STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525362	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lafayette Manor	719 E Catherine St Box 167 Darlington, WI 53530

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure adequate supervision and safety to prevent accidents from occurring for 3 of 3 residents (R8, R42, and R44) reviewed for falls. R8 had a history of falls including one that resulted in a rib fracture. The facility did not complete a fall investigation, a thorough root cause analysis, or ensure that care planned interventions were appropriate and in place for R8.R42 had a fall that was not thoroughly investigated for a root cause and an intervention was not put in place to prevent further falls. The facility did not complete ongoing monitoring for R42 after his fall.R44 had a fall that was not thoroughly investigated for a root cause and an intervention was not put in place to prevent further falls.This is evidenced by:The facility policy Accidents and Supervision, dated 1/6/26, includes: The resident environment will remain as free of accident hazards as possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes: 1. Identifying hazard(s) and risk(s). 2. Evaluating and analyzing hazard(s) and risk(s). 3. Implementing interventions to reduce hazard(s) and risk(s). 4. Monitoring for effectiveness and modifying interventions when necessary. 1. Identification of Hazards and Risks- the process through which the facility becomes aware of potential hazards in the resident environment and the risk of a resident having an avoidable accident. a. All staff . are to be involved in observing and identifying potential hazards in the environment, while taking into consideration the unique characteristics and abilities of each resident. 2. Evaluation and Analysis- the process of examining data to identify specific hazards and risks and to develop targeted interventions to reduce the potential for accidents. b. Both the facility-centered and resident-directed approaches include evaluating hazard and accident risk data, which includes prior accidents/incidents, analyzing potential causes for each hazard and accident risk, and identifying or developing interventions based on the severity of the hazards and immediacy of risk. 3. Implementation of Interventions- using specific interventions to try to reduce a resident's risks from hazards in the environment. The process includes: a. Communicating the interventions to all relevant staff d. Documenting interventions (e.g., .care plans for the individual resident) e. Ensuring that the interventions are put into action f. Interventions are based on the results of the evaluation and analysis of information about hazards and risks. i. Resident-directed approaches may include: i. Implementing specific interventions as part of the plan of care ii. Supervising staff and residents, etc. iii. Facility records document the implementation of these interventions 4. Monitoring and Modification- Monitoring is the process of evaluating the effectiveness of care plan interventions. Modification is the process of adjusting interventions as needed to make them more effective in addressing hazards and risks. Monitoring and modification processes include: a. Ensuring that interventions are implemented correctly and consistently b. Evaluating the effectiveness of interventions c. Modifying or replacing interventions as needed d. Evaluating the effectiveness of new interventionsThe facility policy Fall Procedure, dated 1/26, includes: Staff shall assess for risk, provide preventative measures, and address falls in a safe and professional manner. Fall risk assessment: 2) Upon assessment, staff will provide needed intervention to prevent fall. Intervention is added to care plan. Fall incident: 1) When a (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	fall is discovered, floor nurse will complete an immediate initial evaluation of resident. Evaluation is to include: a. Head to toe check for injury b. Vital signs c. ROM (Range of Motion) of all extremities: note any deformities or changes from baseline. d. Pain check 2) All unwitnessed falls and noted head injuries on witnessed falls are to include neuro checks including: a. LOC (Level of Consciousness): note any change from baseline b. Pupil response c. Hand grasp: note change from baseline 3) Neuro checks and follow up is to be completed. 4) Fall is to be reported immediately to the charge nurse. Additionally, any changes in neuro checks should also be reported to charge nurse immediately. 7) Notify DON (Director of Nursing) and NHA (Nursing Home Administrator) 8) Documentation: a Fall note b. Neuro check (if applicable) c. Pain assessment d. Fall risk assessment e. Update fall care plan of immediate interventionExample 1:R8 admitted to the facility on [DATE] with diagnoses including dementia and need for assistance with personal care.R8's Brief Interview for Mental Status (BIMS) on 8/22/25 has a score of 10, indicating R8 has moderate cognitive impairment.R8's Fall Risk Evaluation, dated 8/19/25, has a score of 24, indicating R8 is at risk for falls.R8's comprehensive care plan includes:Focus: Potential for falls r/t (Related To) dementia, self care deficit, weakness, balance deficit, recent h/o (History Of) falls, incontinence, intermittent pain, medications received. Last revised on 5/26/24. Goals: resident will have tab and/or cushion alarm for safety r/t wandering and new fall. Last revised on 11/4/25. Interventions: Ensure bed is kept in lowest position (Initiated 6/12/24). Ensure call light is available to Resident (Initiated 6/12/24). If fall occurs, alert provider (Initiated 5/21/24). If fall occurs, initiate frequent neuro and bleeding evaluation per facility protocol (Initiated 5/21/24). Utilize devices as appropriate to ensure safety (i.e. bed mats, sensor alarms, etc.) Tab and/or pressure alarms and floor mat while in bed (Initiated and revised on 6/12/24). Assistive devices: Walker, manual wheelchair, and gait belt (Initiated and revised on 5/21/24)R8's nurse progress notes, dated 9/5/25 at 10:51 AM, written by RN G (Registered Nurse), states: Late entry for 9-4-25 at 0900 (9:00 AM) resident was headed to thpy (Therapy) session with thpy staff and had informed them earlier that he had missed sitting back down in w/c (Wheelchair) after going to the BR (Bathroom) and sat on the floor during the night around 0400 (4:00 AM). He stated night shift staff had assisted him and that he was not hurt and did not hit his head. Resident had vitals checked and WNL (Within Normal Limits). Will monitor for changes updated residents wife and Admin staff, and provider updated.Of note, R8's medical record does not have a fall report for R8's reported fall on 9/4/25. R8 did not have neuro checks completed. R8's reported fall was not thoroughly investigated to find a root cause and no interventions were put in place to prevent future falls.On 3/24/26 at 11:28 AM, Surveyor interviewed RN G regarding falls. RN G indicated if a resident falls there is a process to follow that includes assessing for injury, obtaining vital signs and neuro checks, and notification to DON, the provider and POA (Power of Attorney). RN G indicated if a fall is unwitnessed or a resident hits their head, neuro checks should be completed for 3 days along with monitoring for injuries every shift for 3 days. RN G indicated all the information should be documented in the resident's medical chart. Surveyor asked RN G what is the process if a resident reports a fall but staff did not observe it or assist the resident getting back up. RN G indicated if a resident reports a fall, staff should treat the report as an actual fall and follow the facility policy. Surveyor asked RN G about R8's 9/4/25 fall. RN G stated she thought it was hearsay and did not complete a fall investigation, neuro checks, or implement a new intervention. RN G indicated she did not treat R8's 9/4/25 report of falling as an unwitnessed fall but should have.On 3/25/26 at 11:22 AM, Surveyor interviewed DON B (Director of Nursing) about falls. DON B indicated if a resident reports a fall, the facility should treat that report as an actual fall and follow the facility's fall process. DON B indicated R8's reported fall on 9/4/25 should have been treated as an actual fall and was not. DON B indicated R8's fall was not thoroughly investigated, a root cause was not completed and no new interventions were put into place to prevent further falls. DON B indicated continued monitoring after R8's fall was not completed.R8's 9/9/25 fall report includes the following: Unwitnessed fall Date 9/9/25 13:15 (1:15 PM)Incident Location: Resident's roomIncident Description: Resident was found on the floor at the end of bed propted [sic] (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	up on his hand and knees and was alert. Housekeeper was staff person that saw resident as she was passing by the room door. Resident was able to be assisted back into w/c (Wheelchair) and nurse was informed of resident being on the floor and was then assessed. Neuro checks were initiated as fall was unwitnessed. BP (Blood Pressure) was elevated the first 3 of 15 min (Minute) checks. Resident has hypertension as diag (Diagnosis). Will relay this to provider. Resident Description: Resident told the staff housekeeper he was looking for his hat and then said he was trying to put on a jacket and looking for it. Immediate Action Taken: Neuro checks initiated and everything WNL (Within Normal Limits) except his BP was elevated x 3. BP now within parameters. A skin check was done and he had red abrasion areas on lower right posterior rib cage. Area palpated and he denied increased pain at any specific area with palpation but had general soreness of lower right rib. Offered to get a x-ray set up for rib but he declined and stated he wanted to wait until tomorrow to see how he feels. He doesn't think its fractured. Wife has been informed of same and she stated it is ok to wait on any x-ray and see how he feels later. Resident was given prn (As Needed) Tylenol for pain around 1415 (2:15 PM). Predisposing Environmental Factors: Other (Describe)Other Info: w/c has anti- roll brakes but one side wasn't fitting tight per resident. Maint (Maintenance) was informed to check for a repair.R8's nurse progress notes include:9/9/25 4:49 PM, Resident has been transported to the ER (Emergency Room) for eval (Evaluation) of right rib pain.9/9/25 9:53 PM, 1932 (7:32 PM) phone call from [Name] at the ER; she states that resident does have a right rib fracture. 2000 (8:00 PM)-resident returned to the nursing home.9/10/25 7:40 AM, Received the response from provider to continue to monitor resident s/p (Status Post) fall.9/10/25 2:53 PM, Resident has been participating in thpy sessions today and was able to propel self about in his w/c with some assist at times to use the bathroom and transfer in and out of bed. Had taken a prn pain med this morning with relief and was offered again but declined. Appetite was good for breakfast as he slept in until aprox [sic] 0900 (9:00 AM). He has been taking naps per his usual routine. 9/11/25 10:48 AM, Resident was up at usual time this morning and had c/o (Complaint Of) soreness/stiffness in right side but had a prn pain med at night that helped. He took prn Tylenol at breakfast and then went to thpy session. Mood is cheerful and he is more talkative today. 9/11/25 2:43 PM, Residents [sic] wife here to visit this afternoon and he is now out of room and socializing with staff. Given cup of coffee per request.On 3/23/26 at 8:20 AM, Surveyor observed R8 in his room, laying in bed. R8's bed height was not in the lowest position. R8 did not have floor mat in his room. R8 did not have a tab or pressure alarm in his room.On 3/24/26 at 10:08 AM, Surveyor observed R8's room and R8's Certified Nursing Assistant (CNA) Kardex. R8's CNA Kardex includes the fall interventions of ensure bed is kept in lowest position and tab and/or pressure alarms and floor mat while in bed. R8 did not have a floor mat in his room. R8's bed was not in the lowest position. R8 did not have a tab or pressure alarm.On 3/24/26 at 11:45 AM, Surveyor interviewed CNA H (Certified Nursing Assistant). CNA H indicated CNAs look at residents' CNA Kardex to determine interventions for fall prevention. Surveyor and CNA H observed R8's room. CNA H indicated R8's fall interventions were not in place. Surveyor and CNA H observed R8's bed was not in the lowest position, there was no floor mat and no alarms.On 3/25/26 at 10:47 AM, Surveyor interviewed DON B (Director of Nursing) about falls. DON B indicated if a resident falls, the staff should follow the facility's fall procedure which includes neuro checks for unwitnessed falls, assessing for injury, notifying the provider and POA. DON B indicated the IDT (Interdisciplinary Team) reviews the falls, looks at current interventions, implement new interventions and update the care plans with the changes. DON B indicated ongoing monitoring should be completed every shift for 3 days after a resident has a fall. DON B indicated if R8's fall on 9/4/25 would have been thoroughly investigated to find a root cause and interventions put in place, it may have prevented R8 from falling on 9/9/25.Example 2:R42 admitted to the facility on [DATE] with diagnoses including muscle weakness, dementia, and mild cognitive impairment.R42's Brief Interview for Mental Status (BIMS), dated 2/24/26, has a score of 12, indicating R42 has moderate cognitive impairment.R42's Fall Risk Evaluation, dated 11/28/25, has a score of 15, indicating R42 is at risk for falls.R42's comprehensive (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	care plan includes:Focus: Potential for falls r/t (Related To) dementia, TBI (Traumatic Brain Injury), weakness, balance deficit.(Initiated and revised 2/17/24)Interventions: Anticipate and meet the resident's needs (Initiated 2/17/24). Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove any potential causes if possible. Educate resident/family/caregivers/IDT (Interdisciplinary Team) as to causes (Initiated 2/17/24). Follow facility fall protocol (Initiated 2/17/24). Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed.(Initiated 2/17/24).R42's nurse progress note include:12/2/25 7:09 PM, Resident was found sitting on his buttocks on the floor propped against the bed. Resident stated he was trying to get in the bed. Denies hitting head, stated all I hit was the floor. Resident denies any pain at this time. No skin tears or bruises noted. Resident vitals 134/80, 90, 97.3, 18, 97% room air. Resident was educated on the importance of using the call light and voiced understanding. At 1839 (6:39 PM) administrator [Name] notified, 1850 (6:50 PM) residents POA [Name] notified. 12/3/25 3:23 PM, Resident was up at usual times today and able to propel self about unit in w/c (Wheelchair) with no new c/o (Complaint Of) pain. Vitals and neuro checks stable.Of note, continued monitoring of R42 after his fall was not documented. R42's assessments include Neurologic Focused Evaluation, dated 12/2/25 6:58 PM. Of note, the Neurologic Focused Evaluation contains one set of neuro checks.On 3/24/26 at 11:28 AM, Surveyor interviewed RN G regarding falls. RN G indicated if a resident falls there is a process to follow that includes assessing for injury, obtaining vital signs and neuro checks, and notification to DON, the provider and POA (Power of Attorney). RN G indicated if a fall is unwitnessed or a resident hits their head, neuro checks should be completed for 3 days along with monitoring for injuries every shift for 3 days. RN G indicated all the information should be documented in the resident's medical chart.On 3/25/26 at 10:47 AM, Surveyor interviewed DON B (Director of Nursing) about falls. DON B indicated if a resident falls, the staff should follow the facility's fall procedure which includes neuro checks for unwitnessed falls, assessing for injury, notifying the provider and POA. DON B indicated the IDT (Interdisciplinary Team) reviews the falls, looks at current interventions, implement new interventions and update the care plans with the changes. DON B indicated ongoing monitoring should be completed every shift for 3 days after a resident has a fall. DON B indicated R42's fall was not thoroughly investigated, a root cause was not completed and no new interventions were put into place to prevent further falls. DON B indicated continued monitoring after R42's fall was not completed.Example 3:R44 admitted to the facility on [DATE] with diagnoses including dementia, anxiety, and fracture of left and right femur.R44's Brief Interview for Mental Status (BIMS), dated 1/16/26, has a score of 0, indicating R44 is severely cognitively impaired.R44's Fall Risk Evaluation, dated 10/26/25, has a score of 10, indicating R44 is at risk for falls.R44's comprehensive care plan includes:Focus: Risk for falls (Initiated 7/16/25)Goal: Resident will be free of falls (Initiated 7/16/25)Interventions: Determine Residents ability to transfer (Initiated 7/16/25). If fall occurs, alter provider (Initiated 7/16/25).R44's Fall report includes:Un-witnessed fall Date 1/13/26 18:10 (6:10 PM)Incident Location: Dining RoomIncident Description: CNA (Certified Nursing Assistant) came and got nurse and resident was noted to be on the floor lying on her left side holding her head. Resident broda chair back wheels were off the ground and the resident calves were on the foot rest of chair. Resident is noted to have an egg size knot to the left upper forehead. When resident was asked if she was hurt she would reply with my head. Admin [Name], [Name] hospice and residents POA (Power of Attorney) [Name] notified. EMS (Emergency Medical Services) was called and report called into [Name] ER (Emergency Room). Immediate Action Taken: Description: Resident was assisted off the floor and into her chair, vitals were taken . Resident was taken to her room to be cleaned up. Predisposing Environmental Factors: NonePredisposing Physiological Factors: NonePredisposing Situation Factors: None(Of note: R44 had a fall that was not thoroughly investigated for a root cause, and an intervention was not put in place to prevent further falls.)On 3/25/26 at 10:47 AM, Surveyor interviewed DON B (Director of Nursing) about falls. DON B indicated if a resident falls, the staff should follow the facility's fall procedure (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	which includes neuro checks for unwitnessed falls, assessing for injury, notifying the provider and POA. DON B indicated the IDT (Interdisciplinary Team) reviews the falls, looks at current interventions, implement new interventions and update the care plans with the changes. DON B indicated ongoing monitoring should be completed every shift for 3 days after a resident has a fall. DON B indicated R44's fall was not thoroughly investigated, a root cause was not completed and no new interventions were put into place to prevent further falls.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interview and record review, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infection. This has the potential to affect the census (42).The facility staff line lists do not monitor specific symptoms.Evidenced by:The facility policy entitled Infection Surveillance, dated 1/05/26, states, in part: . Policy: 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.Definitions: Infection surveillance refers to an ongoing systemic collection, analysis, interpretation, and dissemination of infection-related data.Policy Explanation and Compliance Guidelines: .6. The facility will collect data to properly identify possible communicable diseases or infections among residents and staff before they spread by identifying: . i. signs and symptoms.13. Data to be used in the surveillance activities may include, but are not limited to: . i. Documentation of signs and symptoms in clinical record.The facility provided staff surveillance line lists for January 2026, February 2026, and March 2026. The line lists include vague symptoms.The January 2026 staff line lists show there were four staff call ins. The recorded symptoms on the line list includes: not feeling well, sick, and not feeling good.Of note: These are not specific symptoms for the facility to track and be able to determine return to work dates correctly.The February 2026 staff line list shows three staff called in with symptoms recorded as not feeling well and sick.Of note: These are not specific symptoms for the facility to track and be able to determine return to work dates correctly.The March 2026 staff surveillance list shows three staff called in with vague symptoms recorded as feeling sick, sick, don't feel well, and flu-like symptoms.Of note: These are not specific symptoms for the facility to track and be able to determine return to work dates correctly.On 3/25/26 at 9:54 AM, Surveyor interviewed IP I (Infection Preventionist) and asked should the facility be tracking specific symptoms on the staff and resident surveillance lists? IP I indicated yes. Surveyor reviewed the vague symptoms sick, not feeling well, and flu-like symptoms with IP I and asked if the symptoms were specific to illness. IP I indicated no. Surveyor asked if the facility would need specific symptoms to track illnesses and determine return to work dates. IP I indicated yes.On 3/25/26 at 10:49 AM, Surveyor informed NHA A (Nursing Home Administrator) of concerns with infection control. Surveyor reviewed the symptoms recorded on the staff line lists with NHA A. NHA A agreeable with needing specific symptoms to track illnesses and determine return to work dates for staff.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure other alternatives were tried prior to installing/utilizing bed rails, failed to accurately assess the risk of possible entrapment, failed to obtain informed consent for bed rails, failed to obtain physician orders for bed rails, failed to care plan the need and use of bed rails, failed to obtain risk versus benefits for bed rails, failed to measure the gap between the mattress and bed rails for entrapment, and failed to ensure the bed dimensions were appropriate for the resident's size and weight for 9 of 14 residents (R30, R17, R6, R5, R2, R27, R8, R42, R44) reviewed for bed rails. R30 did not have physician order's for bed rails, did not have measurements for gaps with the mattress and bed rails, did not have a bed rail assessment for entrapment, did not have proof of risk vs. benefits for bed rails, did not have ongoing monitoring or audits of bed rails, did not have alternatives tried prior to installing bed rails, there was no evidence that bed dimensions were based on resident's size and weight, no adherence to manufacturer's guidelines, and bed [NAME] were not included on R30's care plan. R2 did not have physician order's for bed rails, did not have measurements for gaps with the mattress and bed rails, did not have a bed rail assessment for entrapment, did not have proof of risk vs. benefits for bed rails, no ongoing monitoring or audits of bed rails, no alternatives tried prior to installing bed rails, no evidence that bed dimensions were based on resident's size and weight, no adherence to manufacturer's guidelines, and bed [NAME] were not included on R2's care plan. R27 did not have physician order's for bed rails, did not have measurements for gaps with the mattress and bed rails, did not have proof of risk vs. benefits for bed rails, no ongoing monitoring or audits of bed rails, no alternatives tried prior to installing bed rails, no evidence that bed dimensions were based on resident's size and weight, no adherence to manufacturer's guidelines, and bed [NAME] were not included on R27's care plan. R6 has grab bars on her bed. The facility did not attempt alternatives to the grab bar, assess for entrapment or risk versus benefits, or obtain consent for the use of grab bars. R8 has grab bars on his bed. The facility did not attempt alternatives to the grab bar, assess for entrapment or risk versus benefits, or obtain consent for the use of grab bars. R42 has grab bars on his bed. The facility did not attempt alternatives to the grab bar, assess for entrapment or risk versus benefits, or obtain consent for the use of grab bars. R44 has grab bars on her bed. The facility did not attempt alternatives to the grab bar, assess for entrapment or risk versus benefits, or obtain consent for the use of grab bars. R17 has grab bars on the bed. The facility did not have evidence of a safety assessment and the grab bars were not care planned. R5 has grab bars on the bed. The facility did not have evidence of an assessment, risk versus benefits and the grab bars were not care planned. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Example 1: Facility policy, titled, Proper Use of Bed Rails, dated 1/5/22 with last review date of 1/6/26, states, in part: Policy: It is the policy of this facility to utilize a person-centered approach when determining the use of bed rails. Appropriate alternative approaches are attempted prior to installing or using bed rails. If bed rails are used, the facility ensures correct installation, use, and maintenance of the rails. Policy Explanation and Compliance Guidelines: Resident Assessment: 1. As part of the resident's comprehensive assessment, the following components will be considered when determining the resident's needs, and whether or not the use of bed rails meets those needs: . b. Size and weight. h. Ability to toilet self safely; i. Cognition. k. Mobility (in and out of bed); l. Risk of falling. 2. The resident assessment must include an evaluation of the alternatives that were attempted prior to the installation or use of a bed rail and how these alternatives failed to meet the resident's assessed needs. 3. The resident assessment must also assess the resident's risk from using bed rails. Examples of the potential risks with the use of bed rails include: a. Accident hazards (e.g. falls, entrapment). 4. The resident assessment should assess the resident's risk of entrapment between the mattress and bed rail or in the bed rail itself. Informed Consent: 6. Informed consent from the resident or resident representative must be obtained after appropriate alternatives have been attempted prior to installation and use of bed rails. This information should be presented in an understandable manner, and consent given voluntarily. 7. The information that the facility should provide to the resident, or resident representative includes, but is not limited to: a. What assessed medical needs would be addressed by the use of bed rails; b. The resident's benefits from the use of bed rails and the likelihood of these benefits; c. The resident's risk from the use of bed rails and how these risks will be mitigated. 8. Upon receiving informed consent, the facility will obtain a physician's order for the use of the specified bed rail and medical diagnosis, condition, symptom, or functional reason for the use of the bed rail. Appropriate Alternatives: 9. The facility will attempt to use appropriate alternatives prior to installing or using bed rails. 10. Alternatives that are attempted should be appropriate for the resident. 11. If no appropriate alternatives are identified, the medical record should include evidence of the following: a. Purpose for which the bed rail was intended and evidence that alternatives were tried and were not successful. b. Assessment of the resident, the bed, the mattress, and rail for entrapment risk (which would include ensuring bed dimensions are appropriate for resident size/weight), and c. Risks and benefits were reviewed with the resident or resident representative, and informed consent was given before installation or use. Installation and Maintenance of Bed Rails: 12. The facility will assure the correct installation and maintenance of bed rails, prior to use. This includes: a. Checking with the manufacturer(s) to make sure the bed rails, mattress, and bed frame are compatible. b. Ensuring that the bed's dimensions are appropriate for the resident by: i. Confirming that the bed rails are appropriate for the size and weight of the resident using the bed; ii. Installing bed rails using the manufacturer's instructions and specifications to ensure a proper fit; iii. Inspecting and regularly checking the mattress and bed rails for areas of possible entrapment; iv. Ensuring the bed frame, bed rail and mattress do not leave a gap wide enough to entrap a resident's head or body. v. Checking bed rails regularly to make sure they are still installed correctly, and have not shifted or loosened over time. c. Observing ongoing precautions. and increasing resident supervision, especially with the use of air-filled mattresses or therapeutic air-filled beds that may present a different entrapment risk than rail entrapments. D. Conducting routine preventative maintenance of beds and bed rails to ensure they meet current safety standards and are not in need of repair. Ongoing Monitoring and Supervision: 15. The facility will continue to provide necessary treatment and care to the resident who has bed rails in accordance with professional standards of practice and the resident's choices. This should be evidenced in the resident's records, including their care plan, including, but not limited to, the following information: a. The type of specific direct monitoring and supervision provided during the use of the bed rails, (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R2 did not have physician order's for bed rails, did not have measurements for gaps with the mattress and bed rails, did not have a bed rail assessment for entrapment, did not have proof of risk vs. benefits for bed rails, no ongoing monitoring or audits of bed rails, no alternatives tried prior to installing bed rails, no evidence that bed dimensions were based on resident's size and weight, no adherence to manufacturer's guidelines, and bed [NAME] were not included on R2's care plan. On 3/23/26 at 7:53 AM, Surveyor observed R2 in her bed sleeping with side rails on her bed. On 2/23/26 at 12:33 PM, Surveyor attempted to interview R2 but R2 was unable to answer any questions about her bed rails. Example 3: R27 was admitted to the facility on [DATE] with diagnoses that include, in part Type 2 Diabetes Mellitus, Kidney transplant, Epilepsy unspecified, and Anxiety disorder. R27's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 1/6/26 indicates R27 has a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating, R27 is cognitively intact. Section GG of R27's MDS indicates that R27 is partially dependent on staff for all Activities of Daily Living (ADLs) including toileting hygiene, bathing, dressing, transferring, but is independent with rolling in bed from side to side. R27 was assessed on 3/7/26 to be at risk for falls. R27's bed rail assessment, dated 11/21/25, indicates that R27 has a history of falls, and that R27 displays poor bed mobility or difficulty moving to a sitting position on the side of the bed. Side rails/assist bar was indicated as enabler to promote independence. R27 did not have physician order's for bed rails, did not have measurements for gaps with the mattress and bed rails, did not have proof of risk vs. benefits for bed rails, no ongoing monitoring or audits of bed rails, no alternatives tried prior to installing bed rails, no evidence that bed dimensions were based on resident's size and weight, no adherence to manufacturer's guidelines, and bed [NAME] were not included on R27's care plan. On 3/23/26 at 11:13 AM, Surveyor observed R27 in her room with bed rails on her bed. R27 stated that she never signed a consent or been provided education on the risks and benefits of the use of side rails. Example 4: R6 was admitted to the facility on [DATE] and has diagnoses that include metabolic encephalopathy (an acute or subacute brain dysfunction caused by systemic illness, toxins, or organ failure rather than structural damage), abnormal posture, and unspecified dementia (when symptoms of cognitive decline- such as memory loss, impaired reasoning, and personality changes- are present, but the specific underlying cause has not been determined). R6's Progress Note, dated 1/02/26 12:36 PM, states, in part: .Resident had a witnessed fall. Jumped out of wheelchair while cna (certified nursing assistant) was wheeling her to the table in the dining room. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R6's Progress Notes, dated 1/02/26 02:55 AM, states, in part: .Resident had an unwitnessed fall. Resident's bed alarm went off only three beeps and when staff got to her room she was on the floor mat crawling; bed in low position, bed alarm on, and floor mat in place. On 3/23/26 at 11:00 AM, Surveyor observed grab bars on R6's bed. The facility was unable to find any risk and benefits for the grab bars. The facility did not have any documentation showing these grab bars were care planned or how they would be monitored to ensure safe and proper fit. Example 5 R8 admitted to the facility on [DATE] with diagnoses including dementia and need for assistance with personal care. R8's Brief Interview for Mental Status (BIMS) on 8/22/25 has a score of 10, indicating R8 has moderate cognitive impairment. On 3/23/26 at 8:20 AM, Surveyor observed R8's bed. R8 had grab bars on his bed. R8's medical record does not contain information on alternatives attempted prior to installing grab bars. R8 does not have an assessment for the grab bars. R8 does not have a risk versus benefits for the use of grab bars. R8 does not have consent for the use of grab bars. R8's comprehensive care plan does not include the use of grab bars. On 3/24/26, Surveyor asked NHA A (Nursing Home Administrator) for documentation regarding R8's grab bars. NHA A was unable to provide any documentation regarding R8's grab bars. Example 6 R42 admitted to the facility on [DATE] with diagnoses including muscle weakness, dementia, and mild cognitive impairment. R42's Brief Interview for Mental Status (BIMS), dated 2/24/26, has a score of 12, indicating R42 has moderate cognitive impairment. On 3/23/26 at 11:49 AM, Surveyor observed R42's bed. R42 had grab bars on his bed. R42's medical record does not contain information on alternatives attempted prior to installing grab bars. R42 does not have an assessment for the grab bars. R42 does not have a risk versus benefits for the use of grab bars. R42 does not have consent for the use of grab bars. R42's comprehensive care plan does not include the use of grab bars. On 3/24/26, Surveyor asked NHA A (Nursing Home Administrator) for documentation regarding R42's grab bars. NHA A was unable to provide any documentation regarding R42's grab bars. Example 7 R44 admitted to the facility on [DATE] with diagnoses including dementia, anxiety, and fracture of left and right femur. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R44's Brief Interview for Mental Status (BIMS), dated 1/16/26, has a score of 0, indicating R44 is severely cognitively impaired. On 3/23/26 at 11:57 AM, Surveyor observed R44's bed. R44 had grab bars on her bed. R44's medical record does not contain information on alternatives attempted prior to installing grab bars. R44 does not have an assessment for the grab bars. R44 does not have a risk versus benefits for the use of grab bars. R44 does not have consent for the use of grab bars. R44's comprehensive care plan does not include the use of grab bars. On 3/24/26, Surveyor asked NHA A (Nursing Home Administrator) for documentation regarding R44's grab bars. NHA A was unable to provide any documentation regarding R44's grab bars. Example 8 R17 was admitted to the facility on [DATE] and has diagnoses of hemiparesis and hemiplegia. R17 is also blind. On 3/23/26 at 11:26 AM, Surveyor observed grab bars affixed to the bed in R17's room. Facility documentation, dated 6/8/22, indicates R17 signed a risks and benefits for the bedrails. The facility was unable to find an assessment for the grab bars. Additionally, the facility did not have any documentation showing these grab bars were care planned or how they would be monitored to ensure safe and proper fit. Example 9 R5 admitted to the facility on [DATE] and has diagnoses that include malignant neoplasm of colon (Cancer). R5 is on hospice. On 3/23/26 at 10:16 AM, Surveyor observed grab bars affixed to the bed in R5's room while she was in it. The facility was unable to find an assessment or any risk and benefits for the grab bars. Additionally, the facility did not have any documentation showing these grab bars were care planned or how they would be monitored to ensure safe and proper fit. On 3/24/26 at 12:34 PM, Surveyor interviewed DON B (Director of Nursing) about the facility's bed rail process. DON B indicated that therapy will let them know that the resident might benefit from bed rails and then an order is requested from the physician. DON B stated that they also complete a bed rail assessment that is included in their chart. DON B indicated that once the order is received and assessment completed, then they let maintenance know to install the bed rails. Surveyor asked DON B if a risk versus benefits was discussed with the resident about bed rail entrapment. DON B stated that she had never done a risk versus benefits for bed rails. Surveyor asked DON B if an air mattress with bed [NAME] would increase a resident's risk for entrapment. DON B stated that she couldn't say if that was a potential risk and that she would have to look further into that. The facility did not ensure other alternatives were tried prior to installing/utilizing bed rails, failed to accurately assess the risk of possible entrapment, failed to obtain informed consent for bed rails, failed to obtain physician orders for bed rails, failed to care plan the need and use of bed rails, failed to obtain risk versus benefits for bed rails, failed to measure the gap between the mattress and bed rails for entrapment, and failed to ensure the bed dimensions were appropriate for the resident's size and weight for R30, R17, R6, R5, R2, R27, R8, R42, and R44.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not provide the proper discharge documentation for 1 of 1 resident reviewed for discharge (R4).The facility sent R4 to the emergency room (ER) on 10/28/25 and 11/19/25. The hospital admitted R4 to the hospital both times. R4 did not receive bed hold notices either time.Evidenced by:The facility policy entitled Bed Hold Policy, dated 1/06/26, states, in part: . Policy: It is the policy of this facility to provide written information to the resident and/or the resident representative regarding bed hold practices both well in advance, and at the time of, a transfer for hospitalization or therapeutic leave.Policy Explanation and Compliance Guidelines:1. As part of the admission packet and at the time of a transfer to the hospital or therapeutic leave, the facility will provide the resident and/or the resident representative written information that specifies:a. The duration of the State bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; b. The reserve bed payment policy in the state plan policy, if any.c. The facility policies regarding bed-hold periods to include allowing a resident to return to the next available bed.2. In the event of an emergency transfer of a resident, the facility will provide written notice of the facility's bed-hold policies to the resident and/or the resident representative within 24 hours.3. The facility will keep a signed and dated copy of the bed hold notice information given to the resident and/or resident representative in the resident's file and/or medical records. R4 admitted to the facility on [DATE] and has diagnoses that include Type 2 Diabetes Mellitus (a chronic condition where the body resists insulin or fails to produce enough, causing high blood sugars) and epilepsy (a chronic neurological disorder characterized by recurrent, unprovoked seizures caused by abnormal electrical activity in the brain).R4's Quarterly Minimum Data Set (MDS) Assessment, dated 1/10/26, shows that R4 has a Brief Interview of Mental Status (BIMS) score of 12 indicating R4 has moderate cognitive impairment. R4's Hospital Discharge summary, dated [DATE], states, in part: . admission: [DATE] D/C (discharge): 10/29/25. R4 presenting to the emergency room with confusion and difficulty swallowing.Surveyor conducted a review of R4's medical record. Surveyor could not locate any evidence that the facility provided R4 or their representative with the required bed hold notice information in writing at the time of the hospitalization transfer.Surveyor requested a bed hold notice for the hospitalization. NHA A (Nursing Home Administrator) returned to Surveyor and indicated the facility did not have the bed hold notice.R4's Hospital Discharge summary, dated [DATE], states, in part: . admission: [DATE]. History of Present Illness: . R4 was sent to the emergency room from nursing home with complaints of confusion, slurred speech and difficulty with swallowing that he noticed this morning.Surveyor conducted a review of R4's medical record. Surveyor could not locate any evidence that the facility provided R4 or their representative with the required bed hold notice information in writing at the time of the hospitalization transfer.Surveyor requested a bed hold notice for the hospitalization. NHA A (Nursing Home Administrator) returned to Surveyor and indicated the facility did not have the bed hold notice.On 3/25/26 at 11:25 AM, Surveyor interviewed NHA A who confirmed the facility did not provide the bed hold notice to R4 on 10/28/25 or 11/19/25 at the time of hospital transfer or after. Surveyor asked NHA A who is responsible for providing the bed hold notices to the residents or to the residents' representatives. NHA A indicated the nurses on the floor are responsible for providing the bed hold notices at the time of transfers. Surveyor asked NHA A if the facility should have provided the bed hold notices to R4 at each time of transfer. NHA A indicated yes.

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Lafayette Manor	719 E Catherine St Box 167 Darlington, WI 53530

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a person-centered comprehensive care plan to meet personal preferences and goals, or address the resident's medical, physical, mental and psychosocial needs for 1 of 14 residents (R30) reviewed for care plans.R30's care plan does not include a focus, goal, or interventions for fall risk.Evidenced by:The facility policy titled, Comprehensive Care Plans states, in part: Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident's rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality. Policy Explanation and Compliance Guidelines: 1. The care planning process will include an assessment of the resident's strengths and needs and will incorporate the resident's personal and cultural preferences in developing goals of care. 2. The comprehensive care plan will be developed with 14 days after the completion of the comprehensive MDS (Minimum Data Set) assessment. 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. 5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. 6. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. 8. Qualified 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.Example:R30 was admitted to the facility on [DATE] with diagnoses that include, in part, Huntington's Disease, Major Depressive Disorder, Anxiety Disorder, and Insomnia.R30's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 2/6/26 indicates R30 has a Brief Interview for Mental Status (BIMS) score of 2 out of 15 indicating, R30 has severe cognitive impairment. Section GG of R30's MDS indicates that R30 is totally dependent on staff for all Activities of Daily Living (ADLs) including eating, toileting hygiene, bathing, dressing, transferring and rolling in bed from side to side.R30 was assessed on 2/4/25 to be at risk for falls.A review of R30's nursing progress notes, includes the following:On 7/15/25: Resident was noted to be very restless early this morning per the night shift and then around 0645 (6:45 AM) staff were in to check on her and she had both legs over the edge of the bed on side closest to the hall door. Resident's torso was on bed yet so she was repositioned and this was reported to the hospice staff today when here and they have updated hospice staffing looking into continued use of the air mattress on bed. Was passed on to the oncoming shift to monitor for safety.Of note, nowhere in R30's comprehensive care plan does it include that R30 is at risk for falls or include any person-centered interventions to keep R30 safe from falling.On 3/25/26 at 12:17 PM, Surveyor interviewed CNA E (Certified Nursing Assistant) who stated that they are made aware of a resident's care by management telling them verbally or posting something in the report room. Surveyor asked CNA E if someone was a fall risk, should it be on their care plan. CNA E stated yes, falls should be on their care plan along with interventions for that resident.On 3/25/26 at 12:16 PM, Surveyor interviewed CNA K who stated that they are made aware of a resident's care through shift-to-shift report, or by the nurses, or by the care plans that are in the resident's rooms and in their online chart. Surveyor asked CNA K if someone was a fall risk, should it be on their care plan. CNA K stated yes, falls should be on their care plan.On 3/25/26 at 12:30 PM, Surveyor interviewed IP I (Infection Prevention Nurse) and asked about the facility's care plan process. IP I stated that the IDT (interdisciplinary team) are the ones who normally update a resident's care plan. Surveyor asked IP I (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	if a resident was assessed to be a fall risk, should that be included on their care plan. IP I stated yes, if someone was a fall risk it should be on their care plan.On 3/25/26 at 1:18 PM, Surveyor interviewed NHA A (Nursing Home Administrator) and asked about the facility's care plan process. NHA A indicated that the head of each department would be responsible for updating their part of the care plan. Surveyor asked NHA A if the resident's care plan should reflect their goals, preferences and needs. NHA A stated yes. Surveyor asked NHA A if the resident's care plan should include person centered interventions. NHA A stated yes. Surveyor asked NHA A if a resident who was assessed to be at risk for falls should have a fall risk care plan. NHA A stated yes, anyone who was considered a fall risk should have a section for falls on their care plan.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility did not ensure that the comprehensive care plan is reviewed and revised for 3 of 14 residents (R1, R8, R42). R8's care plan did not have safety interventions in place, had fall interventions in place that were no longer appropriate, and did not have fall interventions revised after a fall. R42's care plan did not have safety interventions in place and did not have fall interventions revised after a fall. R1 has an order for Prevalon boots to always be on. The facility did not add the order to R1's Care Plan. R1's Care Plan indicates R1 requires assistance with ambulation. R1 does not ambulate. This is evidenced by: The facility policy. entitled, Comprehensive Care Plans, dated 1/5/22, includes It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident. Other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will also be addressed in the plan of care. The comprehensive care plan will describe, at a minimum, the following: f. Resident specific interventions that reflect the resident's needs and preferences. The facility policy, entitled, Accidents and Supervision, dated 1/6/26, includes: Monitoring for effectiveness and modifying interventions when necessary. a. All staff . are to be involved in observing and identifying potential hazards in the environment, while taking into consideration the unique characteristics and abilities of each resident. 2. Evaluation and Analysis- the process of examining data to identify specific hazards and risks and to develop targeted interventions to reduce the potential for accidents. b. Both the facility-centered and resident-directed approaches include evaluating hazard and accident risk data, which includes prior accidents/incidents, analyzing potential causes for each hazard and accident risk, and identifying or developing interventions based on the severity of the hazards and immediacy of risk. 3. Implementation of Interventions- using specific interventions to try to reduce a resident's risks from hazards in the environment. The process includes: a. Communicating the interventions to all relevant staff d. Documenting interventions (e.g., .care plans for the individual resident) e. Ensuring that the interventions are put into action f. Interventions are based on the results of the evaluation and analysis of information about hazards and risks. i. Resident-directed approaches may include: i. Implementing specific interventions as part of the plan of care ii. Supervising staff and residents, etc. iii. Facility records document the implementation of these interventions 4. Monitoring and Modification- Monitoring is the process of evaluating the effectiveness of care plan interventions. Modification is the process of adjusting interventions as needed to make them more effective in addressing hazards and risks. Monitoring and modification processes include: a. Ensuring that interventions are implemented correctly and consistently b. Evaluating the effectiveness of interventions c. Modifying or replacing interventions as needed d. Evaluating the effectiveness of new interventions The facility policy, entitled, Fall Procedure, dated 1/26, includes: Staff shall assess for risk, provide preventative measures, and address falls in a safe and professional manner. e. Update fall care plan of immediate intervention. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy Abuse, Neglect and Exploitation, dated 3/18/26, includes: VI. Protection of Resident G. Revision of the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse. Example 1 R8 admitted to the facility on [DATE] with diagnoses including dementia and need for assistance with personal care. R8's Brief Interview for Mental Status (BIMS) on 8/22/25 has a score of 10, indicating R8 has moderate cognitive impairment. R8's comprehensive care plan includes the following interventions: Ensure bed is kept in lowest position (Initiated 6/12/24). Utilize devices as appropriate to ensure safety (i.e. bed mats, sensor alarms, etc.) Tab and/or pressure alarms and floor mat while in bed (Initiated and revised on 6/12/24).Assistive devices: Walker, manual wheelchair, and gait belt (Initiated and revised on 5/21/24).Chair/bed-to-chair transfer: Independent (Initiated 6/20/25). R8 has antiroll back brakes applied to his wheelchair as a fall prevention intervention. R8's care plan did not reflect this. R8 has interventions for a floor mat, bed in low position, and tab and/or pressure alarms. R8's care plan did not reflect this. On 3/24/26 at 11:45 AM, Surveyor interviewed CNA H (Certified Nursing Assistant) regarding care plans. CNA H indicated CNAs use the CNA Kardex to see what interventions a resident has in place. Surveyor asked CNA H about R8's care plan interventions. CNA H indicated R8 does not utilize these interventions. CNA H indicated R8 transfers independently. CNA H indicated if the floor mat was in place or if the bed was in a low position, it would increase the falling risk for R8. R8 had a fall on 9/4/25 and 9/9/25. R8's fall care plan was not revised with new interventions. On 3/25/26 at 10:40 AM, Surveyor interviewed DON B (Director of Nursing) regarding care plans. DON B indicated the IDT (Interdisciplinary Team) reviews and revises care plans as needed. DON B indicated the care plan should be accurate and reflect the resident's needs. DON B indicated R8's care plan was not revised as it should have been, and it is not accurate. Example 2: R42 admitted to the facility on [DATE] with diagnoses including muscle weakness, dementia, and mild cognitive impairment. R42's Brief Interview for Mental Status (BIMS), dated 2/24/26, has a score of 12, indicating R42 has moderate cognitive impairment. On 3/13/26 the facility initiated an investigation of an allegation of abuse. As a result of the investigation, the facility implemented interventions for R42. The facility placed a motion sensor at R42's bedroom door. The facility also educated the staff that R42 was not to be placed next to female residents when he is out of his room. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/24/26 at 10:02 AM, Surveyor interviewed CNA F (Certified Nursing Assistant) regarding interventions for R42. CNA F indicated R42 has a door motion alarm and is not to be placed by female residents when he is out of his room. On 3/24/26 at 10:27 AM, Surveyor interviewed RN G (Registered Nurse) regarding interventions for R42. RN G indicated when R42 is out of his room, he is kept at a distance from female residents. RN G indicated they do not sit R42 next to females in the dining room or lounge. R42's comprehensive care plan does not include these interventions. On 3/25/26 at 10:40 AM, Surveyor interviewed DON B (Director of Nursing) regarding R42. DON B indicated these safety interventions should be on R42's care plan but are not. R42 had a fall on 12/2/25. R42's fall care plan was not revised with new interventions. On 3/25/26 at 10:54 AM, Surveyor interviewed DON B regarding R42's fall care plan. DON B indicated R42's fall care plan was not revised with new interventions after his fall and the care plan should have been updated. Example 3: R1 was admitted to the facility on [DATE] and has diagnoses that include central spinal cord syndrome (incomplete spinal cord injury, characterized by disproportionately greater motor weakness in the upper extremities (arms/hands) compared to the lower extremities (legs)) and muscle weakness. R1's admission Orders, dated 9/5/24, states, in part: .Pressure Ulcer/Injury: Risk of Pressure Ulcers/Injuries- Yes.Prevelon boots at all times for pressure relief. *Note: R1's comprehensive care plan or CNA Kardex do not list R1's Prevalon boots to be on always as ordered. R1's Comprehensive Care Plan, dated 9/11/24, states, in part: . Focus: Risk for falls r/t (related to) central cord syndrome with significant physical limitations. Medications received, intermittent pain. Date Initiated: 9/11/24. Revision on: 9/28/24. Interventions: *Assist Resident with ambulation and transfers, utilizing therapy recommendations. Date Initiated: 9/11/24. R1's Physical Therapy (PT) Discharge summary, dated [DATE]- 12/24/25, states, in part: .Ambulation: Walk 10 Feet- not applicable. On 3/25/26, at 1:00 PM, Surveyor interviewed TD P (Therapy Director) and asked if R1 was ever able to ambulate. TD P indicated no. Surveyor read R1's Care Plan intervention: Assist Resident with ambulation and transfers, utilizing therapy recommendations. Date Initiated: 9/11/24 to TD P. TD P indicated therapy never made recommendations for R1 to ambulate. TD P indicated therapy never (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	attempted to ambulate R1 due to safety concerns and medical diagnosis. TD P indicated therapy had tried to stand R1 but that was never successful. TD P indicated R1 wants to walk but R1 cannot. On 3/25/26 at 1:29 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked when R1 is to have Prevalon boots on and if there was an order for the Prevalon boots. DON B brought Surveyor R1's admission orders to the facility. In the admission orders was the order for Prevalon boots to always be on. DON B indicated the staff had missed that order. Surveyor asked if the Prevalon boots should be on the care plan. DON B indicated yes. Surveyor asked DON B who is responsible for updating the care plans with new interventions and revising the interventions. DON B indicated everyone is. Surveyor asked if the intervention on R1's care plan indicating R1 requires assistance to ambulate per therapy recommendation is current. DON B indicated no, R1 cannot ambulate due to his legs/knees. DON B indicated the facility did not revise that intervention.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not ensure 1 of 1 resident (R7) who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for resident's experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. R7 has a diagnosis of Post Traumatic Stress Disorder (PTSD) and does not have a complete trauma assessment or a care plan addressing triggers, resident specific approaches, or interventions.Evidenced by:The facility policy entitled Comprehensive Care Plans, dated 1/06/26, states, in part: . Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality.Definitions: . Trauma-informed care is an approach to delivering care that involves understanding, recognizing, and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact, and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures and practices to avoid re-traumatization.Policy Explanation and Compliance Guidelines: .3. The comprehensive care plan will describe, at a minimum, the following: . g. Individualized interventions for trauma survivors that recognizes the interrelation between trauma and symptoms of trauma, as indicated. Trigger-specific interventions will be used to identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident. R7 admitted to the facility on [DATE] and has diagnoses that include PTSD (a mental health condition triggered by experiencing or witnessing terrifying events, causing symptoms like flashbacks, nightmares, severe anxiety, and uncontrollable thoughts about the event). R7's Social History Information form, dated 3/23/25, states, in part: . Additional Information: About 15 years ago she fell over a second story banister while on a ladder painting. Shattered her whole mid-section, several 20 hours + surgeries, 6 month stay at UW. Had to learn how to walk again.History of Trauma/Traumatic events: About 10 years ago she suffered a terrible seizure letting us know she had a large brain tumor. Since then, she has had 3 to 4 major brain operations, three sets of chemo and radiation. Potential Triggers: Bright and blinking lights can set off seizures for her. Surveyor reviewed R7's medical record and could not locate a trauma informed care assessment.Surveyor reviewed R7's Care Plan and the Certified Nursing Assistant (CNA) Kardex and found no focus areas regarding PTSD or PTSD interventions for R7's triggers.On 3/24/26 at 2:53 PM, Surveyor interviewed CNA L and asked if CNA L was aware of R7 having PTSD. CNA L indicated no. Surveyor asked CNA L if CNA L was aware of R7 having any triggers for PTSD. CNA L indicated no.On 3/24/26 at 2:55 PM, Surveyor interviewed CNA M and asked if CNA M was aware of R7 having PTSD. CNA M indicated no. Surveyor asked CNA M if CNA M was aware of R7 having any triggers for PTSD. CNA M indicated R7 just gets anxious and worries easily.On 3/24/26 at 2:58 PM, Surveyor interviewed LPN N (Licensed Practical Nurse) and asked LPN N if she was aware of R7 having PTSD. LPN N indicated no. Surveyor asked LPN N if LPN N was aware of R7 having triggers for PTSD. LPN N indicated no.On 3/24/26 at 3:03 PM, Surveyor interviewed SW O (Social Worker) and asked if SW O was aware of R7's diagnosis of PTSD. SW O indicated she was not aware. Surveyor asked SW O if she recalled completing a Trauma Informed Care Assessment on R7 on admission. SW O indicated no. Surveyor asked SW O what the facility process is for a resident admitted with a history of PTSD. SW O indicated at admission the facility completes a social history and PTSD is captured in there. SW O indicated with R7 being less vocal SW O worked with the family on the social history. SW O pulled up R7's Social History and reviewed the Traumatic event section with Surveyor. Surveyor asked SW O for a resident with a history of PTSD (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should there be a Trauma Informed Care Assessment completed on admission. SW O indicated the facility typically does not complete Trauma Informed Care Assessments. Surveyor asked SW O if the facility should be aware of PTSD triggers. SW O indicated if the triggers are related to the facility somehow yes. Surveyor asked SW O with a Trauma Informed Care Assessment not completed, how would the facility know what the triggers are. SW O indicated the facility does the triggers in the social history. Surveyor asked SW O if PTSD and triggers should be care planned. SW O indicated if triggers were something here like anxiety, depression, for veterans for loud noises. Surveyor asked SW O how staff would be aware of a resident with PTSD and the triggers. SW O said the social history is in the residents' medical records. Surveyor asked if staff on the floor would be looking through a resident's medical record. SW O indicated PTSD, and triggers should be on the CNA Kardex and on the care plans for CNAs and nurses to see. Surveyor asked if there was something on R7's care plan or CNA Kardex regarding PTSD and triggers and SW O indicated no.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on interview and record review, the facility did not establish an antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use for 3 of 5 residents (R50, R6, R27) reviewed for antibiotic stewardship.R50 was treated prophylactically with an antibiotic for prevention of urinary tract infections (UTI). The facility did not have an antibiotic stewardship conversation with the Provider regarding R50.R6 was treated with an antibiotic without a sensitivity completed to be able to identify what antibiotics would be susceptible to the bacteria.R27 was treated with an antibiotic that was not susceptible to the bacteria identified. Evidenced by:The facility policy entitled Antibiotic Stewardship Program, dated 1/05/26, states, in part: . Policy: It is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use.4. The program includes antibiotic use protocols and a system to monitor antibiotic use. a. Antibiotic use protocols: .ii. Laboratory testing shall be in accordance with current standards of practice. b. Monitoring antibiotic use: .ii. Antibiotic orders obtained from consulting, specialty, or emergency providers shall be reviewed for appropriateness. Example 1:R50 is on the January 2026 line list for a prophylactic antibiotic for UTI.R50's Physician Order, dated 12/15/25, states: Cephalexin (Keflex) 250 mg (milligrams) two times daily. Take BID (two times a day) for Uti prophylaxis (prevention).R50's December 2025 Medication Administration Record (MAR) shows R50 received Cephalexin 250 mg BID from 12/15/25-12/18/25. Cephalexin was stopped while R50 was treated with Ciprofloxacin for a wound infection.R50's January 2026 MAR shows R50 received Cephalexin 250 mg BID from 1/9/26-1/31/26.R50's February 2026 MAR shows R50 received Cephalexin 250 mg BID from 2/1/26-2/3/26.On 3/25/26 at 9:54 AM, Surveyor interviewed IP I (Infection Preventionist) and asked if it is appropriate to treat prophylactically with antibiotics. IP I indicated no. Surveyor asked IP I if there was a conversation with the physician regarding antibiotic stewardship. IP I looked and found no documentation. Surveyor asked IP I, if a physician chooses to treat prophylactically with an antibiotic should there be documentation showing the facility had a conversation regarding antibiotic stewardship. IP I indicated yes.Example 2:R6 is on the February 2026 line list for UTI. A positive urinalysis (UA) was collected on 2/09/26. A urine culture, dated 2/11/26, identifies bacteria >100,000 CFU (colony forming unit) per mL (milliliter) Aerococcus Urinae. There was no sensitivity (lab test to determine the most effective antibiotic for treatment). R4 was treated with Nitrofurantoin and Levaquin antibiotics.R6's February 2026 MAR shows R6 received Nitrofurantoin 100 mg (milligrams) BID (twice a day) from 2/5/26-2/17/26. R6 received Levaquin 500 mg daily from 2/18/26-2/27/26.On 3/25/26, at 9:54 AM, Surveyor interviewed IP I and asked if there was a sensitivity completed with R6's culture. IP I indicated she had called Health Information at the hospital on 2/23/26 and the Health Information informed IP I the sensitivity was not completed. IP I indicated R6 was treated with Nitrofurantoin, starting on 2/10/26 for four days. R6 was not improving. The physician then started her on Levaquin for 10 days. Surveyor asked IP I if R6 should have been treated with the Nitrofurantoin and Levaquin without having a sensitivity to show what antibiotics would treat the Aerococcus Urinae. IP I indicated no, there should have been a sensitivity completed prior to initiation of antibiotics.Example 3:R27 is on the March 2026 line list for a uti. R27's urine culture, dated 3/12/26, shows >100,000 CFU/mL (colony forming unit per milliliter). Enterococcus faecuim Vancomycin-Resistant and >100,000 CFU/mL Aerococcus urinae. R27 was treated with Ciprofloxacin for 7 days for uti. R27's sensitivity shows the following antibiotics are susceptible:-Daptomycin, Linezoid, Nitrofurantoin, and Tigecycline.*Note this does not include ciprofloxacin or antibiotics from Ciprofloxacin's class. Therefore, Ciprofloxacin would not be appropriate to treat the bacteria.R27's March 2026 MAR shows R27 received Ciprofloxacin 500 mg (milligrams) BID (twice a day) from 3/15/26- 2/21/26.On 3/25/26 at 9:54 AM, Surveyor interviewed IP I and asked if Ciprofloxacin was (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sensitive to the bacteria identified in R27's culture. IP I looked at the sensitivity list and indicated no. IP I indicated R27 should not have been treated with the Ciprofloxacin.