4 also stated R4 did not receive a protein item for breakfast. During a continuous kitchen observation that began at 11:30 AM on 4/7/26, Surveyor observed District Manager (DM)-H put serving size scoops in lunch items on the steam table. Surveyor reviewed residents' meal tickets and noted the ordered serving sizes were as follows: ~ Pureed diet: #10 (3 oz) scoop for beef pot roast, wax beans, parslied noodles, and pureed dinner roll (R1 and R47) ~ L2/L3: #10 scoop (3 oz) for beef pot roast, 4 oz wax beans, half cup parslied noodles, 1 dinner roll for L3 (R7, R27, R15, and R41) and 1 dinner roll slurry (R20 and R11) Surveyor observed CK-G serve the following: (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	~ Pureed diet: Two tablespoons of pureed beef pot roast, 2 tablespoons of wax beans, #10 scoop of mashed potatoes. (Parslied noodles were not pureed for residents; R1 and R47 did not receive dinner rolls). ~ L2/L3: #16 (2 oz serving) scoop for beef pot roast, two tablespoons of wax beans, #8 scoop of mashed potatoes. (Parslied noodles were not mechanically-altered for residents; R20 and R11 did not receive a dinner roll or bread item). Surveyor also noted the following ordered menu items were not provided during lunch on 4/7/26: ~ R4's meal tray did not contain a vegetable or a half portion of carbohydrate. ~ R7 did not receive Boost. ~ R15 did not receive a cookie. ~ R20 did not receive a mechanically-altered (L2) half cup of cottage cheese. ~ R1 did not receive Greek yogurt. On 4/8/26 at 11:48 AM, Surveyor interviewed Registered Dietitian (RD)-C who confirmed R7 and R14 have orders for mechanically-altered diets and ground or minced and moist meat. RD-C verified staff made mistakes with textures, but indicated RD-C pointed out the errors to staff and felt staff were making improvements. RD-C provided education to kitchen staff on diet textures when RD-C noted diets were not being followed. RD-C instructed staff to read meal tickets to ensure the correct diet is served. RD-C indicated meal tickets contain a physician ordered diet and resident preferences to ensure residents receive the correct diet and ordered foods. RD-C verified R7 should receive Boost at all meals to ensure no further weight loss. RD-C indicated R7 had significant weight loss that had since become stable due to the addition of Boost three times daily. RD-C verified R1 should receive double portions of eggs at breakfast. RD-C stated due to R7's cancer diagnosis and R1's declining health and progressing dementia, some weight loss could be contributed to their diagnoses. RD-C also stated R7 and R41, as well as all residents who do not receive the correct portions or foods ordered to assist with weight loss, wound healing, diabetic management, and infection, could be affected negatively. RD-C indicated despite providing extensive education and being in the facility weekly, RD-C needs to spend time retraining staff during meal times on serving sizes and diet textures to ensure orders, meal tickets, and preferences are followed.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, staff and resident interview, and record review, the facility did not consistently obtain food temperatures to ensure food was served at safe and palatable temperatures In addition, the facility did not ensure residents on a pureed diet had meals prepared by a method that conserved the nutritive value. This practice had the potential to affect more than 4 of the 49 residents (R) residing in the facility. Kitchen staff did not appropriately temp food served to residents (including R43) and falsified temperature logs. As a result, food was not served at the correct temperatures. Kitchen staff did not follow a recipe during preparation of pureed food items to conserve or ensure the nutritive value. Findings include: The facility's Food: Quality and Palatability policy, revised 2/2023, indicates: Food will be prepared by methods that conserve nutritive value, flavor, and appearance. Food will be palatable, attractive, and served at a safe and appetizing temperature. Food and liquids are prepared and served in a manner, form, and texture to meet the resident's needs .1. Menu items are prepared according to the menu, production guidelines, and standardized recipes. The facility's Menus Policy Statement, dated 10/2022, indicates: Menus will be planned in advance to meet nutritional needs of the residents in accordance with established national guidelines .3. Menus will include standardized recipes. The facility's Food Temperatures policy, revised 8/16/22, indicates: The temperatures of all food items will be taken and properly recorded prior to service of each meal. 1. All hot food items must be cooked to appropriate internal temperatures, held, and served at a temperature of at least 135 degrees Fahrenheit (F) .2. All cold food items must be stored and served at a temperature of 41 degrees F or below .4. Foods should be transported as quickly as possible to maintain temperatures for delivery and service. If food transportation time is extensive, food should be transported using a method that maintains temperatures .6. Foods sent to the units for distribution (such as meals, snacks, nourishments, oral supplements) will be transported and delivered to unit storage areas to maintain temperatures at or below 41 degrees F for cold foods and above 135 degrees F for hot foods (to keep food out of the temperature danger zone) . 1. During an initial kitchen tour with Account Manager (AM)-K that began at 9:12 AM on 4/6/26, AM-K indicated AM-K often worked due to low staffing in the kitchen. During the tour, Surveyor noted food temperature logs were not filled out for multiple meals. Surveyor observed the March 2026 and April 2026 logs (there was one sheet for April, dated 4/4/26) and noted most days contained temperatures for only one meal and several days did not contain temperatures for any of the three daily meals. Surveyor noted the following: March 2026: ~ For 28 of 93 meal,s there were no temperatures doucumented for any food items. ~ For 82 of 93 meals, there were no temperaturess documented for pureed food items. ~ Of the 12 meals with pureed temperature documentation, only one meal had actual temperatures recorded. The other 11 meals had an arrow indicating the same temperature as whole food above it. ~ For 84 of 93 meals, there were no temperatures documented for hot/cold beverages. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	April 2026 (through survey date of 4/6/26): ~ For 16 of 18 meals, there were no temperatures documented for any food items. ~ For 18 of 18 meals, there were no temperatures documented for pureed food items. ~ For 18 of 18 meals, there were no temperatures documented for any hot/cold beverages. Surveyor interviewed AM-K who indicated it is not acceptable for staff to not take or document food temperatures. Surveyor and AM-K reviewed the logs together and noted only two meals were documented in April. AM-K did not know why staff were not taking or recording food and beverage temperatures and stated staff know they should do so. AM-K verified all food items need to be temped and documented, including mechanically-altered foods and beverages. On 4/7/26 at 7:19 AM, Surveyor observed food temperatures and meal service in the kitchen. Surveyor noted there were now April food temperature logs in the binder and each meal was filled out for 4/1 through 4/6. They temperatures appeared to be documented in the same handwriting with the same pen. Surveyor noted temperatures for 18 of 18 meals were documented, including beverages for most meals; however, there were no pureed food temperatures documented, just arrows. Surveyor noted a sheet started for 4/7/26 to record breakfast already contained 2 temperatures (bacon and sausage). Surveyor noted the steam table was full of food and [NAME] (CK)-G was already serving meals. Surveyor noted the temperatures log had not been filled out for the rest of the breakfast items even after breakfast service ended. On 4/7/26 at 7:23 AM, Surveyor interviewed AM-K who stated AM-K did not create new temperature sheets for April. AM-K indicated District Manager (DM)-H filled out the April temperatures logs the evening prior. AM-K indicated DM-H did not work all those days and did not take the temperatures. On 4/7/26 at 7:27 AM, Surveyor interviewed CK-G who stated CK-G did not document food temperatures for April. When Surveyor asked if CK-G had taken temperatures for the meal CK-G was serving, CK-G stated CK-G had not taken temperatures because AM-K took them before CK-G began serving. On 4/7/26 at 7:41 AM, Surveyor interviewed AM-K who indicated AM-K did not temp the food being served that morning because CK-G had done so. When Surveyor informed AM-K that CK-G did not temp the food and thought AM-K had done so, AM-K walked away from Surveyor and stated CK-G should have taken the temperatures. On 4/7/26 at 7:46 AM, Surveyor interviewed DM-H and indicated Surveyor had reviewed the March and April temperature logs on 4/6/26 with AM-K. DM-H verified DM-H put the April food temperatures on the logs and created the logs the evening prior. DM-H stated DM-H worked some of the days on the logs. When asked how DM-H obtained all the food temperatures that were not previously recorded and how DM-H remembered temperatures DM-H completed earlier that month, DM-H stated DM-H guestimated the temperatures. DM-H confirmed DM-H should not have recorded food temperatures for all of April the evening prior. DM-H verified food temperatures should be taken and recorded at the time of service. DM-H indicated DM-H needed to educate kitchen staff on taking and recording food temperatures. On 4/7/26 at 12:31 PM, Surveyor observed the food temperature logs and noted the lunch (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	~ Oatmeal - 142.1ˆ ~ Pureed sausage - 82.2ˆ ~ Pureed scrambled eggs - 85.2ˆ ~ Pureed pancake - 82.0ˆ ~ Coffee - 134.6ˆ ~ Milk - 49.6ˆ ~ Juice - 49.4ˆ Surveyors noted the hot food was below the 135ˆ required minimum temperature for 4 of 5 items (everything except the oatmeal). Surveyor noted the cold beverage temperatures were above the safe serving temperature of 41ˆ. On 4/8/26 at 8:27 AM, Surveyor interviewed CK-G who indicated slurried foods such as pancakes and French toast are not hot after CK-G pours cold milk on them. CK-G verified hot food should not be served cold. CK-G indicated if CK-G received food at that temperature, CK-G would not eat it and would probably send it back. CK-G verified residents complain about cold food. CK-G was aware residents were served frozen English muffins by AM-K a few days prior. CK-G stated the English muffins were frozen and AM-K put cooked eggs in them; however, residents complained they were cold. CK-G was unsure of the serving temperature for hot foods and thought it was 165ˆ for meat. On 4/8/26 at 8:33 AM, Surveyor interviewed DM-H who had observed staff make slurried food by pouring cold milk on it. DM-H indicated staff should use hot liquids for slurried food items. DM-H indicated staff should warm the milk first so the food is served hot. When asked if DM-H had educated staff about pouring cold milk onto slurried food, DM-H indicated DM-H had not. 3. On 4/6/26 at 10:18 AM, Surveyor interviewed R43 who indicated R43 had worked in food preparation and catering and the facility didn't know how to provide hot food to residents. R43 indicated all meals were delivered cold. R43 stated cold foods like milk were lukewarm when delivered. R43 stated R43 informed staff, but nothing changed and the food was still cold when delivered. R43 also stated the serving sizes seemed small. R43 did not want to keep asking Certified Nursing Assistants (CNAs) to reheat food or get more portions because the CNAs were overworked and understaffed. (R43's medical record indicated R43 had intact cognition.) On 4/7/26 at 7:19 AM, Surveyor interviewed R43 who stated dinner last night was good but was lukewarm. On 4/7/26 at 8:49 AM and 4:16 PM, Surveyor interviewed R43 who stated breakfast was good but was warm which was better than cool or cold. R43 indicated staff say they can reheat food; however, R43 does not ask because they are short staffed. R43 stated food is delivered on a cooling rack (like one for cooling bread and baked goods) covered in plastic and the cooling rack does exactly what it is supposed to do which is cool food. On 4/8/26 at approximately 8:30 AM, Surveyor tasted a tray that contained pancakes covered in milk (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to attain an altered texture. The pancakes were cold. 4. On 4/7/26, Surveyor observed breakfast service in the kitchen and noted the pureed food items varied in thickness and texture. The pureed French toast appeared thick and stiff and the pureed sausage had the consistency of yogurt. On 4/7/26 at 7:39 AM, Surveyor interviewed CK-G who indicated CK-G made the French toast by pureeing two slices of French toast, maple syrup, and hot water from the coffee machine. CK-G verified CK-G did not measure the water or syrup and just added what CK-G thought would work. On 4/7/26 at 7:41 AM, Surveyor interviewed AM-K who stated AM-K does not follow a recipe when preparing oatmeal. AM-K stated AM-K uses 3 or 4 cereal bowls of oats and 3 or 4 quarts of hot water. AM-K puts the oats and water in a steam table pan, stirs and covers the mixture, and lets the steam table cook and bring the oatmeal to temperature. On 4/8/26, Surveyor observed breakfast service in the kitchen and noted the pureed food items varied in thickness and texture. The pureed pancakes appeared thick and stiff. The pureed sausage had the consistency of applesauce. On 4/8/26 at 7:58 AM, Surveyor received a test tray with a slurried pancake, pureed pancake, pureed eggs, pureed sausage, and oatmeal. Surveyor tasted the pancakes which were thick and sticky. Surveyor noted fluid seeping onto the plate from the sausage which was spread out on the plate. On 4/8/21 at 8:21 AM, Surveyor interviewed CK-G who stated CK-G was not trained to use recipes for pureed, mechanically-altered, or slurried foods. CK-G stated CK-G prepares slurried food by pouring cold milk on the item and uses an approximate amount of water to puree food. CK-G indicated if there is a meal with meat and gravy, CK-G uses the gravy to puree food. When Surveyor asked how CK-G measures how much liquid to add to pureed and slurried food, CK-G indicated CK-G visually estimates the amount. At 8:23 AM, DM-H joined the interview with CK-G. Surveyor observed DM-H tell CK-G not to puree food with water because it takes away the nutritional value. DM-H told CK-G to use stock or juice to puree food. Surveyor interviewed DM-H who indicated staff should follow recipes to prepare all food, including pureed, mechanically-altered, and slurried food. When Surveyor asked to review the recipes for that day's meals, DM-H stated DM-H was working on the recipes which were vague. DM-H indicated all the recipes were not in the binder. When asked how staff should prepare meals with a recipe if all recipes aren't available, DM-H stated, Yeah. DM-H was aware staff do not measure the liquid poured onto slurried food and indicated DM-H needs to provide more staff education. On 4/8/26 at 12:11 PM, Surveyor interviewed Registered Dietitian (RD)-C who indicated staff should be aware of and follow the facility's food preparation and serving policies. RD-C indicated hot food should be served hot and cold food and beverages should be served cold. RD-C indicated staff should use and follow recipes for preparing and pureeing food. RD-C indicated staff should not use water to puree food, and should use broth for meat or other appropriate liquids. RD-C indicated using water to puree food can impact the food's nutritional value. On 4/8/26 at 3:04 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated kitchen and dining staff should be aware of and follow the facility's food preparation and serving policies. DON-B indicated hot food should be served hot and cold food and beverages should be served cold. DON-B indicated staff should use and follow recipes for preparing and pureeing food. DON-B indicated kitchen staff should obtain food temperatures and record them. DON-B indicated staff should not falsify documentation, including food temperatures.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interview and record review, the facility did not ensure meals were served at regular times and per resident preferences for 6 residents (R) (R39, R55, R18, R45, R46, and R43) of 7 sampled residents.During a Resident Council meeting on 4/7/26, R39, R55, R18, R45 and R46 stated they are not offered a snack before bedtime (HS) as preferred. R43 did not receive a diabetic snack at HS on 4/6/26.Findings include: 1. On 4/6/26 at 3:23 PM, Surveyor observed a cart in the 200 wing hallway with fruit, sandwiches, and various cracker snacks. Surveyor observed nursing staff enter rooms and offer snacks to residents. During a Resident Council Meeting conducted on 4/7/26 at 1:07 PM, R39, R55, R18, R45, and R46 indicated they are not offered a bedtime (HS) snack as preferred. The residents indicated they receive an afternoon snack between 3:00 PM and 3:30 PM but are not offered a snack at HS. R39 stated R39 was never offered an HS snack. R45 stated R45 was not offered a snack in the afternoon or at HS. R45 stated R45 was previously offered snacks and refused but would still like to be offered each time snacks are offered in case R45 wants one. On 4/7/26, Surveyor reviewed R39, R55, R18, R45, and R46's medical records and noted the following: ~ R39 was admitted to the facility on [DATE]. R39's Minimum Data Set (MDS) assessment, dated 1/23/26, indicated R39 had moderately impaired cognition. ~ R55 was admitted to the facility on [DATE]. R55's medical medical record did not contain cognition information. ~ R18 was admitted to the facility on [DATE]. R18's MDS assessment, dated 3/23/26, indicated R18 had moderately impaired cognition. ~ R45 was admitted to the facility on [DATE]. R45's MDS assessment, dated 4/7/26, indicated R45 had intact cognition. ~ R46 was admitted to the facility on [DATE]. R46's MDS assessment, dated 4/13/26, indicated R46 had intact cognition. On 4/8/26 at 11:48 AM, Surveyor interviewed Registered Dietitian (RD)-C who indicated RD-C was usually in the facility once per week but was recently in the facility more frequently due to changes in dietary staff. RD-C stated RD-C has been working with staff regarding diets to ensure residents receive nutrition as ordered. RD-C indicated HS snacks should be offered and provided to all residents daily. RD-C indicated kitchen staff provide the snacks so nursing staff can offer the snacks. RD-C indicated some residents are diabetic and have orders for specific snacks to be provided at HS. RD-C stated it is imperative residents with diabetes receive an HS snack to stabilize and manage their blood sugar. RD-C was not aware the kitchen is locked after kitchen staff leave for the day and nursing staff do not have access to snacks. RD-C indicated education was provided to staff that snacks need to be provided at HS. RD-C indicated RD-C's number one priority in regard to education (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	will be that HS snacks are provided since the current practice does not ensure residents are receiving nutrition as required. 2. From 4/6/26 to 4/8/26, Surveyor reviewed R43's medical record. R43 had a diagnosis of diabetes with neuropathy. R43's MDS assessment, dated 3/24/26, indicated R43's cognition was intact. A care plan, dated 3/18/26, indicated R43 was diabetic with neuropathy and had long-term use of oral hypoglycemics and insulin. The care plan contained interventions to consult dietary for nutritional regimen and ongoing monitoring; provide diet per MD orders; and report signs of low and high blood sugars. R43's medical record indicated R43 received insulin glargine 28 units every morning and at HS for diabetes with neuropathy (start date: 2/27/26). R43's blood sugar was checked every Wednesday. Over the last 4 months, R43 had a documented high of 260 milligrams (mg)/deciliter (dL) and low of 90 mg/dL. On 4/6/26 at 10:18 AM, Surveyor interviewed R43 who indicated R43 was diabetic and did not receive diabetic snacks at night anymore. R43 did not feel R43 was getting enough protein for a diabetic diet. On 4/7/26 at 7:20 AM, Surveyor interviewed R43 who stated R43 did not receive a diabetic snack the night before. On 4/7/26 at 4:28 PM, Surveyor interviewed Registered Nurse (RN)-Z who indicated RN-Z worked the PM shift for approximately 9 months. RN-Z stated most diabetic residents get snacks unless they refuse. RN-Z indicated the unit had a cart with crackers, cookies, apples, oranges, and bananas. RN-Z indicated residents ask for snacks or Certified Nursing Assistants (CNAs) check if residents want snacks. On 4/8/26 at 11:47 AM, Surveyor interviewed RD-C who stated RD-C sent specific snacks to the units for weight loss, wounds, or problems with diabetes. RD-C indicated CNAs should offer snacks to everybody. RD-C indicated snacks for diabetic residents include peanut butter sandwiches, crackers and cheese, cheesy crackers, cheese sticks, and sugar-free juice. RD-C was not aware residents were not receiving HS snacks but knew CNAs offered snacks right after dinner instead of waiting until HS. RD-C indicated RD-C had educated CNAs not to do that.

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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. Based on staff interview and record review, the facility did not maintain an infection prevention and control program designed to prevent the transmission of communicable disease and infection. This practice had the potential to affect more than 4 of the 49 residents residing in the facility. During March of 2026, the staff line list indicated one staff had a fever, one staff had vomiting, two staff had diarrhea, and two staff had vomiting and diarrhea. The facility allowed staff to return to work without identifying if or when their symptoms were resolved.Findings include:The facility's Infection Surveillance policy, revised 3/8/23, indicates: A system of infection surveillance serves as a core activity of the facility's infection prevention and control program. Its purpose is to identify infections and to monitor adherence to recommended infection prevention and control practices in order to reduce infections and prevent the spread of infections .Data to be collected, including how often and the type of data to be documented, includes: i. The infection site, pathogen (if available), signs and symptoms, and resident location, including summary and analysis of the number of residents (and staff, if applicable) who developed infections .Employee, volunteer, and contract employee infections will be tracked, as appropriate, such as influenza or gastrointestinal infection outbreaks.The Wisconsin Department of Health Services (DHS) online booklet Prevention and Control of Acute Gastroenteritis Outbreaks in Wisconsin Long-Term Care Facilities, dated 12/2017, indicates: .A staff illness policy should be developed and implemented, and all employees should be educated about the policy. The policy should clearly outline staff responsibilities for when and how to inform management of illness .and should outline the policy for returning to work (48 hours after signs and symptoms subside) .Staff should exclude themselves from resident care and food service duties at the onset of symptoms, including nausea, vomiting, abdominal pain, and/or diarrhea. Such exclusions shall remain in effect until the employee is asymptomatic and free of diarrhea and vomiting for 48 hours.The Wisconsin DHS memo Health Care Personnel (HCP) Exclusion and Return to Work Following an Acute Respiratory Illness, dated 11/10/25, indicates: .The purpose of this guidance is to prevent healthcare-associated transmission of respiratory viral infections by defining when HCP should be excluded from work and when they may safely return.HCP with respiratory virus symptoms.may return to work when all of the following are met: At least three full days have passed since symptom onset.and symptoms are improving, including being fever-free for 24 hours without fever-reducing medications, and the individual feels well enough to work.On 4/8/26, Surveyor reviewed the facility's March 2026 staff infection line list. The line list header titles included: Date of onset, name, identify resident or staff, room number, last day worked, area worked, fever, cough new or worsening, cough productive, runny nose or congestion, shortness of breath, new loss of taste or smell, headache, sore throat, muscle or body aches, nausea, vomiting (2 or more in 24 hours), diarrhea (more than 2 episodes in 24 hours above their norm), fatigue, date and time of last symptoms, well date, return to work (staff), and removed from precautions (residents). The form indicated the Director of Nursing (DON) would complete the date and time of last symptoms, well date, return to work (staff), and removed from precautions (residents) portions of the form.The March 2026 staff infection line list indicated one staff had a fever, one staff had vomiting, two staff had diarrhea, and two staff had vomiting and diarrhea and returned to work without documentation of the date and time of last symptom and/or well date in accordance with Wisconsin DHS recommendations.~ Certified Nursing Assistant (CNA)-L had a fever on 3/1/26 and returned to work without a date and time of last symptom, well date, or return to work date indicated on the line list. CNA-L also had diarrhea (more than 2 episodes in 24 hours above their norm) and returned to work without a date and time of last symptom, well date, or return to work date indicated on the line list.~ CNA-M had diarrhea (more than 2 episodes in 24 hours above their norm) and returned to work without a date and time of last symptom, well date, or return to work date indicated on the line list.~ CNA-N had nausea, vomiting (2 or more episodes in 24 hours), and diarrhea (more than 2 episodes in 24 hours above their norm). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA-N returned to work without a date and time of last symptom, well date, or return to work date indicated on the line list.~ CNA-O had cough new or worsening and vomiting (2 or more episodes in 24 hours). CNA-O returned to work without a date and time of last symptom, well date, or return to work date indicated on the line list.~ Registered Nurse (RN)-P had headache, vomiting (2 or more episodes in 24 hours), and diarrhea (more than 2 episodes in 24 hours above their norm). RN-P returned to work without a date and time of last symptom, well date, or return to work date indicated on the line list.On 4/8/26 at 10:21 AM, Surveyor Interviewed Infection Preventionist (IP)-Q who indicated IP-Q had not completed the staff infection line lists and had started the IP position in February of 2026. IP-Q indicated IP-Q was still learning and was scheduled to work 20 hours per week in the position. IP-Q indicated if the floor needs help, IP-Q's first priority is to work the floor as a staff nurse before completing IP duties.On 4/8/26 at 10:39 AM, Surveyor interviewed Director of Nursing (DON)-B who stated the IP completes staff infection line lists and indicated IP-Q should take the lead on completing the line lists. DON-B indicated if DON-B was sick, DON-B would call IP-Q to determine a return to work date. DON-B indicated Nursing Home Administrator (NHA)-A had been assisting with staff infection line lists since the previous IP left the position.On 4/8/26 at 11:03 AM, Surveyor interviewed NHA-A who indicated staff cannot return to work until 24 hours after a fever is resolved without the use of medication. NHA-A indicated NHA-A was not sure when the staff listed on the staff infection line list returned to work. NHA-A indicated RN-P's symptoms were related to the start of a new medication and RN-P wasn't actually ill. NHA-A verified the dates and times of last symptoms and well dates were not documented but should have been. NHA-A reviewed line lists dating back to August of 2025 and indicated none of the line lists were filled out accurately, including two months during that time period were no staff infections were documented.

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. Based on staff interview and record review, the facility did not ensure protective placement was obtained for 1 resident (R) (R1) of 2 sampled residents.R1 had a legal Guardian upon admission to the facility on 1/30/26. Protective placement in the facility was not obtained for R1.Findings include:State Statute Chapter 55.03(4) indicates the law requires court-ordered protective placement for any resident admitted to a nursing home who has a legal Guardian and whose nursing home stay exceeds ninety days (State Statute Chapter 55.055(b)). Protective placement is reviewed annually (State Statute Chapter 55.18) to determine if placement continues to be least restrictive and in the best interest of the individual.On 4/6/26, Surveyor reviewed R1's medical record. R1 had a diagnosis of dementia. R1's Minimum Data Set (MDS) assessment, dated 3/9/26, had a Brief Interview for Mental Status (BIMS) score of 2 out of 15 which indicated R1 had severely impaired cognition. R1 had a court-ordered Guardian (dated 2015).R1's medical record did not contain protective placement paperwork. On 4/7/26 at 2:50 PM, Surveyor interviewed Social Services Coordinator (SSC)-D who was not aware R1 required protective placement in the facility and confirmed R1 did not have protective placement. SSC-D did not know it was SSC-D?s responsibility to ensure protective placement was obtained and did not know whom to contact to obtain protective placement.

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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 staff and resident interview and record review, the facility did not report an allegation of abuse/neglect to the State Agency (SA) for 1 resident (R) (R5) of 23 sampled residents. R5 reported that Registered Nurse (RN)-T refused to change R5's wound dressing or cover a pressure injury on R5's buttocks multiple times after R5 was incontinent of stool. The facility did not report the allegation of abuse/neglect to the SA. Findings include: The facility's Abuse, Neglect and Exploitation policy, revised 7/15/22, indicates: .2. The facility will designate a leadership position in the facility who is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the State Survey Agency and other officials in accordance with state law .The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, State Agency, Adult Protective Services (APS), and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than two hours after the allegation is made, if the events that caused the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury .The Administrator will follow-up with government agencies to report the results of the investigation when final within five working days of the incident, as required by state agencies. Between 4/6/26 and 4/8/26, Surveyor reviewed R5's medical record. R5 was readmitted to the facility on [DATE] and had diagnoses including pressure ulcer of the right buttock stage 4, local infection of the skin and subcutaneous tissue, chronic ulcer of right lower leg, pressure ulcer of left heel stage 2, and anxiety. R5's Minimum Data Set (MDS) assessment, dated 3/30/26, had a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated R5 had moderate cognitive impairment. On 4/6/26 at 12:07 PM, Surveyor interviewed R5 who indicated R5 felt neglected or abused by a staff member a few weeks prior. R5 could not recall the date but indicated it was an overnight shift and R5 had diarrhea and several loose stools. R5 stated the Certified Nursing Assistants (CNAs), including CNA-L, did a great job of cleaning up R5. R5 stated R5 had an open pressure ulcer on the buttocks and was concerned about stool getting into the wound and causing an infection. R5 indicated the wound is normally covered, however, the bandage and wound were soiled with stool after each diarrhea episode. R5 stated R5 asked the CNAs and RN-T to cover the wound to protect it from feces and potential infection. R5 stated RN-T refused multiple times to cover the wound after the CNAs cleaned it. R5 stated RN-T indicated R5 would soil the bandage and wound again so there was no sense covering it. R5 asked CNA-L several times to ask RN-T again to cover the wound but RN-T refused. R5 stated R5 was brought to tears. R5 eventually asked CNA-L to cover the wound with a bandage even though R5 knew it was outside CNA-L's scope of practice. R5 stated R5 would take the blame for CNA-L doing something CNA-L wasn't qualified to do because R5 felt it was they only way to protect the wound from feces and infection. R5 reported the abuse/neglect from RN-T to Director of Nursing (DON)-B and Nursing Home Administrator (NHA)-A the next day. R5 stated NHA-A spoke with R5 but did not follow-up with R5. On 4/8/26, Surveyor requested the facility's investigation and State Agency report for the incident with R5 and RN-T. On 4/8/26 at 10:26 AM, Surveyor interviewed NHA-A who was aware of the incident reported by R5. NHA-A indicated the staff felt they shouldn't put a new dressing on the wound because R5 continued to have diarrhea. NHA-A was aware R5 asked CNA-L to put a dressing on the wound to protect it from infection. NHA-A stated NHA-A asked the AM shift nurse to appropriately dress the wound because RN-T did not cover the wound on the night shift. NHA-A confirmed NHA-A did not report the allegation of abuse/neglect to the SA. On 4/8/26 at 3:04 PM, Surveyor interviewed DON-B who indicated dressings should be changed after CNAs finish cleaning a resident following a bowel movement. DON-B verified R5's wound should be covered and confirmed physician orders should be followed. DON-B indicated potential abuse/neglect should be documented and reported to the SA.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interview and record review, the facility did not thoroughly investigate an allegation of abuse/neglect for 1 resident (R) (R5) of 23 sampled residents. R5 reported that Registered Nurse (RN)-T refused the change R5's dressing or cover a pressure injury on R5's buttocks after R5 was incontinent of stool multiple times. The facility did not thoroughly investigate the allegation of abuse/neglect. Findings include: The facility's Abuse, Neglect and Exploitation policy, revised 7/15/22, indicates: .The facility will designate a leadership position in the facility who is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the State Survey Agency and other officials in accordance with state law .An immediate investigation is warranted when an allegation or suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect or exploitation occur .The Administrator will follow-up with government agencies to report the results of the investigation when final within five working days of the incident, as required by state agencies. Between 4/6/26 and 4/8/26, Surveyor reviewed R5's medical record. R5 was readmitted to the facility on [DATE] and had diagnoses including pressure ulcer of the right buttock stage 4, local infection of the skin and subcutaneous tissue, chronic ulcer of right lower leg, pressure ulcer of left heel stage 2, and anxiety. R5's Minimum Data Set (MDS) assessment, dated 3/30/26, had a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated R5 had moderately impaired cognition. On 4/6/26 at 12:07 PM, Surveyor interviewed R5 who stated R5 felt neglected or abused by a staff a few weeks prior. R5 could not recall the date but indicated it was on the night shift when R5 had diarrhea and several loose stools. R5 stated the Certified Nursing Assistants (CNAs), including CNA-L, did a great job of cleaning up R5. R5 stated R5 had an open pressure ulcer on the buttocks and was concerned about stool getting into the wound and causing an infection. R5 indicated the wound was usually covered, however, but the bandage and wound were soiled with stool after each diarrhea episode. R5 asked the CNAs and RN-T to cover the wound to protect it from feces and potential infection. R5 stated RN-T refused multiple times to cover the wound after the CNAs cleaned it. R5 stated RN-T said R5 would soil the bandage and wound again so there was no sense covering it. R5 asked CNA-L several times to ask RN-T again to cover the wound but RN-T refused. R5 stated R5 was brought to tears. R5 eventually asked CNA-L cover the wound with a bandage even though R5 knew it was outside of CNA-L's scope of practice. R5 stated R5 would take the blame for CNA-L doing something CNA-L wasn't qualified to do because R5 felt it was the only way to protect the wound from feces and infection. R5 reported the abuse/neglect from RN-T to Director of Nursing (DON)-B and Nursing Home Administrator (NHA)-A the next day. R5 stated NHA-A spoke with R5 but did not follow-up with R5. On 4/6/26, Surveyor reviewed the facility's grievances which did not include a grievance from R5 regarding the incident with RN-T. On 4/8/26 at 10:26 AM, Surveyor requested the facility's investigation and the State Agency report related to the incident with R5 and RN-T. NHA-A stated NHA-A had a file started that was on NHA-A's desk. On 4/8/26 at 10:50 AM, NHA-A told Surveyor NHA-A could not find the investigation. NHA-A found a Medication Administration Record (MAR) for R5 and indicated the date of the incident in question was 3/5/26. NHA-A stated NHA-A needed more time to find the investigation file for the allegation of abuse/neglect. On 4/8/26, Surveyor noted R5's medical record did not contain progress notes regarding R5's diarrhea episodes, wound dressing, or the allegation of abuse/neglect reported by R5 and observed by CNA-L on 3/5/26. On 4/8/26 at 1:00 PM, NHA-A gave Surveyor the facility's investigation and indicated it was not a complete investigation. Surveyor reviewed a grievance form for R5, filled out by NHA-A and dated 3/6/26, that was not previously provided. The grievance indicated R5 complained that RN-T did not change R5's wound dressing after R5 had loose stools. The corrective action on the grievance included education to RN-T regarding changing wound dressings and infection control. The resolution indicated RN-T will cover the wound when R5 has loose stools. Documentation from NHA-A, dated (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/7/26, indicated NHA-A provided education to RN-T via phone on the infection risk of not covering the wound when stool is present. The investigation contained undated, signed education provided to CNAs regarding their scope of practice and job description. NHA-A indicated communication and follow-up with R5 was not documented. Surveyor noted the investigation did not contain resident or staff interviews or education to all nurses regarding wound care and infection control. The investigation did not contain education signed by RN-T or education regarding recognizing and reporting abuse/neglect. On 4/8/26 at 3:04 PM, Surveyor interviewed DON-B who indicated a wound dressing should be changed after CNAs finish cleaning up a resident who had a bowel movement. DON-B verified R5's wound should be covered and confirmed physician orders should be followed. DON-B indicated allegations of abuse/neglect should be documented and thorougly investigated.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on staff interview and record review, the facility did not ensure a care plan was revised for 1 resident (R) (R10) of 1 sampled resident.R10's care plan was not revised to include behavioral interventions following resident-to-resident altercations on 3/29/26.Findings include:The facility's Comprehensive Care Plan policy, revised 9/23/22, indicates: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with residents' rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment .This policy does not set the standard of care. The care and services provided to each resident are dependent on the individual resident and circumstances present at the time .3.The comprehensive care plan will describe, at a minimum, the following .resident-specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity, as indicated.On 4/7/26, Surveyor reviewed R10's medical record. R10 had a diagnosis of dementia with behavioral disturbance. R10's Minimum Data Set (MDS) assessment, dated 1/20/26, had a Brief Interview for Mental Status (BIMS) score of 5 out of 15 which indicated R10 had severely impaired cognition.Progress notes in R10's medical record, dated 3/29/26, indicated:~ R10 was observed pushing a resident down the hallway in a wheelchair. Staff separated the residents and redirected R10.~ R10 was observed pushing a resident (a different resident than the first incident) down the hallway in a wheelchair while stating, I have had it. R10 turned at the end of the hallway and positioned the resident in the wheelchair with the resident's knees against the wall. A Registered Nurse (RN) separated the residents and assessed the other resident for injuries with none noted. R10 indicated R10 was sick of the other resident talking down to R10 and not listening. Following the incident, R10 did not remember pushing the resident in the wheelchair and stated, I am angry. Surveyor reviewed R10's plan of care and noted it was not revised to include behavioral interventions following the resident-to-resident altercations.On 4/7/26 at 2:17 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who verified R10 was involved in a resident-to-resident incidents with two separate residents. NHA-A indicated R10 was initially placed on 15-minute checks, however, the checks were discontinued. NHA-A was not aware of revisions or interventions to R10's care plan following the incidents. At that time, [NAME] President of Success (VPS)-Y indicated VPS-Y did not see an intervention added to R10's care plan following the incidents and VPS-Y and NHA-A would investigate further.On 4/8/26 at 9:19 AM, Surveyor interviewed NHA-A who verified R10's care plan was not revised following the incidents on 3/29/26.

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interview, and record review, the facility did not provide the necessary care and treatment to prevent pressure injuries and/or promote healing for 2 residents (R) (R6 and R5) of 3 sampled residents. R6 had an order for a specialty air mattress set to R6's weight and to monitor the setting every shift. R6's air mattress was not set to the desired firmness to prevent pressure injuries. R5 had a pressure injury on the buttocks. Staff refused to dress R5's pressure injury to keep it free of feces and potential infection during multiple episodes of diarrhea. Findings include: The facility's Comprehensive Care Plan policy, revised 9/23/22, indicates: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident .8. Staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made. The facility's Clean Dressing Change policy, revised 1/19/26, indicates: It is the policy of this facility to provide wound care in a manner to decrease potential for infection and/or cross-contamination. Physician orders will specify type of dressing and frequency of changes .12. Cleanse the wound as ordered, taking care to not contaminate other skin surfaces or other surfaces of the wound (i.e., clean outward from the center of the wound). Pat dry with gauze .15. Apply topical ointments or creams and dress the wound as ordered. Protect surrounding skin as indicated with skin protectant 1. On 4/7/26, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] and had diagnoses including cerebral palsy, quadriplegia, seizures, and a gastrostomy. R6's Minimum Data Set (MDS) assessment, dated 3/15/26, had a Brief Interview for Mental Status (BIMS) score of 0 out of 15 which indicated R6 had severe cognitive impairment. R6 had a Guardian for medical decisions. R6's comprehensive care plan indicated R6 was at risk for alteration in skin integrity related to impaired mobility and incontinence. The care plan contained interventions to provide an air mattress set to R6's weight and check the function every shift. R6's medical record contained a physician order, dated 2/21/25, for an air mattress set to R6's weight and to check the function every shift. On 4/7/26 at 10:11 AM and 4/8/26 at 7:33 AM, Surveyor observed R6 in bed with the air mattress set at greater than 350, maximum firmness. On 4/8/26 at 10:01 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-J who verified R6's air mattress was set at greater than 350, maximum firmness. LPN-J was not familiar with R6's air mattress setting. After reviewing R6's orders, LPN-J verified R6's air mattress should be set at R6's weight and adjusted the air mattress to R6's weight which was 101 pounds (lbs). LPN-J indicated R6 was bed bound except for one hour a day when R6 was in a Geri chair. On 4/8/26 at 2:13 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated staff should (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	follow medical orders for R6's air mattress setting. 2. Between 4/6/26 and 4/8/26, Surveyor reviewed R5's medical record. R5 was readmitted to the facility on [DATE] and had diagnoses including pressure ulcer of the right buttock stage 4, local infection of the skin and subcutaneous tissue, chronic ulcer of right lower leg, pressure ulcer of left heel stage 2, methicillin-resistant Staphylococcus aureus (MRSA), and anxiety. R5's MDS assessment, dated 3/30/26, had a BIMS score of 11 out of 15 which indicated R5 had moderate cognitive impairment. R5's care plan, initiated 8/16/25 and revised 4/7/26, included a goal that R5's pressure ulcer will show signs of healing and remain free from infection. The care plan contained the following interventions: Administer treatments as ordered and monitor for effectiveness (8/16/25); Clean wound to right ischial (buttock) with normal saline, pat dry, put skin prep around wound, apply silver 7 (acticoat flex) to cover granulation tissue and bone, then green foam and wound vac. Two times weekly and PRN (as needed) if the green wound dressing is soiled or compromised . On 4/6/26 at 12:07 PM, Surveyor interviewed R5 who indicated R5 felt neglected or abused by a staff a few weeks prior. R5 couldn't recall the date but indicated it was on the night shift when R5 had diarrhea and several loose stools. R5 stated the Certified Nursing Assistants (CNAs), including CNA-L, did a great job of cleaning up R5. R5 stated R5 had an open pressure ulcer on the buttocks and was concerned about stool getting into the wound and causing an infection. R5 indicated the wound is usually covered, however, the bandage was soiled with stool after each diarrhea episode. R5 stated R5 asked the CNAs and Registered Nurse (RN)-T multiple times to cover the wound to protect it from feces and potential infection but RN-T refused. R5 said RN-T stated R5 would soil the bandage and wound again so there was no sense covering it. R5 asked CNA-L several times to ask RN-T again to cover the wound but RN-T refused. R5 stated R5 was brought to tears. R5 eventually asked CNA-L to cover the wound with a bandage even though R5 knew it was outside CNA-L's scope of practice. R5 stated R5 would take the blame for CNA-L doing something CNA-L wasn't qualified to do because R5 felt it was they only way to protect the wound from feces and infection. R5 stated R5 had to advocate for R5's self so R5 was not left lying in filth. R5 stated R5 used to have a wound vac and didn't want the wound to get that worse again. R5 reported RN-T's refusal to cover the wound to DON-B and Nursing Home Administrator (NHA)-A the next day. Surveyor reviewed R5's Medication Administration Record (MAR) and Treatment Administration Record (TAR) and noted the following order: ~ Clean right ischial buttock area stage 4 pressure ulcer with normal saline, pat dry, cover with collagen, calcium alginate then a foam dressing. Once daily every two days (Start date: 2/20/26) On 4/7/26, Surveyor interviewed CNA-L who recalled the night R5 had diarrhea. CNA-L indicated R5 had significant tunneling pressure wounds on the buttocks and had several bouts of diarrhea. CNA-L asked RN-T to dress R5's wound after CNA-L cleaned R5's buttocks; however, RN-T refused to clean and dress the wound. CNA-L indicated RN-T did not want to dress the wound and said R5 was going to have diarrhea and soil the dressing again. CNA-L asked RN-T to cover the wound multiple times during the shift but RN-T refused. CNA-L verified R5 asked CNA-L to dress the wound to cover it from feces and protect it from infection. CNA-L retrieved bandages from the closet and did CNA-L's best to cover the wound. CNA-L also indicated RN-T didn't dress the wound after R5 stopped having loose stools. CNA-L reported the issue to the AM shift nurses and asked them to dress R5's wound. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/7/26 at 4:06 PM, Surveyor left a message for RN-T who did not return the call. On 4/7/26 at 4:09 PM, Surveyor interviewed Confidential Staff (CS)-U who worked the morning after the reported incident. CS-U verified R5 reported that RN-T refused to dress and clean R5's wound. On 4/8/26 at 10:26 AM, Surveyor interviewed NHA-A who was aware of the incident reported by R5. NHA-A indicated the staff felt they shouldn't put a new dressing on the wound because R5 continued to have diarrhea and loose stools. NHA-A was aware R5 asked CNA-L to dress the wound to protect it from infection. NHA-A indicated NHA-A asked the AM shift nurse to appropriately dress the wound since RN-T did not cover the wound on the night shift. On 4/8/26 at 2:52 PM, Surveyor interviewed Wound Care Registered Nurse (WCRN)-V who indicated R5 had an open pressure wound on the buttocks that had improved but was still open. WCRN-V indicated the wound should be covered at all times. WCRN-V verified if R5 had a bowel movement, feces could get into the wound. WCRN-V indicated nursing staff should change a dressing any time it is soiled, any time a resident asks, and as ordered by the physician. On 4/8/26 at 3:04 PM, Surveyor interviewed DON-B who indicated a soiled wound dressing should be changed after staff finish cleaning up a resident after a bowel movement. DON-B verified R5's wound should be covered and confirmed physician orders should be followed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not ensure the resident environment remained as free of accident hazards as possible for 1 resident (R) (R10) of 1 sampled resident.R10 was at risk for falls and had multiple falls in the facility. R10's care plan contained interventions for increased supervision and to ensure R10 had shoes on in the dining room. The interventions were not consistently implemented. Findings include:The facility's Fall Prevention and Management Guidelines policy, revised 7/18/24, indicates: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized plan of care to minimize the likelihood of falls or reduce the possibility/severity of injury .The nurse will initiate interventions to help prevent falls on the resident's baseline care plan.The facility's Comprehensive Care Plan policy, revised 9/23/22, indicates: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with residents' rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment .The care and services provided to each resident is dependent on the individual resident and circumstances present at the time .8. Staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.On 4/7/26, Surveyor reviewed R10's medical record. R10 had diagnoses including dementia with behavioral disturbance, Parkinson's disease, unspecified protein calorie malnutrition, difficulty in walking, anxiety, pelvic muscle wasting, and low back pain. R10's Minimum Data Set (MDS) assessment, dated 1/20/26, had a Brief Interview for Mental Status (BIMS) score of 5 out of 15 which indicated R10 had severely impaired cognition. R10's medical record indicated R10 fell on [DATE], 11/14/25, 11/15/25, 11/16/25, 11/26/25, 12/22/25, 1/4/26, 2/2/26, 2/3/26, and 2/5/26.R10's care plan, initiated 1/13/25, indicated R10 was at risk for falls due to Parkinson's disease and dementia. The care plan contained interventions for more frequent checks (dated 9/28/25) and for R10 to wear shoes when in dining room (dated 1/5/26).On 4/6/26 at 12:03 PM, Surveyor observed R10 in the dining room for lunch with grippy socks on and no shoes.On 4/7/26 at 8:17 AM, Surveyor observed R10 in the dining room for breakfast with grippy socks on and no shoes.On 4/7/26 at 8:23 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-E who indicated R10 always wears grippy socks when walking and does not usually fall. CNA-E indicated shoes are required for falls prevention, however, shoes are not put on R10 because R10's feet swell and the shoes do not fit properly and cause pain. On 4/8/26 8:28 AM, Surveyor and Director of Nursing (DON)-B observed R10 in the dining room for breakfast with grippy socks on and no shoes. DON-B confirmed R10 should wear shoes when ambulating. DON-B was not aware R10's shoes did not fit properly and were not applied according to R10's care plan. DON-B confirmed increased supervision was an intervention added to R10's care plan following falls in November of 2025. DON-B indicated the root cause of R10's falls indicated R10 was walking without a walker. DON-B verified the intervention of increased supervision did not have measurable parameters or documented time intervals to ensure R10 was being adequately supervised and to ensure the intervention was working. DON-B confirmed R10's care plan interventions were not being implemented or reviewed to ensure they were appropriate and effective for R10.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on staff interview and record review, the facility did not ensure 1 resident (R) (R9) of 1 sampled resident received appropriate care and services after removal of a Foley catheter to prevent urinary retention and avoid infection.R9's Foley catheter was removed on 4/1/26. Staff did not monitor R9's urinary output as ordered by the physician.Findings include:The facility's Indwelling Catheter Use and Removal policy, revised 7/26/22, indicates: To ensure that indwelling urinary catheters that are inserted or remain in place are justified or removed according to regulations and current standards of practice.From 4/6/26 to 4/8/26, Surveyor reviewed R9's medical record. R9 had diagnoses including obstructive uropathy and diabetes. R9's Minimum Data Set (MDS) assessment, dated 3/16/26, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R9's cognition was intact.R9's medical record contained a physician order, dated 4/1/26, to discontinue R9's Foley catheter, monitor input and output, and reinsert the Foley catheter if R9 is unable to void or has low urinary output.R9's urinary output was documented each shift from 3/25/26 to 4/1/26. There was no output documented on 4/2/26. R9's urinary output was documented on 4/3/26 as 400 milliliters (ml) at 1:59 PM and 600 ml at 9:59 PM. R9's urinary output was doucmented on 4/4/26 as 300 ml at 1:59 PM. On 4/5/26 and 4/6/26, there was no output documented.On 4/7/26 at 12:03 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-X who indicated there should be a hat in R9's toilet to collect urine. LPN-X indicated if R9 was incontinent, the frequency of brief changes and the amount of saturation should be documented. LPN-X indicated LPN-X would notify the doctor and reinsert the Foley catheter if R9 had low or no output. LPN-X reviewed R9's medical record and verified staff hadn't consistently documented output. LPN-X indicated R9 had a mix of continence and incontinence. LPN-X stated if LPN-X was uncertain of output, LPN-X would monitor for abdominal distension and ask if R9 felt like R9 needed to urinate but was unable to. LPN-X could not determine at that time if R9 had decreased outputOn 4/7/26 at 1:53 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated staff would know if R9 had low or no output if R9 was heavily incontinent or if staff monitored the number of times R9 was incontinent. DON-B reviewed documentation of R9's urine output and could not determine if R9 had low or decreased urine output at that time. On 4/7/26 at 2:16 PM, Surveyor interviewed [NAME] President of Success (VPS)-Y who verified R9's urine output was not accurately documented and indicated R9 voided independently at times. VPS-Y indicated without parameters, it is difficult to follow the order. VPS-Y indicated it would be appropriate to complete an assessment and update the physician to get a different order or discontinue monitoring R9's urine output.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, staff and resident interview, and record review, the facility did not provide the necessary respiratory care and services for 1 resident (R) (R4) of 2 sampled residents.Staff did not clean R4's continuous positive airway pressure (CPAP) machine per manufacturer's instructions or facility policy. In addition, R4's medical record did not contain an order for use of a CPAP machine.Findings include:The facility's CPAP Therapy policy, revised 6/4/22, indicates: Continuous positive airway pressure (CPAP) is used to treat obstructive sleep apnea. The goals of this therapy include: improve ventilation, improve quality of sleep, decrease hospitalizations, improve cognitive function, improve oxygen saturation during sleep, decrease work of breathing, and improve lung compliance .Verify physician orders .Follow these steps for cleaning your CPAP patient circuit .wash your hands .Remove headgear from the mask or nasal pillows shell, disconnect mask or Shiley swivel and tubing with a soft cloth, gently wash mask or pillows with a solution of warm water and a mild clear liquid detergent .Rinse thoroughly. If mask still feels oily, repeat .allow mask or pillows to air dry. Do not place any supplies in the dryer .Wash tubing as necessary with a solution of warm water and a mild clear liquid detergent .rinse thoroughly and allow to air dry .According to the Air Fit ResMed Mask User Guide: Mask and headgear should only be handwashed by gently rubbing in warm water using mild soap. All components should be rinsed well with drinking quality water and allowed to air dry out of direct sunlight .Daily/After each use: Disassemble the mask components according to the disassembly instructions. Handwash the separate mask components (excluding headgear and soft sleeves). To optimize the mask seal, facial oils should be removed from the cushion after use. Use a soft bristle brush to clean the vent. Inspect each component and, if required, repeat washing until visually clean. Rinse all components well with drinking quality water and allow air to dry out of direct sunlight. When all components are dry, reassemble according to the reassembly instructions. Disposable filter to be replaced monthly.On 4/6/26, Surveyor reviewed R4's medical record. R4 had diagnoses including hypertensive heart disease with heart failure and dysphagia (difficulty swallowing), obstructive sleep apnea, and pneumonia (2/2026). R4's Minimum Data Set (MDS) assessment, dated 2/16/26, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R4 had intact cognition.A care plan, dated 1/12/26, indicated R4 had sleep cycle issues as evidenced by obstructive sleep apnea. The care plan contained an intervention for CPAP on at bedtime (HS) and off in AM. Surveyor noted the care plan did not contain an order or instructions for cleaning the CPAP machine or its parts.On 4/6/26 at 10:34 AM, Surveyor interviewed R4 and noted R4 had an Air Fit ResMed CPAP machine. R4 indicated R4 used the machine nightly and did not receive assistance with cleaning. R4 stated R4 had pneumonia and required hospitalization in February of 2026. R4 stated since admission to the facility in January of 2026, staff had not cleaned the mask or the tubing. Surveyor noted the mask was unclean.On 4/6/26, Surveyor requested CPAP orders for R4 from Nursing Home Administrator (NHA)-A.On 4/7/26 at 8:09 AM, Surveyor interviewed R4 who indicated staff had not yet cleaned the CPAP mask or tubing. Surveyor noted the mask was in the same unclean condition as the day before.On 4/8/26 at 8:33 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated prior to Surveyor's request for CPAP orders, DON-B was not aware R4 did not have an order for CPAP use. DON-B verified all residents who have CPAP machines should have orders for use and cleaning of the machine and/or its parts.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and staff interview, the facility did not ensure nurse staffing was posted daily. This practice had the potential to affect all 49 residents residing in the facility.The facility did not post the nurse staffing for all shifts on 4/6/26 or on 4/7/26 prior to the start of the AM shift.Findings include:Division of Quality Assurance (DQA) memo 12-020 Clarification Concerning Posting Requirements for Nurse Staffing indicates: Required Staffing Information .Nursing homes must post information about the number of staff directly responsible for resident care on each shift. This information must be posted in a prominent place, readily accessible to residents and visitors at the start of each shift. Facilities are not required to post staffing information on each floor, unless they choose to do so. The information that is posted must include the following .1. Facility name; 2. The current date; 3. The total number of staff directly responsible for resident care per shift for each of the following categories: Licensed (Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and unlicensed Certified Nursing Assistants (CNAs). (For example, 1 RN, 2 LPNs, 4.5 CNAs). The number of RNs must be separate from the number of LPNs; 4. The actual hours worked per shift for each of the following categories: Licensed (RNs, LPNs) and unlicensed (CNAs); 5. Resident census .Information is to be posted daily and must be present at the start of each shift. Nursing homes can choose to post staffing information for the entire day or for the current shift .Upon entrance to the facility on 4/6/26, Surveyor did not observe a nurse staffing posting in the facility.During environmental tours conducted on 4/6/26 at 9:24 AM, 10:31 AM, and 2:00 PM, Surveyor did not observe a nurse staffing posting in the facility.On 4/7/26 at 6:45 AM and 8:10 AM, Surveyor did not observe a nurse staffing positing in the facility.On 4/7/26 at 8:11 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated NHA-A had learned how to do the nurse staffing posting which would be posted shortly. NHA-A verified NHA-A was employed as the NHA since 4/2/25.